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Being Connected:
An exploration of women's weight loss experience and the implications for health education

By

Teresa Marion Burdett

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ABSTRACT
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BEING CONNECTED: AN EXPLORATION OF WOMEN'S WEIGHT LOSS EXPERIENCE AND THE IMPLICATIONS FOR HEALTH EDUCATION

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The focus of this thesis is the experience of intentional weight loss. There is a growing recognition that the rising levels of obesity are contributing to a global health problem. Although the costs and consequences of obesity for both individuals and societies are many; research in the field of obesity has so far failed to offer successful solutions to these problems. This thesis argues that the reason for this failure is that research has focused primarily on finding the causes of obesity and has ignored to a large extent the experiences of obesity and intentional weight loss. Furthermore, what little qualitative research that has been conducted into obesity and intentional weight loss tends to be short term and fails to follow participants for extended periods of time.

In order to address the perceived gaps in knowledge, this thesis adopts a qualitative approach, informed by phenomenology, to explore the experience of intentional weight loss. This thesis intends to explore the following research questions:

- What feelings or beliefs motivate individuals to start trying to lose weight and to continue trying to lose weight?
- What strategies do individuals employ to try to lose weight and what decisions, feelings or beliefs underpin or influence these strategies?
- What factors help or hinder individuals in their attempts to lose weight?

Ten overweight or obese women in the South of England were interviewed four times over the period of a year about their experiences of trying to lose weight. Semi structured interviews were used to explore weight loss goals and strategies; feelings and beliefs about losing weight and factors that help and hinder weight loss. The interview transcripts were analysed using Hycner's (1985) framework and an overarching theme of connectedness was identified linked to four key themes of self-sabotage, internal conflict, control and choice.

The results reveal wide variations across the ten participants in their motivations for losing weight, many of which are different to the reasons that health educators give for losing weight. The strategies that participants used to lose weight seemed to have less influence on weight loss than participants' beliefs regarding their chosen strategy and in their own ability. The majority of participants experienced a weight loss relapse. Explanations for these results are sought using two theories of mindfulness and intuitive eating. Implications for weight loss focused health education are considered and recommendations are made both for future health education practice and future research.

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and the work presented in the thesis are both my own, and have been generated by me as the result of my own original research. I confirm that:

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ACKNOWLEDGEMENTS

CHAPTER ONE: INTRODUCTION

Personal motivation for research into obesity and weight loss

The research reported in this dissertation stems from a professional and personal interest in the field of human change and weight loss, particularly why some individuals are able to change and adopt the healthier patterns of living they aspire to such as being slimmer, and why other individuals who appear equally as committed are unable to achieve their stated goal.

Professionally, I work as a health visitor in a primary care trust, and I have an interest in addressing obesity issues within my own locality. As a health professional, I am well acquainted with the medical aspects of obesity and being overweight. However, my personal experience leads me to believe that it is important to take a more holistic view and look not just at the medical aspects, but also the social and psychological factors involved in being obese or overweight and also the weight loss process.

In order to gain a more holistic view of obesity and the experience of trying to lose weight, the longitudinal research study reported in this thesis was designed to give the opportunity for the ten women who were the participants in this study, to have their voices heard and their experience, opinions and ideas listened to, whilst they were in the process of trying to lose weight. This can be an area that is often neglected by clinicians and researchers involved in the field of weight loss.

In this chapter I will discuss the definitions of obesity and overweight, the research problem, the causes and costs of obesity, the rationale for the study and the overarching research objectives the study will attempt to answer.

The definitions and measurements of obesity and overweight

Tools utilised to define obesity and overweight may vary according to researchers and practitioner's disciplines and backgrounds. However, to a medical clinician, health worker or educator the Body Mass Index (BMI) is frequently cited as the standard medical measurement of obesity (Shepherd, 2009; Wadden & Stunkard, 2002 and World Health Organisation, 1998). The BMI is defined as:

1

Clinical guidelines define overweight at Body Mass Index (BMI) of 25 to 29.9kg per m^2, while obesity is defined as a (BMI) of 30kg per m^2 (National Audit Taskforce, 2002).

Alternatives for measuring obesity include waist circumference, percentage body fat and population means. Increased abdominal obesity is associated with increased mortality (Nishida and Funahashi, 2009) and morbidity (Pi-Sunyer, 1993) when compared with individuals who have excess adipose tissue evenly spread or centred around their hip region. Researchers originally used waist to hip ratios to assess obesity, but recently waist circumference on its own has become the preferred approach (Aronne & Segal, 2002 and Wadden & Stunkard, 2002). Weight reduction is recommended when waist circumference is greater than 102cm in men and greater than 88cm in women, (90cm and 80 cm in the Asian population). A reduction in waist circumference is associated with a reduction in cardiovascular risk factors, and abdominal obesity is associated with insulin resistance and the development of type two diabetes. Waist circumference has been suggested as the basis for routine screening in primary care (Despres *et al.*, 2001), although Little & Byrne (2001) have argued that more evidence is needed before such a programme should be implemented.

Health care professionals also measure percentage body fat. This is because as health is mostly associated with fat rather than weight per se, researchers and clinicians have also developed methods of measuring percentage body fat directly. For instance, one method at it's most basic involves assessing skin fold thickness using callipers, normally around the upper arm and the upper and lower back (McLannahan & Clifton, 2008). This is not suitable for those individuals who are severely obese, as it misses abdominal fat (Wadden & Stunkard, 2002). It is also not very popular with the individuals trying to lose weight (Wadden & Stunkard, 2002). At a more advanced level, body fat can be measured using bioelectrical impedance, which involves passing an electrical current between a person's hand and foot. As water conducts electricity and fat is an insulator, the impedance of the current can be used to calculate the ratio between water and fat and therefore an overall estimate of percentage body fat can be made (Sattar & Lean, 2007). This method is primarily used in the research environment (Wadden & Stunkard, 2002), and very infrequently in the clinical or

primary care setting because it is not convenient for the patient and it can be time consuming.

The use of population means to define obesity involves exploring mean weights within a specific population and deciding whether someone is below average weight, average weight or above average in terms of percentage overweight for a given height. This approach is problematic as it depends on which population is being considered. For example, someone could be considered obese in India but not in America. It is therefore not used for adults but is still used for children as it enables the child's height and weight to be examined separately.

For the purposes of the study reported in this thesis obesity has been defined in relation to the BMI (see appendix 1 for a table of how BMI is calculated). Participants were eligible to be included in the study if they were three stone or more overweight. The BMI was used because it uses height and weight, two measurements most people are familiar with and can generally ascertain for themselves. Whilst most people are familiar with the BMI, it is recognised that individuals may define themselves in different and more meaningful terms (Barron-McBride, 1988) and it is these definitions that this study is interested in identifying as part of a wider exploration of how people discuss and feel about their body weight.

The Research Problem

The desire to explore the experience of intentional weight loss stems from the identification of three key problems. Firstly, there is recognition that there is a growing global health issue in terms of numbers and demographics of obesity. Secondly, that there is a growing acceptance in the field that researching the causes of obesity alone is not sufficient and that thirdly there is a growing awareness of the costs and consequences of obesity for individuals and for societies.

Obesity demographics

In addition to wide variations in the measurement and hence understanding of obesity, there are also wide variations in the estimates of how many people are overweight or obese. For instance, an estimate of the number of obese individuals in the world varies from fifteen to forty percent (Wilding, 1997). James *et al*., (2004) estimated that three hundred and twelve million are obese and the World Health Organisation reported "almost all countries (high-income and low income) are experiencing an obesity epidemic" (2002:61). To add to the disagreement and confusion; figures for obesity are often combined with figures for overweight (Hacking, 2007) and the terms overweight and obesity are often used interchangeably (Field *et al*., 2002) in the different types of literature although the two categories are not identical. Although, statistically as correct as they can be at the time of collection such estimated figures do not take into account the fact that obesity and overweight affects all ages and both genders in societies throughout the world and there are regional, gender and socio-economic differences (James *et al*., 2004).

There are also differences in obesity levels between continents, countries, and states or counties in the same country. The highest rates of obesity in the world are found in the Pacific islands. Prevalences of 80% in Nauru and 47% to 79% in Samoa have been reported (World Health Organisation, Samoa Report, 2000). In this area and others such as the sub-Saharan desert, the Gambia, Africa and Asia under-nutrition co-exists with rising rates of urban obesity (Waine, 2006 and Popkin & Doak, 1998). More than 64% of the United States adult population have a body mass index greater than 25kg/m^2 (National Centre for Health Statistics, 2000). There are disparencies in the Baltic States with women from Latvia and Lithuania being approximately three times as likely to be obese as those from Estonia (Pomerleau *et al*., 2000). Europe has lower rates of obesity, although there are regional differences (Livingstone, 2001). Sweden has lower rates of obesity than France whereas rates in Italy are rising rapidly (James *et al*., 2004). The rate of increase in England is higher though than in other parts of Europe (Scarborough & Allender, 2008). In fact, overweight has become usual, rather than unusual and the United Kingdom government's Foresight programme predicts that over half of the UK adult population could be obese by 2050 (McPherson *et al*., 2007). Furthermore, the most recent data from the health survey

for England shows that, in 2004 nearly a quarter of men (23.6%) and women (23.8%) were obese. These figures have been predicted in a recent report for the Department of Health to increase to approximately 50% in men and 33% in women by 2025 (NHS Information Centre for Health and Social Care, 2009).

There are variations in levels of obesity linked to a number of factors including gender. When considering the gender issue it would appear that currently more women than men are obese (Crowther, 2005 and World Health Organisation, Geneva, 2004). Women have a higher percentage of body fat than men. This increase in body fat for women is observed across many countries and seems stable across cultures and dietary habits (Bray, 1994). In the UK 24% of women and 21% of men were obese (Crowther, 2005). Although, regardless of their gender, obesity is lower in vegetarians and smokers (Fehily, 1999). However, there is a swing predicted which would appear to see this gender imbalance reversing as more men become obese than women by 2025 (NHS Information Centre for Health and Social Care, 2009).

There are a number of different ways to define socio-economic class but Pomerleau *et al*., (2000) used education as a class identifier and found that obesity was inversely related to education in Latvian and Lithuanian women. Lissner *et al*., (2000:801) also concurred on this point stating "The inverse educational gradient with respect to obesity is still present in both sexes". In the 2003 Health Survey for England significant health inequalities were revealed. In social-economic class one, 16% of individuals were obese compared to 62% of individuals who were obese in social-economic class five. In England the rise in obesity in children is particularly significant in the lower income groups.

One in five children in the United States of America are overweight (National Centre for Statistics, 2000). Other studies indicate higher rates of childhood obesity among certain populations such as Hispanic and African American and Native Americans (World Health Organisation, 2000). In New Zealand the rate of obesity is continuing to rise in children (Tyrrell *et al*., 2001). A 2004 Report by the Royal College of Physicians, the Faculty of Public Health and the Royal College of Paediatrics and Child Health estimated that based on current trends, twenty per cent of boys and thirty three per cent of girls will be obese by 2020.

It appears that an individual's ethnic origin does affect how their health is determined when they become obese. Asian populations are prone to higher morbidity as a result of obesity (Royal College of Physicians, Royal College of Paediatrics and Child Health and the Faculty of Public Health, 2004). However, in the Southern and South East region of the U.K. the numbers of individuals from black and minority groups are too small to make meaningful comparisons (Crowther, 2005). However, it would appear that although South Asian and Afro-Caribbean women are more likely to be obese they are less likely to rate themselves as obese (Pomerleau *et al*., 1999).

Multi factorial causes of obesity

It is not the intention of this research to discuss the causes of obesity in depth, which have been extensively researched elsewhere. Furthermore, a refocusing has been recommended by bodies including the Health Development Agency (2003:42) who advocated that researchers should:

> Redress the balance by focussing on research that assesses the actual effectiveness of interventions rather than the current research focus on measuring the prevalence and aetiology of obesity and overweight.

However, in order to set the scene and place this research in context it is noted that the causes of obesity are multi factorial (Ahearne-Smith, 2008) and range from the potentially extreme suggestion that "obesity is the result of modernity" (Hutton, 2002:1), to a more established and accepted explanation that although there are other indicative factors, a sedentary lifestyle and poor dietary patterns are significant factors in the development and continuance of obesity. A number of researchers including Cairns and Stead (2009), the World Health Organisation (Geneva, 2000; Samoa, 2000) and Grundy (1998), have concurred on these points including (Rippe *et al*., 1998:10):

> The aetiology of obesity is multi factorial. Genetic, environmental, metabolic and behavioural issues may all contribute to the development and progression of obesity…although lifestyle factors such as the over consumption of energy and decreases in physical activity offer more reasonable explanations.

The theories of the causes of obesity are varied, but tend to fall into two groupings: biological and social and economic.

A summary of the biological theories that may be the cause of the obesity.

The theories of obesity that are biologically based have tended to focus on metabolism, genetics and appetite control hormones. One metabolic theory of obesity that is now primarily outdated argued that the obese may have lower metabolic rates so that they burn up fewer calories. There was some tentative support for this suggestion (Ravussin, 1993 and Ravussin *et al*., 1988). However, most research now suggests that overweight people tend to have slightly higher metabolic rates than thin people of similar height (Garrow, 1987). They also tend to exert more energy for a given activity (Prentice *et al*., 1989). Although these views have not gone unchallenged (Astrup *et al*., 1999) it would appear that the slow metabolism theory is not upheld significantly by research. However, obese and overweight individuals may cite this theory as a reason for their size. This may well be a firmly held belief in some individuals and may affect their ability to change their weight related behaviours and perceptions.

Other theories focus on the influence of genetics. Obesity does appear to run in families. It has been identified by a number of studies (Grilo & Pogue-Geile, 1999 and Maes *et al*., 1997) that obesity and thinness follow family lines. Garn *et al*., (1981) for example, found that the probability that thin parents will produce overweight children is very small, about seven per cent. This observation has been repeated in studies exploring populations from different countries and living in different environments (Maes *et al*., 1997). Parents and children both share environment and genetic constitution, so this likeness could be due to either factor. To address this problem research has examined twins and adoptees.

Twin studies examined the weight of identical twins reared apart, which have identical genes but different environments. Studies have also examined the weights of non-identical twins reared together, who have different genes but similar environments. The results show that identical twins reared apart are more similar in weight than non-identical twins reared together. For example Stunkard *et al*., (1990) concluded that genetic factors accounted for 66-70 % of the variance in their body

weight, suggesting a strong genetic component in determining obesity, and stated that genetic influences on body weight were significant whereas the nurturing of the child had only a limited impact. Allison *et al*., (1996) also estimated the heritability of obesity in twins from the US, Finland and Japan and they concluded that 50 percent of the total variance found in BMI resulted from genetic factors. However, the role of genetics appears to be greater in lighter twin pairs than in heavier twin pairs.

Research has also examined the role of genetics in obesity using adoptees. Such studies compare the adoptees weight with both their adoptive parents and their biological parents. Stunkard *et al*., (1986) gathered information in Denmark about 540 adoptees, their adopted parents and their biological parents. The results showed a strong relationship between the weight class of the adoptee and their biological parents weight class, but no relationship with their adoptive parents weight class. This suggests a major role for genetics and was also found across the whole range of body weights. Interestingly, the relationship to the biological mother's weight was more significant than to the relationship to the biological father's weight. Recognising this, Stunkard *et al*., (1990) compared BMI and Stunkard *et al*., (1986) compared weight class and although slightly different measuring tools were used, both studies do indicate the strong role that genetics play in body weight.

Research into the genetics of obesity has continued and this was further investigated when it was found that there might be a genetic predisposition related to appetite control (Zhang *et al*., 1994). Research then focused on the protein hormone Leptin that is thought to inhibit eating and regulate energy expenditure (Taheri *et al.,* 2004). Research in this area is often on small samples and on children. However, it appears that too much or too little Leptin may result in weight gain and obesity (Farooqui *et al*., 1999). Recent studies have demonstrated a strong positive correlation of Leptin with body fat percentage (Friedman & Halaas, 1998).

Research therefore suggests a strong role for genetics in predicting obesity. However, exactly how this genetic predisposition expresses itself is unclear. Metabolic rate and appetite regulation are just two factors that may be influenced by genetics.

Social and economic causes of obesity

A number of factors appear to be contributing to what has been called an obesogenic environment (The House of Commons Select Committee Report, 2004 and Nestle & Jacobson, 2000) including: easy access to foodstuffs; increased reliance on eating out; increased use of vending machines; sedentary lifestyle; a change in work and hobby patterns; an increasing reliance on the motor car (World Health Organisation, 2000) and pedestrian unfriendly areas. Brownell (1994) and Horgen & Brownell (1998), have described this development as a 'toxic environment' whereas Egger & Swinburn suggest that obesity is "a normal response to an abnormal environment" (1997:477).

Increasingly in today's society access to high fat, processed foodstuffs (World Health Organisation, 2000), is readily available and at a relatively low cost (Squires, 2002 and Hill *et al.*, 2000). Over consumption has replaced malnutrition as the world's top food problem (World Health Organisation, 1998). Higher fat diets lead to increasing rates of obesity (Rissanen *et al.*, 2002 and French *et al.*, 2000) and also poorer health (Krebs-Smith, 1998).

Numerous studies such as the World Health Organisation (2000) and the Institute of Medicine Report (1995) indicate that individual's relative expenditure levels are decreasing due to a global lifestyle that is increasingly sedentary. Increasing numbers of energy saving devices are utilised in everyday home and work environments and motorised transport is relatively common. This is probably a key factor in an increasing worldwide population of overweight and obese individuals.

The costs of obesity

As well as obesity having multiple definitions and causes, obesity also has multiple consequences, for both the individuals and the society they belong to. For individuals obesity can have health, social and psychological costs (Fine *et al.*, 1999). For societies, obesity can have financial and economic costs; McCormack and Stone (2007), for example, predict yearly costs of £49.9 billion at today's prices, in the United Kingdom.

The cost to individuals

Being obese and overweight may significantly affect an individual's health as "it is a serious…health problem" (Field *et al.,* 2002:13). There is now a significant body of research to support this (National Audit Office, 2001 and Jung, 1997). Obesity is known to increase the risk of more than thirty medical conditions (Brownell & Horgen, 2004). Indeed obesity may prove to be one of the future greatest health threats to modern man. This may sound overly pessimistic but significant evidence now points to the continued advance of obesity (Department of Health, 2009a and NHS Information Centre, 2009) and to the potentially damaging consequences it may have on health (Cook, 2009 and the World Health Organisation, 1997):

> There is now extensive evidence that links excessive body weight with overall mortality…and…obesity is associated with the development of some of the most prevalent diseases of modern society (Jung, 1997:307).

In fact Sturm and Wells (2001) in a large study of nearly ten thousand American subjects compared the effects of overweight, smoking, heavy drinking and poverty on the occurrence of chronic medical conditions and physical health-related quality of life. The results were clear, obesity was more detrimental to health than smoking, drinking or poverty. The second Wanless Report (2004) in the United Kingdom recognised that obesity could be equal in importance to smoking as a determinant of future health.

Being obese or overweight is a precursor for a wide range of illnesses and conditions and affects all ages and both genders. Such diseases include:

- Cardiovascular Disease (Kopelman, 2007 and Eckel *et al.*, 2002).
- Hypertension (Kopelman, 2007 and Kearney *et al.*, 2005).
- Diabetes (Kopelman, 2007 and Boitard, 2002).
- Cancers (Dobson, 2009; Kopelman, 2007 and Lagergren *et al.*, 1999).
- Gallstones (Must *et al.*, 1999 and Stampfer *et al.*, 1992).
- Osteo-arthritis (Cooper *et al.*, 1998 and Cicuttini *et al.*, 1996).
- Benign Prostatic Hyperplasia (Giovannucci *et al.*, 1994).

- Obstructive Sleep Apnoea (Grunstein *et al*., 1995a and Grunstein *et al*., 1993a).

- Implications for fertility (Pettitt *et al*., 1988 and Pettitt *et al.,* 1983).

- Women with a body mass index of thirty or more have two to three times more post operative infections (Myles *et al*., 2002).

- Effects of maternal obesity on the foetus include: Foetal Hyper Insulinaemia (Hoegsburg *et al*., 1993) and Foetal macrosomia (Maresh *et al*., 1989).

Although the study reported in this thesis focuses on the adult's experience of trying to lose weight the health implications for children being obese or overweight is as significant as adults, if not more so:

- Childhood obesity increases the risk that the individual will be an obese adult (Freedman *et al.,* 2005a; Guo *et al*., 2000 and Power *et al*., 1997).

- Childhood obesity also increases the likelihood of morbidity and mortality in adulthood (Must *et al*., 1992 and Nieto, 1992).

- Increasing body fatness in children is associated with an increase in cardiovascular risk factors and cardiac abnormalities (Alpert, 2001 and Martini *et al*., 2001).

- Hypertension is also increasingly prevalent in obese children (Wolin & Petrelli, 2009; Sorof & Daniels, 2002 and Rosner *et al*., 2000).

- Type 2 diabetes, in one study 95% of the children diagnosed with type 2 diabetes were overweight or obese (Pinhas Hamiel *et al*., 1996).

The experience of obesity has been discussed in the research literature in relation to a number of psychosocial factors including stigma (Monoghan, 2005a) and discrimination. Wooley & Wooley (1983) argue that body weight is more stigmatised than "colour" because body weight is considered to be under voluntary control and "colour" is not. On the whole it appears that individuals who are obese view it negatively and perceive they are viewed disapprovingly by society because of their obesity (Puhl & Brownell, 2001 and Van der Wal & Thelen, 2000). This perception appears prominent for both children and adults (Lawson, 1980 and Monello & Mayer, 1963). For example, Dixey *et al*., (2001:209) posed the research question what

attitudes do English children have about fatness? Three hundred nine to eleven year olds were included in the study and the children clearly identified this negative perception about fat children:

> They'll be miserable for the rest of their lives…it's not a very good image if you are going around with a fat person…nowadays it's all on your looks.

The stigmatisation and negativity displayed to the obese and overweight person appears to be a multi-cultural phenomena. Although it is currently primarily confined to industrialised countries, it is spreading. Research studies from the USA, Australia, Canada, Brazil, Japan and the UK all concur. One quote from an Australian research study speaks volumes: "I would rather be size 10 than have straight A's" (Tiggemann *et al*., 2000:1).

Although obesity is a global issue it is at the individual, human level that it has the most impact. Discrimination it would appear is widespread (Strauss & Pollack, 2003 and Neumark-Sztainer *et al*., 1998). Individuals who are obese or overweight in today's modernised western and industrialised society are often pigeon holed, labelled and treated differently:

> Many negative stereotypes are associated with being overweight e.g. they are lazy, slovenly, dumb and their health problems are always their own fault (Barron-McBride 1988:9)

Other studies reveal the negativity associated with obesity (Latner & Stunkard, 2003; Neumark-Sztainer *et al*., 1998). In fact this stereotyping and discrimination is commonplace in the school and college setting (Pargaman, 1969 and Canning & Mayer, 1966) and also in the workplace setting (Roehling, 1999 and Pingitore *et al*., 1994).

The social and the psychological consequences of overweight and obesity are complex and linked to societal expectations of the individual and how these are absorbed into the obese individual's psyche. Individuals who are obese and overweight may have issues with altered self-esteem, their self-image and depression

and anxiety. A number of studies have reported that self-esteem and self-perception can be fundamentally affected by feeling too large (Strauss, 2000 and Miller & Downey, 1999). This lowered self-esteem can affect the individual in a number of ways:

> Being fat is going to kill me not because of the strain on my heart but because of the strain on my soul (Barron McBride, 1988:12).

In the reviewed literature overweight individuals were often unhappy with themselves, which resulted in both children (Young-Hyman *et al*., 2003) and adults having a negative self or body image. Weight related discontent is the most negative salient feature of negative body image (Cash *et al*., 1986). For example, in a study of African-American children, Young-Hyman *et al.,* (2003) investigated weight status, skin tone and peer teasing. The study results supported the relationship between increased weight status and decreased self-esteem and body image.

The costs to women

It would appear that the prevailing cultural and societal factors impinge more on women than men especially in industrialised countries (Davies *et al.,* 1996 and Tiggemann & Rothblum, 1988). This affects how women respond to their surrounding environment and how women attempt to control their bodies by eating and dieting practices:

> For many western women it is now "normal" to be on a diet whatever their body weight (Germov & Williams, 1996:100).

Body image appears to be a particular issue for women and is often attributed to cultural and media pressure. It is argued that the majority of women do absorb the multitude of messages that say, "to be thin is to be good" (French *et al*., 1995 and Striegel-Moore *et al*., 1986), and this consequently results in them feeling unhappy with themselves. "My body is fat, overworked, unattractive and out of proportion" (Boyd, 1989:48).

Studies have shown that individuals can feel very unhappy with their self-image if their bodies carry excess weight (Rosen, 1996 and Cash *et al*., 1986). However, in today's increasingly industrialised society that values physical looks highly, women in particular, can feel being obese impacts negatively on them (Grogan, 2007; Sarwer *et al*., 1998 and Regan, 1996). Self-image can therefore have a significant impact on the lives of individuals:

> Being overweight can be a terrible burden. How we look strongly influences how most of us feel and … for most of us being fat is the worst aspect of our lives (Shreeve, 2002:6).

Depression can be both caused and deepened by individuals' especially women feeling they are too big or fat and individuals' anxiety levels can be heightened because they feel they are too large especially in social situations and encounters. In both adults and children, negative self-feelings are induced by obesity (Ruxton, 2005 and Zametkin *et al*., 2004).

In an American nationally representative sample of 32,000 persons, aged between 25 and 74, Istvan *et al*., (1992) found a positive if weak correlation between body mass index and symptoms of depression in women, as measured by the Centre of Epidemiological Studies Depression Scale (Radloff, 1977). In a later study, Carpenter *et al*., (2000) used a structured interview to establish a diagnosis of major depression in an American nationally representative sample of 40,289 persons. They found that obese women, as defined as having a body mass index greater than 30kg/m^2, were 37% more likely to have experienced a major depression in the last year than were average-weight women. Obese women were more likely to report suicidal ideation and suicide attempts (Carpenter *et al*., 2000). By contrast, for men, obesity was associated with significantly reduced risks of major depression and suicide attempts.

Studies clearly suggest that excess weight has different psychological consequences in females and males in the general population (Striegel-Moore, 1993 and Polivy & Herman, 1985). Women and teenage girls appear to be particularly vulnerable to symptoms of low self esteem and depression when they fail, in their own eyes, to measure up to the thin ideal that haunts them. Women of upper middle to upper socio-

economic status would appear to be particularly vulnerable to weight related distress given the greater social sanctions against obesity at these socio-economic levels (Sobal & Stunkard, 1989). Other specific subpopulations may be more vulnerable to depression related to obesity such as binge eaters, obesity treatment seeking populations and certain social strata groups (Musante *et al*., 1998 and Kuehnel & Wadden, 1994). Some have suggested that women from ethnic minorities may be protected against such adverse effects because they do not appear to seek figures as thin as those desired by European American women (Fitzgibbon *et al*., 2000). Results, however of the Carpenter *et al*., (2000) study showed the same relationship between obesity and depression in African American women as in European American women when socio-economic status was controlled for.

Consequently, women more often than men perceive societal negativism due to their size (Himes & Thompson, 2007) and respond by changing their eating patterns (McKinley, 1998 and Tiggemann & Rothblum, 1988). Women's eating patterns appear to respond in a number of ways including eating healthily (Wardle *et al.,* 2004), eating in response to perceived feminine or masculine eating styles (Bock & Kanarek, 1995) and the often overwhelming pressure for women to be thin (Rodin, 1993 and Polivy & Herman, 1987).

Wardle *et al.,* (2004) reported women chose to eat healthier than men partly due to their greater desire for weight control and also due to their beliefs in healthy eating (less fat, more fruit and fibre and less salt). These findings were consistent in almost all of the 23 countries in which the study was conducted. Bock and Kanarek (1995) examined individuals perceived beliefs about an individual's female or male characteristics in relation their meal size. Women choosing to eat a smaller meal were regarded as more socially appealing and more feminine than when they chose a larger meal. Eating lightly appears to relate to being feminine (Caplan, 1996 and Bourdieu, 1984). Women who are not trying to lose weight are also very aware of their food consumption (Pliner & Chaiken, 1990). For instance, women more often than men felt guilty about eating and often missed meals (Seim & Fiola, 1990).

Consequently, women are more dissatisfied with their weight than men "a normative discontent" (Rodin *et al.,*1985). This is despite their actual body weight, more women

diet than men and more desire to be thinner (Sobal & Stunkard, 1989 and Dornbush *et al.,* 1984). Jeffery *et al.,* (1984) reported that only 23% of men but 64% of women who had never been overweight had previously tried to diet.

Therefore more women than men, due to complex factors including perceived societal pressure desire to be thin, which appears to equate to attractiveness for women (Morris *et al.,* 1989 and Polivy *et al.,* 1986). Women often take measures to chronically restrict their food intake (dieting) (Bock & Kanarek, 1995 and Herman & Polivy, 1984):

> The social construction of overweight has meant that dieting is an experience of being a woman in western society (Germov & Williams, 1996:97).

Despite women repeatedly trying to diet (Finegood, 2010) and their often-limited success (Miller, 1999b; Brownell, 1982 and Wooley & Wooley, 1979) womens' experiences of dieting often appear to be negative, traumatic (McFarlane, *et al.,* 1999 and Robinson, 1997), futile (Pasman *et al.,* 1999) and distressing. This assertion is supported by some of the findings in this thesis (see chapter four).

The costs to society

The health costs of obesity worldwide are significant. In the USA, research has shown that an obese person costs the health service approximately 30% more to treat. In 1988 obesity accounted for eighteen million days of sickness absence and forty thousand lost years of working life (National Audit Office, 2001). In the same year over thirty thousand deaths in England alone were attributable to obesity. This equates to 6% of all deaths.

The financial costs of obesity are also significant. In the United Kingdom, the House of Commons Health Committee report on obesity (2004) estimated the costs of obesity to be between £3.3 billion and £3.7 billion a year, rising to approximately £7 billion for obesity and overweight combined. The National Health Service costs are predicted to rise to £10 billion per year by 2050 (McPherson *et al*., 2007 and McCormack & Stone, 2007). In the United States of America, the direct costs of obesity have been estimated to be $70 billion, or about 7% of the health care

expenditure. In France and Australia, the costs are 2% (Levy *et al*., 1995 and Segal *et al*., 1994) but rise to 4% of the national health care costs in the Netherlands (Seidell, 1995). Gorsky *et al*., (1996) simulated three hypothetical cohorts to estimate the costs of health care according to level of obesity over a 25 year period, discounting future costs at 3% per year. They estimated that an additional $16 billion would be spent over the next 25 years in treating adverse health effects of obesity in middle-aged women. However, other researchers (Coakley *et al*., 1998 and Fontaine *et al*., 1996) state other factors such as reduced physical functioning; maternal health and the increased risk of asthma were not considered in previous estimates and will need to be accounted for in the future. When considering fertility, in one retrospective study, the cost of prenatal care in overweight women exceeded that in normal weight control subjects by 5.4 to 16.2 fold; this was dependent upon the degree of obesity (Galtier-Dereure *et al*., 1995).

Other indirect costs of obesity to society include the effect obesity and illness has on a countries productivity and their economic development. For example, among adult women in Sweden, obese individuals were 1.5 to 1.9 times more likely to take sick leave, and 12% of obese women had disability pensions directly attributable to obesity (Narbro *et al*., 1996). Another indirect cost is that obesity is also responsible for the costs associated with back and other injuries to care staff involved with obese individuals (Health Professionals and Allied Employees, 2006). Colditz (1999) estimated that the indirect costs attributable to obesity in the United States amounted to at least $48 billion in 1995. These costs in the United Kingdom are predicted to reach £49.9 billion pounds at today's prices (Mcpherson *et al.,* 2007 and McCormack & Stone, 2007).

The rationale for the study

Governments have generally been slow to respond to the issues and problems associated with obesity, when they were first identified. This may be in part due to the fact that obesity has multiple causes and health care researchers and clinicians have been unsure what approach to take, a population based or an individual approach or a combination of both. In the UK, one of the first signs that the government was responding to the issue was the National Service Framework to reduce Coronary

Heart Disease published in March 2000, which included combating overweight and obesity as one of the four priority areas for local health improvement programmes. The National Service Framework for Diabetes (2001) also emphasised the importance of prevention, including the reduction of obesity and overweight. In 2004, the Department of Health identified reducing obesity and improving diet and nutrition as an "overarching priority".

At an individual level, as obesity rates soar more individuals than ever are trying to lose weight. The methods they choose include utilising the National Health Service, by attending specialist clinics in the acute sector or opting for surgery. They may also attend clinics in the primary care setting. Individuals may also access the private medical sector for surgery and assistance. Individuals may also opt to try to lose weight via established commercial organisations and by using commercially obtained products and services. Geoffrey & Richardson (2002) estimated that 30-40% of women and 20-25% of men are trying to lose weight at any one time. Although actual figures may be much higher.

Whilst governmental motivation for reducing obesity levels is linked to the health of the nation and associated costs, the motivation or primary driver for individuals to lose weight is likely to be much more complex. Improved health may not be the primary motivator for an individual to wish to lose weight; often social and psychological factors are more important triggers to motivating an individual to wish to lose weight (Putterman & Linden, 2004; Hurd Clarke, 2002 and Wertheim *et al*., 1997). This mismatch or difference in drivers and motivations may help to explain why the present obesity reducing strategies are failing to lessen the worldwide increase in obesity (Tsichlia & Johnstone, 2010 and Hitchcock-Noel & Pugh, 2002).

The rationale for this study is therefore that if governments and in particular health promotion and health education professionals are going to develop effective strategies for helping obese individuals to lose weight, we need to develop a greater understanding of individuals' actual experiences of trying to lose weight. There is a colossal amount of literature surrounding the definitions of obesity and a multitude written about its causes. There is also an overwhelming amount of quantitative research in the field. I would argue however, that the right research questions are not being asked. The significant gaps or deficits that do appear to be evident in the

research literature relate to the fact that there is very little qualitative research data in this field that explores the experience of obesity and weight loss. Therefore, there should be, I believe a paradigm shift to trying to understand in much more detail the actual experience of trying to lose weight.

The need to focus on more qualitative psychological aspects of obesity is beginning to be recognised and advocated as being useful for investigating weight loss. For example, the Health Development Agency (2003:42) stated that future research should:

> Include an assessment of the psychosocial impact of interventions by collecting qualitative data on the views of participants

However, in today's research and political arena randomised, controlled trials are advocated and are more likely to be funded than smaller, qualitative studies. Therefore, there is a tension between what is needed and what is currently primarily funded. The field of obesity and intentional weight loss is a difficult arena to research and yet it is this very intangibleness that provokes the author's interest. Although obesity clearly has very visible effects on the individuals involved. It also provokes a unique response in each individual, it is because of the multi layered effects that obesity and being overweight imposes on the individuals that this field is an important arena to address for research and for health promotion workers and clinicians to become involved in.

The purpose of the study and the overarching research objectives

This thesis intends to examine the issues that surround obesity and the individual's actual experience of trying to lose weight. The overarching research aim of this thesis is to explore the experience of trying to lose weight. Linked to this, the study reported in this thesis will address three specific research questions:

- What feelings or beliefs motivate individuals to start trying to lose weight and to continue trying to lose weight?
- What strategies do individuals employ to try to lose weight and what decisions, feelings and beliefs underpin or influence these strategies?

- What factors help or hinder individuals in their attempts to lose weight?

In this thesis, I will argue that individuals try to lose weight for a variety of reasons and it is by investigating these diverse reasons and the individuals' experience of their intentional weight loss process that increased knowledge will be gained. This knowledge can help practitioners and policy makers in the fields of education, health education and promotion to assist individuals in the future to enhance their rates of success of achieving their goal to lose the weight they seek to shed.

Conclusion and overview of thesis

Obesity and overweight is a condition that is acknowledged as being multi-faceted and is on the increase globally. Despite this, there is a distinct lack of knowledge in the actual area of the weight loss experience itself and it is this identified gap that this research will seek to address.

One of the founding beliefs underpinning this research is that obesity does significantly affect all aspects of an individual's psychological and physical health. Therefore combating obesity falls firmly in the remit of health education and health promotion because of the impact obesity has on the individual. Obtaining more information about the individual's actual experience of trying to lose weight is crucial to valuing the individuals undergoing the experience, and also in promoting their success at weight loss, which is the goal that the greater majority of individuals wish to achieve.

In chapter two of this thesis, research literature in three main arenas including approaches to weight loss; the experience of obesity and intended weight loss and a conceptual framework for understanding obesity and weight loss are reviewed and discussed. This chapter also introduces key concepts in understanding the experience of obesity: motivation; rationality; control; choice; coping and self-efficacy.

In chapter three of this thesis, the rationale for the approach utilised in this study is outlined particularly focussing on Hycner's (1985) framework for data analysis. The

data collection tools, recruitment and sampling processes are described and key ethical principles are discussed.

Chapter four presents the results from the longitudinal study of ten women trying to lose weight. Vignettes for each woman are presented followed by detailed illustrations of each of the themes that emerged from the interview analysis. A central concept of connectedness is identified and evidenced through presentation of three exemplar case studies.

Chapter five of this thesis discusses the implications of the results and seeks to explain the experiences of the ten women in the study in relation to a number of models and theories. The potential contribution this study has produced in relation to the research arena is also discussed. The implications of the results in relation to both the clinical and education arenas are discussed. My personal reflections on the research journey are also discussed in this final chapter of the thesis. Finally, I discuss further potential research and recommendations.

CHAPTER TWO: LITERATURE REVIEW

Introduction

Intentional weight loss is a goal of a significant number of individuals throughout the world, particularly in the industrialised countries. The process of trying to lose weight is often frustrating and may be a traumatic endeavour for the individual concerned. However, the reviewed research, my clinical practice and anecdotal evidence suggests that such attempts are often futile and even if weight loss does occur it is often regained. In this chapter I will argue that we need to understand the experience of losing weight in increased detail in order to develop more effective health education strategies. This is because the current health intervention strategies are not very effective and the actual experience of the weight loss process has not been widely researched. I will argue that such enhanced knowledge will, by appropriate application by the health care practitioners and educators, improve the health education strategies currently available and improve the individual's experience of the process of losing weight and also enhance their rates of success of achieving their goal of weight loss.

The limited available research about the experience of trying to lose weight is considered prior to contextualising the proposed research study. There is an immense volume of literature in the sphere of obesity, weight and weight change both in the field of research and also in popular literature. In order to obtain a comprehensive overview of the literature in this arena a number of searches were conducted. The time span considered was the last thirty years. These included searching electronic databases such as ERIC, Web of Knowledge, BOPCAS, PsychInfo, PUBMED, Medline, SOSIG and the Silverman collection. Search terms of key phrases for searching included obesity, overweight, fat, experience of obesity, overweight and weight loss, trying to lose weight and weight loss. A search of specialist bibliographies and hand searching key journals was also undertaken. Obtaining access to as yet unpublished data was also carried out as was the so-called process of ancestry tracing which involves identifying listed literature in other author's published work. By obtaining the appropriate permission I also accessed closed collections. The

literature in the commercial field such as the commercial weight loss arena and individual profiles regarding weight were also reviewed. It was anticipated that this comprehensive approach would provide the appropriate global and national literature to review.

In this chapter, the practical approaches currently available to help people lose weight will be explored and discussed. Secondly, the current evidence available about the experience of the weight loss process will be reviewed. Thirdly, the conceptual framework will be presented in order to understand the experience of obesity and the experience of the weight loss process. Finally, the purpose of the proposed study will be discussed in order to justify its potential contribution to the field of obesity and weight loss.

Approaches to weight loss

In this section of the chapter I will review the practical approaches currently in use to promote weight loss. In other words, the actual strategies individuals are choosing to help themselves lose weight. Throughout the world a number of interventions are in place to help people lose weight. These interventions tend to be in response due to a number of drivers including the World Health Organisation and national governments who wish to reduce obesity and overweight. This is because of the cited disadvantages to individuals and to the nation's health of those conditions and also the economic burden of treating individuals who are obese and overweight. Secondly, interventions are also in place as a response to the public demand from many individuals who are overweight and obese and wish to lose their excess weight due to psychological, social and health reasons.

These strategies differ depending on country and region, whether the focus is on children and adults, females and males. For example, nationally in the United Kingdom a number of strategies are in place to help individuals to lose weight. These initiatives include commercial and non-commercial organisations, but they are often implemented in a piece meal way, dependent on region and funding. Although individuals and clinicians and commercial organisations are working hard to combat obesity, in reality there has only been some evidence of joined up working. This is

despite United Kingdom directives to combat obesity such as Saving Lives: Our Healthier Nation (1999) and Choosing Health: Making Healthier Choices Easier (2004). There has also been the emergence of organisations such as the Association for the Study of Obesity and the National Obesity Forum.

In 2006 the Forecasting Obesity to 2010 document was prepared on behalf of the Department of Health (Zaninotto *et al.*, 2006). In this report the authors used the most recent data available to extrapolate and forecast what future levels of overweight obesity may be in 2010 if current rates of national obesity remained unchanged and combating strategies were not effective. This report predicted a significant rise in obesity in men and still a rise but to a lesser extent in women. The rise of obesity in children was also predicted, especially for girls.

Following on from both the actual and the predicted rise in overweight and obesity, the Government published three key policy related initiatives. These included the Foresight Report (2007); 'Healthy Weight, Healthy Lives: A Cross Governmental Strategy for England', 2008 and the Change4Life campaign (currently being disseminated throughout the country). The National Health Service also responded to this actual and predicted health problem and published 'Healthy Weight, Healthy Lives: A Tool Kit for Developing Strategies (Swanton, 2008). I will briefly describe each in turn.

The Foresight Report (2007) despite its detractors (Hawkes, 2008), did identify that numerous factors and forces were involved in the rise of overweight and obesity and that significant players in society including the National Health Service would need to be involved to reduce obesity and overweight. In January 2008 the Government published Healthy Weight, Healthy Lives: A Cross Governmental Strategy For England. £372 million pounds was released to enable everyone in society to maintain a healthy weight. The National Health Service response followed later in the same year, Healthy Weight, Healthy Lives: A Tool Kit For Developing Strategies (Swanton, 2008). This 250-page document usefully highlights the resources available both for the community and for National Health Service professionals to assist individuals in their weight loss efforts.

The current Change 4Life campaign is a multi-faceted programme utilising a number of partners to enable messages of healthy living to be viewed by the population. Despite its detractors (Hawkes, 2008) the Change4Life advocates support such a fused approach. "It is only through the combined power of government, commercial and non-commercial organisations that we reach and resonate with a huge range of people" (Fletcher, 2009:721).

However, despite these policy initiatives and governmental publications many individuals who are trying to lose weight often try to tackle this complex issue on their own. Personal initiatives include following specific diet plans and taking diet supplements to assist with weight loss such as Hoodia and Green Tea. Overweight and obese individuals may also buy meal replacements from the supermarkets such as Slim Fast or from dietary counsellors such as the Cambridge Diet. Other individuals join commercial slimming organisations such as Slimming World, Weight Watchers and Lighter Life. Such initiatives are available nationwide but they can be short lived and are often ineffective in the long term assisting individuals to lose weight (Kaissirer & Angell, 1998) and they usually require self funding.

Strategies for losing weight fall broadly into three categories: personal self help focused; primary care focused and surgical and specialist focused. I will discuss each of these in turn.

Personal self-help approaches

Personal self-help focused strategies include individuals dieting, using meal replacement products, commercial self-help products, exercise and an alternative non-dieting approach.

Dieting

Millions of individuals in industrialised countries are constantly attempting to lose excess weight through dieting, either on their own, under the care of their doctor, or through other programmes (Galuska *et al*., 1999). However, most fail in the process, often growing more discouraged and even more obese as a result (Pasman *et al*., 1999 and the National, Heart, Lung and Blood Institute, 1998). The numerous different

weight loss approaches may lead dieters to choose inappropriate options (Galuska *et al*., 1999).

Ironically, dieting and repeated dieting may also contribute to obesity. Research indicates that dieting is characterised by periods of overeating which are precipitated by factors such as lowered mood, cognitive shifts, a dieting reduced sensitivity to palatable foods, shifts in self-awareness and weight variability. Dieting could therefore play a causal role in the development of obesity. It is possible that dieting results in the relative over-consumption of high fat foods when individuals lapse from their diet plans, as these are the foods that dieters routinely avoid when dieting (Hill & Peters, 1998 and Rodin *et al*., 1989).

Although dieting aims to reduce food intake and cause subsequent weight loss, research indicates that dieting causes episodes of over eating (Ogden, 2003). Some research has been inspired by restraint theory (Hibscher & Herman, 1977 and Herman & Mack, 1975) and has highlighted disinhibitory behaviour as a consequence of attempts to impose cognitive limits on food intake. Explanations of disinhibition include the boundary model of overeating (Herman & Polivy, 1984), which emphasises the dieters' cognitive limits and changes in both cognition and mood. Heatherton *et al*., (1993) highlights the role of self-awareness. However, there are problems with restraint theory, with researchers questioning the link between dieting and overeating, the validity of restraint measures, and the nature of dieting itself. It would seem that dieting does not always lead to overeating and that some measures of restraint specifically select those dieters with a tendency to overeat. It is most likely that there are some dieters who are always successful in their attempts to eat less, but there is also a large number of dieters who fluctuate between episodes of under eating and periods of disinhibitory behaviour.

A number of different diets are available and recommended and can often be contradictory with one another. These include, total fasts, very low calorie diets, low protein diets and high protein diets to name but a few. The high protein, low carbohydrate diet often termed the Atkins diet will be discussed here as an illustration of the potential diets an individual can choose.

A popular diet is the high protein low carbohydrate diet. Some variants are also quite high in fat. Many best selling diet books promote this type of diet, including 'Sugar Busters!' (Steward, 1999); 'The Carbohydrate Addict's Diet' (Heller & Heller, 1999b), 'Protein Power: The Metabolic Breakthrough' (Eades, 1996) and Dr Atkins' New Diet Revolution (Atkins, 1999). The Physicians Committee for Responsible Medicines (2004) does not recommend these types of high fat diets. Such diets are lacking in sufficient carbohydrate and some micronutrients (Physicians Committee for Responsible Medicines, 2004 and Kappagoda, 2004) and such diets advocate intakes of protein and fat that are argued to be potentially harmful (Kappagoda, 2004 and Denke, 2001). The reasons these diets work are their energy deficits (Rolls, 1986) most provide about 1,200kcal/day or less, and the fact that they are ketogenic and lead to a state of relative dehydration. This may be a factor in the popularity of high protein diets. Although this can have deleterious effects on physical and mental health, dieters may perceive the water loss associated with dehydration as beneficial and thus may think the diet is particularly effective. Weight loss is not primarily the result of alterations in the insulin metabolism that the diets engender.

An important aspect of any weight loss regime is that it must provide strategies for maintenance of weight loss after a healthier weight is achieved. This is critical considering the extremely high relapse rates as individuals move from weight loss into weight management (Pasman *et al*., 1999). In order to prevent weight regain, permanent changes in diet and lifestyle must be learned and adopted. Long- term adherence to a low carbohydrate, high protein diet that is also high in fat and saturated fats could pose significant health risks. Also, the protective effects of a diet high in whole grains, fruits and vegetables, soluble and insoluble fibre, and antioxidant nutrients would be missed. This could increase the risk of a number of chronic degenerative diseases, including certain cancers and diverticulosis. The fact that a high protein, low carbohydrate diet does not teach healthful lifelong eating habits is a strong argument against such a regime.

However, in recent years the Atkins diet has evolved so that it addresses some of these concerns, it now contains an active weight loss phase and a maintenance programme. In the maintenance programme, fruit and vegetable consumption is encouraged. In a multi-centre randomised trial looking at the difference between a

conventional calorie controlled diet and the Atkins diet, a greater net loss was achieved with the Atkins diet. However, the difference was not significant at the end of twelve months, indicating that regain was greater in the Atkins diet.

The relationship between fat and weight gain remains controversial, as evidence from the various studies is inconsistent. The message to eat less fat has been around for decades. However, weight is increasing, whether fat intake in the diet leads to weight gain seems to be dependent on the activity patterns of the individual (Stubbs *et al.*, 1995) and the individual's genetic predisposition to obesity (Heitmann *et al.*, 1995). These factors may explain why the relationship between weight and fat is not as strong as one would expect, given the properties of fat (Pirozzo *et al.*, 2002).

At best, it seems that a small weight loss (2-5kg) for a brief period can be expected, with higher values achieved by people with initially heavier weights (Willet, 2002 and Lissner & Heitmann, 1995). A meta-analysis demonstrated a dose-dependent relationship between decreased fat intake and weight loss (Astrup, 1998). For every 1% decrease in energy from fat there was a 0.28kg decrease in body weight (Astrup *et al.*, 2002 and Yu-Poth *et al.*, 1999) therefore focusing on fat intake rather than counting calories does not seem to produce greater weight loss. However, there have been reports that it is a more palatable way to lose weight, and can often be advantageous with binge eaters (Jeffery *et al.*, 1995). However, long term studies, (18 months or more) have not shown any more additional benefits (Pirozzo *et al.*, 2002 and Willett, 2002). Reducing both calories and fat seems to produce significantly greater weight loss than just counting calories (Glenny *et al.*, 1997).

Evidence suggests that no single approach to diet works for everyone (Mulvihill & Quigley, 2003) and the best approach is to try to customise the diet to the individual (National Institute for Clinical Excellence, 2006 and Dennis & Goldberg, 1996). Truby *et al.*, (2006:1311) conducted a randomised controlled trial of four commercial weight loss programmes commonly used in the United Kingdom. The authors concluded that:

> Currently, we cannot predict the dietary approach best suited to each person, but it is clear that 'one size does not fit all'.

The best diet is the one with which the individual will comply initially and long term. Recent findings suggest that foods with a lower glycaemic index (blood glucose rise per ounce of food) may reduce consumption and those with a lower calorie density (number of calories per ounce) such as vegetables, appears to be more filling and may reduce overall food consumption (Pawlak *et al*., 2002). As a result, diets with a higher percentage of carbohydrate from vegetables and legumes and less from starch and sugar, and adequate amounts of lean protein and large quantities of vegetables as the mainstay of the diet with smaller amounts of whole grains and healthy oil sources are advocated (Aronne & Waitman, 2004).

Meal replacement products

One weight loss strategy that individuals can pursue themselves is to substitute meals for low calorie replacements such as Slim Fast and the Cambridge Diet. The discussion of these products in this thesis is not intended to be exhaustive they are simply examples of what are currently available. It is not my intention that their inclusion or exclusion should be construed as endorsement or rejection.

Slim Fast is a meal replacement product that can be bought over the counter. It is freely accessible in shopping venues. Slim Fast products provide low calorie meal replacements in the form of drinks or bars. These products contain no drugs, stimulants or appetite suppressants. The slim fast programme recommends the use of two meal replacements per day and a healthy balanced meal is suggested for the third meal. It is suggested that this should induce a loss of 1-2 pounds (0.5-1kg) per week (Slim Fast, 2000). Slim Fast is a worldwide product that has been available since the 1970's. However, how many meal replacements are bought and consumed, and how many customers there are of Slim Fast is hard to generalise from the sales figures as some products will be bought and never utilised.

In a multi centre study, women who consumed Slim Fast twice a day for 12 weeks lost 6.3kg and men lost 8.6kg (Heber *et al*., 1994). After the initial 12 weeks, participants entered a 2-year maintenance phase, in which they used Slim Fast only once daily. After 1 year, 41% of the participants maintained their full 12 week weight loss and at 2 years, 22.8% of participants met this weight loss criterion, however, only

44.2% of the participants remained in the study after 2 years, an occurrence which probably resulted in an overestimation of treatment effectiveness.

In a randomised trial of 100 overweight men and women Ditschuneit *et al*., (1999) found that participants assigned to the Slim Fast plan lost significantly more weight after 3 months than did participants who were assigned an identical daily calorie goal but who consumed a diet of conventional foods (7.1kg vs. 1.3kg). This trial showed that patients who adhered to the Slim Fast plan lost 11.3% of initial weight during 27 months of treatment. The control group lost an additional 4.2kg for a total loss of 5.9%. Reductions in weight, as well as in triglycerides, glucose and insulin were all significantly greater (Ditschuneit *et al*., 1999). A follow up study, showed that weight losses were well maintained at 51 months (Flechtner-Mors *et al*., 2000). However, in the Ditschuneit *et al*., (1999) study, participants met monthly with a nutritionalist. They were provided with a diet plan, along with diet menus and recipes, and taught to keep food diaries. Consumers who use Slim Fast products on their own will not receive these interventions, which makes it difficult to generalise the findings of the study to the average Slim Fast customer. It is relevant to indicate to the reader that the Heber *et al*., (1994); Ditschuneit *et al*., (1999) and Flechtner-Mors *et al*., (2000) studies are all Slim Fast sponsored research publications.

The Cambridge Diet was launched commercially in the United States of America in 1980 and in the United Kingdom in 1984. The Cambridge Diet is a meal replacement plan that is bought through Cambridge counsellors. The Cambridge products may be used as a sole source of food for up to four weeks or longer with medical supervision. Liquid meal replacements can be of value in certain individuals who prefer this mode of therapy. Use of these diets to substitute for a meal has been shown to reduce body weight and assist with weight maintenance (Heymsfield *et al*., 2003). Noakes (2004) concurred but with reservation as the study found meal replacements needed to be used appropriately and diligently to ensure weight loss was maintained.

Commercial self-help groups

As a number of self-help slimming groups exist both Slimming World and Weight Watchers will be discussed as examples of commercial self-help groups. Slimming

World (Bye *et al*., 2005) has 250,000 members who attend 5,500 weekly group sessions, paying a small weekly fee. Slimming World members "lose 17,867 stones every week" (Craven, 2008:7). Slimming World is a group-based programme, which is open to anyone to join. Groups meet weekly and include a weigh in and dietary advice, the food plan is a flexible programme termed food optimising and uses free foods and sins. A bi monthly magazine can also be bought.

Weight Watchers International was established in 1963 in the United States of America and was in the United Kingdom by 1967. Weight Watchers has reportedly helped 25 million people worldwide to manage their weight (Weight Watchers International, 2000) and in the USA alone 30.8 million Americans attended 3,600 groups in 2002 (Weight Watchers, 2002). Individuals are charged a fee to join and also pay a weekly fee when they attend their group and are weighed and receive an educational group programme. Weight Watchers leaders who run the groups have successfully lost their weight through the weight watchers programme and have successfully maintained it. Studies have shown that weight watchers produce significant weight loss (Heshka *et al*., 2003 and Lowe *et al*., 1999) and a recent economic analysis suggested that Weight Watchers is a cost effective service option for National Health Service patients (Trueman & Flack, 2006). Successful long-term weight watcher participants have also been studied (Christakis & Miller-Kovach, 1996 and Lowe *et al*., 1996). The research showed that 19.4% were within 5lb (2.2kg) of their goal weight after five years of treatment (Lowe *et al*., 1999). However, this may not be a true representation of all members as the ease of enrolment as well as the ease of exit may mean that many members may not achieve such success. One study (Volkmar *et al*., 1981) indicated that 50% of participants in a weight watchers group attended fewer than 7 sessions and lost only about 1kg.

There has been surprisingly little research on the credentials or training experiences that are required to successfully provide behavioural treatment within commercial programmes (Wang *et al*., 2003). Results of several studies suggest that laypersons can be effective treatment providers. Individuals without professional training in fact, staff most commercial weight loss programmes. This is an area that requires further research to identify the type of professional training and personal characteristics required to provide effective weight management.

Exercise

Most experts and recent guidelines acknowledge a role for physical activity in the aetiology and treatment of overweight and obesity (Department of Health, 2009b; Bouchard & Blair, 1999b and the World Health Organisation, 1998). Although attention to physical activity in the prevention and treatment of obesity has increased in the past few years, it clearly receives less attention than diet does (Levy, 1993). However, over the past few years exercise has played an increasingly important role in the treatment of obesity, either as an adjunct to dieting or as a stand-alone approach. For example, Brownell (1995, 1998) has argued that exercise should be central to any weight loss intervention.

Physical activity alone produces only modest weight loss. A meta analysis of weight loss studies found that 21-week aerobic exercise programmes produce weight losses of 2.9kg, compared with losses of 11kg from 15-week programmes of calorie restriction (Miller *et al.*, 1997). 30-60 minutes of physical activity, three times a week in combination with a calorie restricted programme increases the amount of weight loss by approximately 2kg (NHLBI. 1998).

Exercise can take many forms, including structured sports such as tennis or aerobics or incidental physical activity such as stair climbing. As a result of this variability, assessments of the effectiveness of exercise as a treatment for obesity are problematic. Several reviews and meta-analyses, however, have been carried out. Ballor & Poehlman (1994) examined 46 diet based weight loss programmes published between 1964 and 1991 and concluded that adding exercise to diet based treatments had no impact on changes in body weight or fat mass. However, Garrow & Summerbell (1995) conducted a meta-analysis and calculated that over 30 weeks, exercise added 3kg extra weight loss in men and over 12 weeks exercise added 1.4kg weight loss for women. They also concluded that exercise resulted in greater loss of fat mass and improved preservation of fat-free mass however Kopelman (1997) has argued that the impact of exercise on fat reduction remains unsupported by a substantial evidence base. Fox (1999:166) concluded:

Aerobic exercise cannot compete with dietary methods for rapid weight loss but that it should be considered as an accompaniment to a moderate dietary regime.

A review by Ross & Janssen (2001) including nine randomised controlled trials and 22 non randomised trials on exercise and weight change in overweight and obese individuals, showed that the amount of energy expenditure by physical activity is positively associated with a reduction of body weight and total body fat in studies with duration of 16 weeks or less. If the range of energy expenditure is limited to 500-2999 kcal per week, which is the range in which most exercise studies are found, a dose response relationship is not very apparent, due to the large variation in body weight reductions. It is therefore not surprising that some studies of longer duration have concluded that there was no dose response relationship. After 26 weeks or more, abdominal fat was also reduced by exercise, although a dose response relationship could not be established owing to limited data (Ross & Janssen, 2001).

Even though physical activity is not the most effective method of losing weight, it appears to be crucial for maintaining weight loss. One study examined self reported activity levels of obese women who regained weight after successful weight loss, (relapsers) formerly obese women who maintained their weight, (maintainers) and normal weight women who maintained their weight, (controls). Kayman *et al*., (1990) reported that 90% of maintainers and 82% of controls, but only 34% of the relapsers reported regular physical activity. These results suggest the importance of physical activity in maintaining weight loss, both among normal weight individuals and formerly obese individuals who have lost weight. Successful weight loss maintainers are characterised by high levels of physical activity, low dietary fat and high dietary carbohydrate intake and regular self-monitoring of weight (Wing & Hill, 2001).

Cognitive factors regarding exercise are of critical importance for the success of exercise in weight management. Analysis of prevailing cognitive rules and schema, or if necessary, intervention should be components of exercise prescription (Dunn *et al.*, 1999). The lifestyle approach helps individuals use cognitive and behavioural strategies to accumulate 30 minutes of moderate intensity exercise over the course of the day (National Institutes of Health, 1998). This approach encourages the accumulation of activity through daily life routines at home and at work, and does not

specifically limit activity to scheduled bouts of exercise. An important facet of this approach is to help people alter their mindset regarding exercise (Downie *et al.,* 1996) and to allow them to adopt a broader definition that focuses on a wider range of options for physical activity. Examples include using the stairs instead of taking the lift, hand delivering messages at work instead of using email or the phone, parking the car further away and walking to work or the shops, and playing with the children or grandchildren.

Conceptually, the lifestyle approach to physical activity is grounded in Prochaska & DiClemente's (1984) transtheoretical model, which stipulates that individuals do not change at the same rate and may require different interventions at various times. This approach used social cognitive theory (Bandura, 1986) to shape physical activity behaviour according to each individual's readiness for change. A variety of cognitive and behavioural strategies are used to tailor the intervention to meet the individual's needs based on the level of motivational readiness and other characteristics. Common techniques implemented in this lifestyle intervention include goal setting, self-monitoring and problem solving regarding barriers to physical activity, along with other traditional cognitive behavioural skills. Anderson *et* al., (1999) found that during the 16-week treatment phase, participants in the lifestyle group and in the control group had both lost similar amounts of weight but during the one year follow up the lifestyle participants had regained significantly less weight. These results suggest that lifestyle physical activity programmes are as effective in promoting weight loss, and are potentially more effective in maintaining weight loss, compared with a structured exercise programme. Due to the poor fitness level of many overweight and obese individuals, the lifestyle approach may be a more feasible way to achieve the recommended level of physical activity. The lifestyle intervention is useful for both adults and children, and may be considered an alternative to the traditional gym or structured exercise programme.

Non-dieting approaches

The growing discontent with dieting and a search for alternative approaches are based on two premises. Firstly, that dieting confers a host of harmful physical and psychological effects (McFarlane *et al*., 1999 and Robinson, 1997) and secondly, that

as dieting does not result in sustained weight loss, it is largely ineffective (Miller, 1999b and Kaissirer & Angell, 1998).

First generation studies of non-dieting programmes were descriptive in nature (Ormichinski & Harrison, 1995 and Carrier, 1994). More recently, second generation studies have employed randomised controlled trials to compare a variety of non-dieting approaches to traditional dieting programmes. Although these recent controlled trials have increased the fund of knowledge about non-dieting approaches which incorporates changing activity levels and the ways individuals feel about themselves and food for instance, such studies are limited by short interventions, incomplete follow ups, small samples and high attrition. Five out of the seven studies employed interventions ranging from eight to thirteen weeks; three studies reported no follow up data (Allen & Craighead, 1999; Ciliska, 1998 and Miller *et al.*, 1993) and another only included 57% of subjects at follow up (Tanco *et al.*, 1998). Furthermore three studies had fewer than 25 subjects (Allen & Craighead, 1999; Sbrocco *et al.*, 1999 and Miller *et al.*, 1993). Based on the available data one consistent finding is that non dieting approaches appear to have a favourable effect on self esteem (Faith *et al.*, 2000). Some studies found that psychosocial changes in non-dieting groups were similar to dieting groups (Rapport *et al.*, 2000 and Sbrocco *et al.*, 1999) while others found greater improvements in non-dieting groups (Tanco *et al.*, 1998). However, most non-dieting programmes produce little or no change in body weight. It seems reasonable to conclude that non-dieting programmes favourably affect mood, self-esteem and body image but result in little change in body weight. However, the so-termed non-dieting programmes that do produce larger weight losses are typically those that have incorporated some elements of traditional dieting (Sbrocco *et al.*, 1999 and Miller *et al.*, 1993).

Perhaps the greatest strength of the non-dieting movement is the affirmation of a person's worth, no matter what he or she weighs. And that they should live life now, rather than waiting until they lose weight (Johnson, 1990). This message is so contrary to popular culture that it can seem ridiculous to suggest that overweight persons should like themselves or that overweight does not result from a lack of character or will power. However, these messages can prompt health education professionals, to remember that as members of our society, they are likely to have

anti-fat attitudes that need to be identified and modified (Yalom, 1993 and Price *et al.*, 1987).

The most significant weakness of the non-dieting approaches is the limited amount of scientific evidence. For instance, the number of books which advocate changing eating styles and patterns of behaviour increases daily despite the dearth of controlled studies to demonstrate their effectiveness. Some of the books presently available that recommend nutrition and lifestyle changes to promote healthful habits and strategies for weight maintenance include, 'The Solution' (Mellin, 1997); 'Intuitive Eating' (Tribole & Resch, 1995), 'Habits, Not Diet: The Secret to Lifetime Weight Control (Ferguson & Ferguson, 1997) and 'Dieting for Dummies' (Kirby, 1998). Mellin (1997) promotes a non-diet approach that focuses on addressing the underlying causes for obesity or overweight, not the symptoms. It encourages the reader to understand why he or she overeats and to address those issues. Tribole &Resch (1995) instruct readers to listen to internal hunger and satiety signals as cues for food ingestion rather than being controlled by external cues. Ferguson & Ferguson (1997) promotes the use of such tools as food intake and activity journals and self-evaluations. The structured approaches of these books teach commitment to change and self-discipline. Kirby (1998) discusses sensible weight loss strategies and healthy approaches to long term lifestyle changes promoting weight maintenance and has tips for spotting fraudulent fad diets. However, these approaches are supported by minimal or no data.

In addition, to the relative efficacy of the discussed studies about the non-dieting approach, it would be useful to identify which persons might benefit most from non-dieting approaches. A final challenge is to decrease the distance between dieting approaches, typically used by professionals in the obesity field and non-dieting approaches, typically used by those in the eating disorders field, this division has sometimes resulted in misunderstanding and a united service would probably serve overweight persons better.

Primary care focused strategies

Some individuals approach their doctors in the primary care setting asking them for help to lose weight. However, in one study (Wadden *et al.,* 2000) nearly 45% of the

respondents indicated that their doctor had not prescribed any of 10 common weight loss methods. Although, on a positive note, fewer than 10% of the patients indicated that their doctor treated them disrespectfully about their weight. However, several barriers to obesity treatment in the primary care setting exist. Many practitioners lack training in the field of obesity treatment and do not feel comfortable administering obesity treatment. Weight reduction therapy is still now often seen as ineffectual, futile and time consuming, with little benefit for patients, (Aronne, 2002 and Frank, 1993). Funding is also limited in this arena as combating obesity may take a back seat to other chronic conditions in primary care. However, perhaps the greatest barrier to treatment is the misconception that patients have caused their obesity simply by not complying with recommendations to eat a healthy diet and to be active. However, this is changing as primary care physicians have more avenues opening up to them to offer treatment to patients wishing to change their weight status. This has coincided with an increased awareness of the problem and also a small increase in funding in the arena. Options now include prescription medication, behavioural support and cognitive behavioural therapy.

Medication in primary care to treat obesity and overweight

Drugs are prescribed in the primary care setting to assist individuals with their weight loss but in many instances they are used as an almost last resort. There is the perception that because patients regain weight when the drugs are stopped, the drugs are ineffective (Bray, 1998b and Bray *et al*., 1995) and therefore individuals are often advised initially to diet and exercise and then in some instances if this has proved ineffective medication may then be prescribed. Anecdotal evidence suggests that the majority of individuals have relentlessly tried these approaches prior to consulting the doctor.

However, a growing body of evidence indicates that obesity is as much a metabolic/endocrine disorder as is diabetes, and therefore is equally deserving of medical treatment (Aronne, 1998 and Bray, 1998) and that obesity is a chronic disease with multiple aetiologies (Bray, 2003 and Friedman, 2003). The World Health Organisation (1998) and the National, Heart, Lung and Blood Institute (1998) recommends that obesity be considered and managed as a chronic illness. In general,

weight loss medications help patients adhere to a reduced calorie regime. However, not every patient responds to a given medicine and all weight loss enhancing medications should be regularly reviewed for effectiveness, adverse effects and patient compliance (National Institute for Clinical Excellence, 2006).

Currently, two drugs being used in the primary care setting in England and other countries are Sibutramine and Orlistat. The National Institute for Clinical Evidence (2006) recommends that these medicines be prescribed only for people with a BMI over 30 or a BMI over 27 and co-morbidities such as Hypertension. They should be prescribed only if eating less and being more active have been tried and not produced enough weight loss.

Behavioural support

Behavioural therapy provides a set of principles and techniques to help people modify their eating. This approach recognises that obesity is influenced by metabolic and genetic factors (Campfield *et al*., 1995 and Stunkard *et al*., 1990), but believes that recent increases in the prevalence of obesity are attributable primarily to universal changes in eating and activity habits (Wadden *et al*., 1992). Behavioural treatment seeks to teach patients to modify their habits, in part by examining the antecedents and consequences of their behaviours. This approach incorporates principles of classical conditioning, which holds that two events will become linked together if they are paired repeatedly (Wing, 2002 and Brownell, 2000). Moreover, the more frequently they are paired, the stronger the association between them, until eventually the presence of one event automatically triggers the other. Behaviour therapy seeks to identify and control cues associated with unwanted eating.

Another goal of treatment is to identify the consequences of behaviours. Behaviours, that produce a reward such as the desired weight loss, are known as the re-inforcers and are theoretically more likely to be repeated (Brownell, 2000). However, behaviours that result in negative consequences such as weight gain are theoretically less likely to be repeated.

Behaviour therapy provides a very goal orientated approach to weight loss. Patients set concrete, tangible goals with measurable outcomes (Wadden & Butryn, 2003 and Brownell, 2000) and they usually leave each session with a strategy of how to achieve their goals, this includes devising a detailed plan of what they will do, when and where they do it and how often. Patients should set small goals, which they can attain in order to maximise their feelings of success. Small successes build upon each other until patients reach their ultimate goal (Brownell, 2000).

Behavioural treatment incorporates multiple components including self-monitoring, stimulus control, diet, exercise, cognitive restructuring, social support, problem solving, slowing the rate of eating and relapse prevention. Self-monitoring is the cornerstone of behavioural treatment for obesity (Wadden & Butryn, 2003 and Wing, 2003). Patients keep detailed records of their food intake and weight. Initially, they record food eaten, including the types and amounts, as well as their calorific value. A number of studies have reported that self-monitoring facilitates weight loss (Berkowitz *et al*., 2003 and Boutelle & Kirshenbaum, 1998). Monitoring food intake helps patients reduce their tendency to underestimate how much they eat (Lichtman *et al*., 1992). It also increases their awareness of their eating habits and identifies behaviours that need to be changed, such as tasting food when they are cooking. Over time, patients increase their self-monitoring to include times, places and feelings associated with eating (Brownell, 2000). This additional recording helps to identify problem areas. Once the problem areas have been identified, the patient and practitioner work together to develop a plan to overcome the obstacle.

Patients are instructed in stimulus control techniques to make their environments more conducive to eating less and healthier food such as storing food out of sight, to reduce unwanted eating by limiting exposure to problem foods. Additional eating cues include places, times and events. Patients are encouraged to limit the places at home in which they eat to the kitchen or dinning room, and to eat at regular times of the day. They also learn not to eat while engaging in other activities such as watching the television. Food cues are neutralised by disconnecting them from eating. Cues can also be used to promote healthy eating such as displaying the fruit basket prominently instead of a bowl of sweets, may encourage their choice of a healthier snack.

Behavioural treatment aims to decrease negative cues while promoting healthier ones (Brownell, 2000).

In behavioural treatment, patients learn to identify, challenge and correct irrational thoughts that may undermine their weight loss efforts. Cognitive restructuring teaches patients to identify their negative irrational thoughts and to replace them with more realistic statements. Through cognitive restructuring, patients can learn to review a setback as a temporary lapse. The ultimate goal is to determine how lapses occurred and to develop strategies to prevent them. Cognitive restructuring may also be useful in helping patients cope with unmet weight loss expectations. Obese individuals often begin treatment expecting to lose up to 25% of their initial weight (Wadden *et al*., 2003 and Foster *et al*., 1997). Failure to meet their expectations may cause patients to feel disappointed or discontinue treatment prematurely. To minimise these risks, providers should help patients set reasonable goals and expectations, and focus on the health benefits of modest weight loss as setting unrealistic goals can seriously hamper individual's success (Linne *et al*., 2002 and Foster *et al*., 1997).

An initial course of behavioural treatment usually consists of 16-26 weekly sessions. Treatment has a clear starting and ending date, which seems to help participants to pace their efforts. Once this initial phase of treatment, is completed; patients are encouraged to participate in a weight maintenance programme. Treatment is typically delivered to groups of 10-20 people who start and end their treatment together. This 'closed group' approach ensures a high level of social support and continuity of care. Participants assist each other in their efforts to modify eating habits. Groups may also provide participants with a healthy dose of competition. Patients take note of members who are losing weight and often decide that they too want to be successful.

A randomised trial demonstrated the superiority of group over individual treatment for inducing weight loss, regardless of patients preferred method of treatment (Renjilian *et al*., 2001). Participants who received group treatment lost significantly more than those assigned to individual therapy (Renjilian *et al*., 2001). This was true even in cases in which participants preferred individual treatment and received it. Individuals who desired and received individual therapy lost significantly less weight, (about 2kg), than individuals who wanted individual treatment and were assigned to

group sessions. The study concluded that group treatment was superior to individual treatment because of the provision of both social support and competition. Wing & Jefferey (1999) also suggested that social support was successful in initiating and maintaining weight loss. Dieticians, psychologists, exercise specialists or health educators typically provide group behavioural treatment.

The data reviewed shows that patients treated at present by a comprehensive group behavioural approach lose about 10-12% of initial weight in 30 weeks of treatment. In addition, about 80% of patients who begin treatment complete it. Thus behaviour therapy yields very favourable results as judged by the current criteria for success such as the NHLBI (1998) and the Dietary Guidelines for Americans, (Agricultural Research Service, 1995).

Without continued treatment, patients typically regain 30-35% of their lost weight in the year following treatment (Wadden & Butryn, 2003 and Wadden & Osei, 2002). Moreover, 5 years post treatment, 50% or more patients regain all of their weight (Wadden *et al*., 1989). Factors responsible for this weight regain have not been fully identified, despite the frequency with which this problem is observed. Contributors to weight regain are likely to include compensatory metabolic responses that include reductions in resting energy expenditure and leptin, as well as increases in ghrelin, a gut peptide associated with reports of hunger (Cummings *et al*., 2002 and Rosenbaum *et al*., 2002). In addition, patients are confronted daily by a 'toxic' environment that explicitly encourages them to consume large quantities of high fat, high sugar foods (Brownell & Horgen, 2004). Weight gain (or regain) appears to be an almost guaranteed response to this environment.

Inadequate treatment also contributes to weight regain. Short-term treatment of 16-26 weeks clearly is no match for what, to most obese individuals, is a chronic disorder (Arterburn *et al.,* 2008 and Wadden & Butryn, 2003). Obesity cannot be cured by 6 months of therapy, any more than type 2 diabetes or hypertension can be controlled by such a brief intervention. The long term results of obesity management have begun to improve with the recognition that obesity is a chronic condition that requires long term care (Perri & Corsica, 2002).

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New weight loss programmes are beginning to utilise media such as television and the internet. Meyers *et al*., (1996) compared a standard face to face treatment group, a group receiving a face to face programme that was videotaped for subsequent use, a group that was shown the videotape via television as its treatment contact and a waiting list control group. The three treatment groups all recorded similar losses and differed from the waiting list control group. However, the group that was shown the television broadcast was treated differently to the other groups. For example, they were weighed before and after the 8 weeks, and could be considered therefore to have received therapeutic contact. They were also asked to send self-monitoring records to the therapist which may have influenced the outcome. Similarly, Harvery-Berino, (1998) found similar losses with individuals who attended a face-to-face programme and those who utilised an interactive television programme.

Recent studies suggest that the internet and email are potentially effective methods for facilitating weight management (Tate *et al*., 2003 and 2001). These studies taken together, underscore the importance of participants keeping records of their food intake, as well as completing other behavioural assignments. It would appear that educational instruction alone is not sufficient to produce clinically significant weight loss. The studies also suggest that even the most effective internet studies are likely to produce only half of the weight loss as traditional on site behaviour programmes. However, from a public health perspective, the greater availability of the internet programmes may result in this approach having a greater impact on obesity management than traditional clinic or hospital based programmes that serve so few individuals.

Behavioural treatments for obesity have evolved since the 1960's when they were first developed. Among these treatments has been the addition of cognitive procedures and sometimes this has resulted in the relabelling of the treatments as 'cognitive behavioural therapy' (Foreyt & Poston, 1998; Kirsch *et al*., 1995; Kalodner & DeLucia, 1991 and DeLucia & Kalodner, 1990). Nowadays, many behavioural programmes include sessions on such topics as negative thinking and relapse prevention (Wardle & Rapoport, 1998). Such behavioural programmes bear almost no resemblance to cognitive behavioural therapy in their theoretical basis (which, if present places little weight on the contribution of cognitive processes or treatment

procedures which are almost exclusively behavioural). Cognitive behavioural therapy will be discussed later in this chapter. Indeed, the highly structured prescriptive format of these groups bears only limited resemblance to behaviour therapy as practiced outside the treatment of obesity. Rather, these programmes might be better characterised as "behaviourally orientated group psycho-educational interventions" (Cooper & Fairburn, 2002). However, it must be acknowledged that there is no evidence that a more flexible and individualised form of behaviour therapy would be any more effective.

Behavioural treatment has been used in some form in nearly every approach to weight control. Good short-term results can be reliably produced (NHLBI, 1998 and World Health Organisation, 1998) but long term maintenance remains elusive (Wadden & Butryn, 2003 and Wadden & Osei, 2002). Although combining behavioural treatment with medication and surgery may enhance weight loss and weight loss maintenance (Wilson & Brownell, 2002).Whether weight loss is produced by surgical, biological or behavioural means, fundamental changes in behavioural and cognitive factors are necessary for the progress to be sustained. Combining behavioural weight loss treatment with other, more modern approaches such as drugs and surgery is an important area of enquiry.

Cognitive behavioural therapy

Cognitive behavioural treatments have three features that together distinguish them from behaviour therapy and other forms of psychological treatment. Cognitive behavioural treatments are based on a cognitive conceptualisation of the processes that maintain the problem in question. In other words, they are devised from theory concerning the maintenance of the problem that places central importance on the contribution of the cognitive processes. Cognitive behavioural treatments are designed to modify the postulated cognitive maintaining mechanism, the prediction that this is necessary for there to be lasting change. The primary aim for cognitive behavioural treatment is to produce cognitive change, although other features are also directly addressed. Cognitive behavioural treatments use a combination of cognitive and behavioural procedures to help the patient identify and change the targeted maintaining mechanisms.

In many respects, cognitive behavioural therapy is similar to behavioural therapy. Many therapeutic techniques are common to both treatments. Both involve the presentation of an explicit model of the maintenance of the problem in question: both use similar collaborative style; and both require patients to be active participants in the change process. Lastly, both are committed to seeking empirical evidence to evaluate their effectiveness and to evolving in response to clinical and research findings. Despite these similarities, behaviour therapy unlike cognitive behavioural therapy, does not stress cognitive processes.

Surgical and specialist care focused strategies

There are two main arenas from which individuals can receive help to lose weight from specialist services. These include surgical treatment and specialist units.

Surgical treatment for obesity and overweight

Due to the increased incidence of obesity surgical treatment, which is known as bariatric surgery (Patient U.K. 2008) has been introduced as a therapy for the severely or morbidly obese, due to the increased incidence of disease (NHLBI. 1998 and NIH. 1992). Bariatric surgery has evolved over the last five decades and it includes a number of different procedures including; Jejuneileol Bypass, Gastric Bypass, Gastroplasty, Vertical Banded Gastroplasty, Gastric Banding and Laparoscopic Bariatric Surgery. These procedures aim to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and/or absorption.

The surgical treatment of patients with a BMI of greater than 40kg/m², or with a BMI of greater than 35kg/m² combined with co-morbid conditions, has gained increased acceptance among surgeons, physicians and the public (NHLBI. 1998). Following such surgery individuals' health can be significantly improved (Haslam, 2008 and Sjostrom *et al.,* 2007) and NICE advocates the appropriate use of bariatric surgery (2006). Although surgery is frequently employed when other methods have failed, it is generally agreed that it should not be used as a stand-alone intervention (Latifi *et al.,* 2002) as surgical intervention only acts on the calorie intake aspect of weight control and not lifestyle issues. However, the effects of surgical procedures can be

greatly improved by lifestyle changes, such as increased exercise, which increases calorie expenditure. Some surgical approaches may lead to nutritionally unsound weight reduction. For example, protein calorie malnutrition has been reported for each of the malabsorptive operations.   Although some of the problems may be attributable to poor patient compliance or failure to keep nutritional follow up appointments, some appear to be intrinsic to the procedures themselves.

Specialist units to treat obesity and overweight

Society has only recently addressed the issues of obesity in the United Kingdom so therefore obesity speciality units are only in their infancy in this country. Consequently, the practitioners who work in this arena often work independently and at present service provision, often due to limited funding, may be ad hoc. Procedures and referral criteria may vary between primary care trusts (Leff & Heath, 2009). This is an arena that is likely to develop with time and substantial funding, although in some instances the private sector would appear to be leading the way, for instance, the opening of new private hospitals such as Dolan Park to perform surgery on the clinically obese. "In fact, only one third of individuals who have surgery to treat obesity in the United Kingdom are treated by the NHS" (McLannahan & Clifton, 2008).

Summary

Different individuals use a variety of means to lose weight and there is a significant choice at their disposal. However, finding exactly the right fit of treatment, product or approach to enable the individual to lose the weight they desire appears to be an elusive goal.

It would appear that the present diverse approaches currently available to assist individuals to lose weight have varying levels of success. Maintaining such weight loss is problematic for the majority of individuals. The fact that such regimes have limited success and individuals are often repeatedly trying to lose weight suggests that we need to understand in more detail the experience of intentional weight loss. This will be discussed in the next section of this chapter.

Researching the experience of obesity and intended weight loss.

Following on from discussing the practical approaches utilised by individuals to help them to lose weight, in this section of the chapter, it is the intention to investigate what is currently known about the experience of obesity by reviewing findings from qualitative research studies. Whilst the number of qualitative studies found and reviewed was very low, the findings reveal issues and themes that merit further investigation.

The psychological aspects of being overweight

Impact on the individual of being overweight

Only four qualitative studies were identified that explored the impact on the individual of being overweight. Two of the studies were international papers: Goodspeed Grant & Boersma (2005) and Johnson (1990). The other two studies, Bidgood & Buckroyd (2005) and Barker & Cooke (1992), were British based. I will give an overview of each study before reviewing the results in detail.

Goodspeed Grant & Boersma (2005) conducted a study in the US which qualitatively investigated the experiences of being overweight, dieting and weight cycling through two in-depth life history interviews with each of the eleven participants attending a hospital based weight management clinic. The research questions or research focus was how individual's explain their obesity. The researchers recorded perception was that emotional issues and barriers to maintaining healthy weight were complex and deep. In conclusion, the researchers advocated the value of investigating the use of the psychodynamic approach as weight programmes based in behavioural or cognitive behavioural paradigms have, according to their study, dismal success rates.

Johnson (1990) conducted a study in the US, which used a qualitative design to interview thirteen informants, although it was unclear how many times the respondents were interviewed. The experiences of these dieters were investigated so that their experience of weight loss could be understood and a theory related to three stages of weight loss was proposed. This study was community based and observation

was an additional mode of data collection. This is admittedly an old research study and some methodological questions remain unanswered but it has provided some useful if possibly historical data.

Bidgood & Buckroyd (2005) conducted a study in Great Britain which qualitatively investigated the experiences and feelings of eighteen obese men and women during their attempts to lose weight and maintain their weight loss. The research participants were recruited from the general public by a series of advertisements. Eight individuals were interviewed once for approximately an hour and the other ten individuals were divided into two focus groups. The study's findings suggested that counselling could play a greater part in the treatment of obesity. The first author was a counsellor and the second author was involved in education.

Barker & Cooke (1992) conducted a British study which was of a qualitative design and consisted of short twenty minute one to one interviews across the north of England in the community setting. The research focused on individuals' perceptions of being overweight, motivations and barriers to losing weight and weight loss strategies. Focus groups were also used as an additional method of data collection. This study is also rather dated but has provided limited but useful data, for instance, individuals' beliefs about metabolism and genetics were explored.

From these studies key factors that were identified as having an impact on overweight individuals range from feeling good, guilt, sense of blame and sense of control. These will be outlined in turn.

Results from Goodspeed Grant & Boersma suggest that some people used food to replace a close relationship. "Some of my eating I think is because I am lonely. I miss my husband" (2005:216). The consumption of food also produces an initial feel good factor in the individual especially when life is challenging:

> I found comfort in food. It was my best friend…There is a connection for me-
> when things aren't going so well, to gain pleasure from food consumption and it
> became a pattern (Goodspeed Grant & Boersma, 2005:216).

However, in many, the initial feel good factor is quickly replaced by guilt for having eaten and then self-loathing, which follows a repeatable pattern:

> Food makes you feel better. Then you overeat, you don't feel very comfortable and you feel worse. Then you say why do you keep doing this to your body? But it is so ingrained; it's very hard to break out of that (Goodspeed Grant & Boersma, 2005:216).

Some individuals feel that genetics, heredity and metabolism are to blame for their size:

> It's the way the whole family is built. If you come from a long line of people who have been overweight in the past…it just goes on and on and on (Goodspeed Grant & Boersma, 2005:217).

> Some people can eat anything they like, it's just your metabolism…you're either going to be slim or you're not (Barker & Cooke, 1992:119).

> My mum was fat, my gran was fat, my aunties are fat, it runs in the family…it must be hereditary, so therefore there's nothing can be done (Barker & Cooke, 1992:119).

The addictive aspect of food has been likened by some to a chronic disease such as alcoholism:

> It's like being an alcoholic…obesity is a disease. It is not curable but it is treatable…Binging my old friend…it is a compulsive behaviour, like drinking leading to alcoholism for some people. It is something I will always have to deal with (Johnson, 1990:1293).

> You've got to have something to eat (Bidgood & Buckroyd, 2005:223).

And yet some of the same individuals blamed themselves for their weight loss failure and not being in control:

It's not easy. It takes a lot of self-control. And I don't think I've ever had the self-control (Goodspeed Grant & Boersma, 2005:217).

However, being in control and out of control appears to be dichotomous. As although individuals blamed themselves for not being in control of themselves they also acknowledge that food exerted a controlling force over them:

I was really addicted to food at that point. There are times when I sit down to eat and it's hard to stop-like there is no turn off switch (Goodspeed Grant & Boersma, 2005:217), a comment also reiterated by a respondent in the Bidgood & Buckroyd (2005) study.

I am addicted to food, it must be like an alcoholic feels he can't pass a pub or an off licence, I'm like that with a cake shop or a sweet shop (Barker & Cooke, 1992:118).

Also these often highly organised individuals seemed unable to organise control of their food intake:

So much of my life I am a checker and an organiser, but when it comes to writing down food, I've struggled always with this, I don't know what it is, I just hate doing it (Goodspeed Grant & Boersma, 2005:217).

On reflection it would appear that only two research studies in this arena are recent and only one of these recent qualitative studies is based in Britain. Such studies even if historically situated have identified themes about individual's experience of weight loss such as self-loathing, feelings of guilt and comfort eating which would be difficult to identify by non qualitative studies. However, gaps are evident. For example, Bidgood & Buckroyd (2005:228) advocate repeating their study in a wider arena and recommended that new participants "add significant new statements of their own."

Only one of the most recent studies, Bidgood & Buckroyd (2005) was set in the community and this is a distinct research gap as the community setting is vitally

important because this is where the greater majority of individuals try to lose weight. For instance, attendees at commercial slimming organisations far exceed the number of individuals undertaking hospital based weight loss programmes. Therefore, it would appear that gathering increased knowledge with respondents in this setting is vitally important. Consequently, this is one of the reasons for the study reported in this thesis to be firmly focused within the community arena.

After considering these papers none were of a longitudinal nature and only used qualitative gathering data tools once, apart from the Goodspeed Grant & Boersma, (2005) study, in which all the respondents were interviewed twice. This certainly highlights a deficit in the research arena. Furthermore, the weight loss process takes time, which is why the study reported in this thesis has a longitudinal nature and has been designed to last for a year, and why each respondent was interviewed four times over that year in order to obtain a fuller picture of the individual's experience of intentional weight loss.

Personal reaction or response to being unhappy with one's self

In non-qualitative studies it has been reported that dissatisfaction with body image can be a real motivator for losing weight (Putterman & Linden 2004; Anderson 2002 and Cash, 1995). However, only a few qualitative studies have explored this in depth. I will provide an overview of each of the following studies in turn before discussing their findings in more detail, Hurd Clarke, (2002); Lopez, (1997) and Boyd (1989) from the international arena and the British studies Ziebland *et al*., (2002) and Roberts & Ashley (1999).

Hurd Clarke (2002) in her Canadian study examined the meanings that the older, female participants attributed to dieting, desired body weights and obesity. Semi structured interviews were conducted usually in the respondent's home. Each respondent was interviewed two or three times but with only one or two weeks between each interview.

Lopez (1997) in her American study investigated women's lived experiences of undergoing treatment for weight loss. Six women were interviewed twice about how

the requirements of trying to lose weight imposed changes on their normal daily life activities. The struggle between trying to lose weight and normal daily life was evident in five out of the six women interviewed.

Boyd's (1989) American study has been included in this section as the qualitative data obtained was very revealing about individuals' feelings about their weight. The twenty women involved in the eight week counselling programme were not actively trying to lose weight but dieting and expectations surrounding dieting were discussed.

Ziebland *et al*., (2002) in their British study investigated men's and women's experiences of weight change in adulthood, body image preferences and beliefs about health. Semi structured interviews were conducted in the respondent's home. Each participant was interviewed once. Respondents were sceptical of the possibility of controlling weight without considerable personal sacrifice. Certain participants were targeted to ensure certain socio-economic groupings and genders were represented.

Roberts & Ashley (1999) in Great Britain sought to identify the characteristics of successful weight loss. This was because they viewed obesity as one of the most difficult areas to influence in relation to modifiable cardio risk factors. The study was community based and both qualitative and quantitative data was obtained. Open semi structured interviews were conducted by a single interviewer in the respondent's homes. Each participant was interviewed once. The quantitative data was collated by a statistical computer package. However, the actual experience of weight loss was not investigated.

Being unhappy with one's self is very often the trigger for action for overweight individuals, action is very often their personal response to their unhappiness and distress they feel about themselves and this leads them primarily to dieting (Boyd, 1989). In all the studies, the respondents report they are unhappy with their selves if they are overweight and their personal response is often to attempt to lose weight. However, their motivators it appears may differ. This study seeks to explore what individuals in this study perceive as helping and hindering factors and their motivation behind such an action. For instance, Roberts & Ashley in their (1999) study stated that health was a major reason for starting a diet but on the whole other

studies such as Putterman & Linden (2004); Ziebland *et al*., (2002) and Lopez (1997) do not concur with their viewpoint. The participants of two studies did however ascribe health as a motivator. Although Roberts & Ashley (1999) did recruit their patients from their own surgery, which may have influenced the findings because of the possibility of a power balance as the individuals were interviewed by their own doctors. In the Hurd Clarke (2002) study six out of the twenty-two women defined health as a reason for dieting. However, this may be because they were older women whereas in other studies it appears even an awareness of the health consequences of being overweight seems to be limited (Ziebland *et al*., 2002). This challenges health professionals who list health concerns to obese individuals as the primary reason for weight loss. This is a research area that needs to be further examined and the individual motivators for weight loss are explored and are addressed by the research questions in the study reported in this thesis.

Individuals often have unrealistic expectations of weight loss and surrounding life factors which affects how they feel about themselves:

> Being thin was equated with happiness, success, marital bliss and positive self-esteem. Most felt that if they were thin, positive life experiences would follow (Boyd, 1989:48).

It would appear that there are still gaps in the knowledge about the experience of intentional weight loss. The duration or process of intentional weight loss was not investigated by the Ziebland *et al*., (2002) and Roberts & Ashley (1999) studies as these respondents were only interviewed once or in the Hurd Clarke (2002) study where each respondent was interviewed in a short space of time. Whereas in the study reported in this thesis each individual will be interviewed four times over a period of a year in order to capture the individuals' experience of their intentional weight loss.

Overview and reflection on the reviewed literature

Although a number of studies have been conducted to investigate the experience of obesity and intended weight loss, a number of gaps in knowledge still exist including

very few studies being British based, set in the community or being longitudinal in nature.

Very few of the studies are British based, only four adult studies were identified: Bidgood & Buckroyd, (2005); Ziebland *et al*., (2002); Roberts & Ashley, (1999) and Barker & Cooke, (1992) and only two of these have been conducted in the last ten years. Primarily, literature in the experience of obesity and intended weight loss tends to be from the USA and then Canada, New Zealand, Europe and the Scandinavian countries. This may well reflect present day society, with the history of increased incidence of obesity in the USA compared to other parts of the world. But the United Kingdom is rapidly catching up and obesity will and is having a major impact on our society and ultimately our nation's health. Hence it would seem timely to conduct research into this arena with a British focus.

Only a few of the studies are set in the community where the majority of larger individuals reside. A number of studies are set in the clinical/hospital venue such as the post bariatric surgical arena (Bennett *et al.,* 2007) or in the academic arena (Heymsfield *et al.,* 1999). Yet many of the individuals who are obese or overweight try to reduce their size in the home arena as the sales of quick fix products and weight loss aids and membership of weight loss groups testifies. Therefore, a community-based study investigating the individuals' experience of trying to lose weight would be appropriate at this juncture.

The long term aspect of trying to lose weight has been previously highlighted but only a few; primarily international studies (Goodspeed Grant & Boersma, 2005; Hurd Clarke 2002 and Lopez, 1997) have been longitudinal in nature, and then only for a short period of time. Therefore conducting a British, community based, longitudinal study would appear to be an appropriate research study to conduct.

During the course of reviewing the lived experience arena a number of themes have been identified. These include:

- Food replacing a relationship (Goodspeed Grant & Boersma, 2005).

- The feel good factor surrounding the consumption of certain types of food (Goodspeed Grant & Boersma, 2005).
- The feelings of guilt and the self-loathing, which quickly replaced the conditioned, feel good factor that the ingestion of the food produces (Goodspeed Grant & Boersma, 2005 and Hurd Clarke, 2002).
- The addictive aspects of food (Bidgood & Buckroyd, 2005 and Johnson, 1990).
- The self-beliefs about genetics, heredity and metabolism (Goodspeed Grant & Boersma, 2005 and Barker & Cooke, 1992).
- The concept of self-blame (Goodspeed Grant & Boersma, 2005).
- The dichotomy of lack of control and self-control (Bidgood & Buckroyd, 2005; Goodspeed Grant & Boersma, 2005 and Barker & Cooke, 1992).

These themes would appear to merit further investigation

A potential conceptual framework for understanding obesity and weight loss

In this section, I will consider the concepts of motivation, rationality and the linked concepts of control and choice, coping, self-efficacy, intuitive eating and mindfulness which I will argue have relevance to the research questions posed in this study. The concepts may also potentially be able to illuminate the central concept of connectedness and the four themes of self-sabotage, internal conflict, control and choice, which have been identified as the findings in this study (see chapter four).

Motivation

It is for a number of reasons that individuals wish to lose weight and are motivated to undertake the weight loss process. Motivation arises from: "psychological events such as thirst to social aspirations and cultural influences such as those that creates the desire to excel" (Hilgard, 1953:349). This definition could be directly applied to the aims of an individual who wishes to change and lose weight, for instance, the individuals in this research state their aim is to become thinner, but their motivation comes from a number of avenues. To achieve their aim they are prepared for instance,

to change their behaviours by increasing their activity levels and reduce their dietary intake. These are the tools by which they aim to achieve their goal and their motivation arises from their desire to lose weight. According to Elfhag & Rossner (2005), motivational factors have been seen as predictors of weight loss.

The concept of motivation has caused controversy and debate in the fields of philosophy and psychology. Freud when he discussed the unconscious mind stated "it contained all kinds of disturbing and emotionally, significant ideas" (Hayes, 1994:227) which led to the assumption that individual motivators could not be detected or challenged because they were inaccessibly hidden in the person's unconscious mind. It could therefore be deduced that learning was preset. This view could seriously hamper people wishing to change their eating habits and weight status. Consequently, individuals who state they feel highly motivated to lose weight may still struggle to achieve their goal. In fact, this belief has been addressed by some weight loss initiatives challenging self-beliefs such as cognitive behavioural therapists working in the field of weight loss. However, humanists such as Abraham Maslow and Carl Rogers held differing views from Freud and believed broadly that individuals have the power to change and choose (Gross, 1992). This places the ability to lose weight into the individual's own hands.

Maslow (1954) proposed the human theory of "hierarchy of needs" in which sating need whether it be hunger or the conflicting desire to lose weight are both motivators. Maslow believed that each level had to be met before each individual could self actualise and this may be seen in the field of weight loss when some individuals only achieved their goal of weight loss when they have confronted deep rooted issues. Some studies have indicated that respondents believe their obesity is partly due to childhood trauma (Bidgood & Buckroyd, 2005).

In the health action model (Schwarzer, 2001) the motivational stage is triggered by the perception of threat to health. However, unlike some expectancy value models such as the health belief model (Becker, 1974) Schwarzer argues that only a minimal level of threat or concern is required to initiate consideration of change, for instance, a health professional recommending weight loss due to a small change in an individual's health status.

The term drive is used in the health action model (Tones, 1994) to describe strong motivating factors such as hunger, thirst, sex and pain. It is also used to describe motivations, which can become drives such as addiction. Some studies suggest that addiction is the consequence of frequently repeated acts, which become a habit and its base is a psychological fear of withdrawal (Davies, 1992). In some qualitative research studies investigating obesity and intentional weight loss, overeating has been termed as a compulsion (Bidgood & Buckroyd, 2005 and Goodspeed Grant & Boersma, 2005) and likened to the addiction of alcoholism by other studies such as Barker & Cooke (1992) and Johnson (1990).

Social learning theory (Bandura, 1977) uses the term 'instinct' to describe behaviours, which are not learned but are present at birth. Instincts can override attitudes and beliefs; hunger for example, can easily override a person's favourable intention to diet. With the role of expectancies, according to Bandura, the individual is motivated to engage in behaviours whose outcome is valued and they feel capable of performing. Many of the behaviours we engage in are a consequence of the role models we have been exposed to over the life course. From observing such models, we vicariously learn behavioural outcomes and establish efficacy expectations, without necessarily having direct experience of these ourselves. On its simplest levels overweight children are more likely to have overweight parents (Grilo & Pogue-Geile, 1999 and Maes *et al*., 1997). Modelling affected dietary intake among college students irrespective of the level of the student's hunger (Goldman *et al*., 1991).

Good health forms an action outcome expectancy and, if valued, a possible reward for engaging in health maintaining and promoting behaviour. It is a long-term outcome; very few health related behaviours especially trying to lose weight have an immediate and noticeable effect on health. The motivation to work towards the long term goal of good health, the appropriate height to weight ratio, frequently competes with the plethora of short term rewards for behaving in health damaging ways. For example, going off the diet to have a meal out. Even when good health is highly valued, lapses in behaviour can be justified through a variety of cognitive processes including denial and some form of bargaining, such as promising to eat healthier tomorrow, short term health outcomes may be much more powerful determinants of behaviour. Looking fit

and being able to get into attractive clothes may be more important determinants of success in dieting than any long term health gain (Norman & Bennett, 1996).

A modern version of behavioural learning theory, which has been applied to obesity, is the behavioural economics model (Epstein & Saelens, 1999). In this model behaviour is viewed as the result of benefits and costs. Benefits are interpreted as reinforcers, the reinforcing value of behaviours or the outcomes of those behaviours differ among people. Obese people obtain more reinforcing value from food than non-obese people (Epstein & Saelens, 1999). The ability to wait longer to earn a larger reinforcer instead of taking a smaller reinforcer immediately is called self-control, which is the opposite of being impulsive. People who were dieting were found to be more impulsive in obtaining food re-inforcers (Herman & Mack, 1975). Research on ways in which the behavioural economics model could be used to prevent obesity could include finding ways to supplement the reinforcing value of low energy foods among those who find high-energy foods highly reinforcing. A limitation of the model is that conducting a cost benefit analysis for every decision centred around food is highly unlikely to happen in reality.

Rationality and linked concepts of control and choice

An educational approach to health promotion has been used to provide knowledge and information to develop the necessary skills so that people can make an informed choice about their health behaviour. The educational approach should be distinguished from a behaviour change approach in that the educational approach seeks to inform the individual. The outcome will be the client's voluntary choice and it may not be the one the health promoter would prefer.

Most health education is given in the form of advice and the advice is usually given in the form of facts. It has been assumed that by providing knowledge there will be a modification in attitude, which will result in behaviour change. The advice model of health education: "Knowledge, Attitudes and Behaviour" (KAB) is based upon the idea that by increasing patient's awareness of the severity and threat of the disease (the cons) together with the benefits of complying with the recommended preventative actions (the pros) will result in a lasting behaviour change (KAB, Naidoo

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& Wills, 2000). This approach is often used in the field of primary care at the initial contact; patients are given the health information to help motivate them to lose weight or a diet sheet to take away with them. Essentially, this model proposes that patients can move from a state of being unaware of the need to change to a state of complete compliance with the recommended actions. However, the advice approach to motivating patients is flawed. The problem with giving advice is that although there may be some short term benefits, for the most part the advice is largely ignored. The limitations of the advice strategy include the behavioural aim of the intervention, the methods used, the time given for imparting the information, the inertia of mental life (resistances) termed cognitive dissonance by Festinger (1957) and the ambivalence or disinterest on either the health practitioner or patient's part.

The central premise of the KAB model is that it assumes that a person is rational and self-aware; having what has been termed the theory of enlightened self-interest (Baranowski, 1997). There has been substantial concern, however, that most people in most situations do not exhibit what would be considered effectively 'rational' behaviour (Shafir & leBoeuf, 2002). Individuals often do not act rationally in relation to eating, for instance, individuals do not just eat when they are hungry but are affected by societal and environmental factors. Attitudes may also influence decisions about eating. The KAB model by itself seems to be inadequate as a means of promoting dietary change. The concepts of knowledge and attitudes need to be more clearly specified conceptually and related to other variables within the overall process of change. This would potentially improve an individual's ability to choose to change their diet. The development of knowledge and attitude scales for each decision in the eating event may be a way of providing the needed specificity. If knowledge is revealed to be a key influence on behavioural change, procedures to change knowledge need to be more clearly specified within the context of effectively promoting behavioural changes in diet.

The educational approach is based on a set of assumptions about the relationship between knowledge and behaviour: that by increasing knowledge, there will be a change in attitudes, which may lead to changed behaviour. The limits of control and choice an individual has depends not just on knowledge but also on a number of other factors some of which the individual may have very little control over including the

very real constraints that social and economic factors place on individual's health related decision making.

To feel empowered increases the chances of a person making rational choices about their food intake. Self-empowerment is:

> A set of competencies and capabilities which together with certain related personality characteristics, contribute to a relatively high degree of actual control over a given individual's life and health (Tones & Tilford, 2001:40).

However, it has to be acknowledged that choice and ability to be empowered is sometimes limited by circumstances such as poverty, environment, and individual's capabilities and actions. In the field of addictions, for instance, the ability to cease smoking and the addictive behaviour may be challenging:

> It is said that the individual may be free to choose (whether he wishes to smoke). But the individual is not free; with the drug of addiction the option is only open at the beginning (McKeown, 1979:125).

Some of the reviewed literature supports the idea of addiction surrounding the compulsion to overeat and may affect what food choices an individual makes.

The health belief model, the theory of reasoned action and the stages of change model all support the idea that people are involved in a rational processing of information when they make a decision. A study by Stott & Pill (1990) was designed to assess patients views on health promotion in the general practice setting. What this study clearly showed was that people are not usually completely rational which may mitigate against the effectiveness of the health belief model, the theory of reasoned action and the stages of change model. For instance, when individuals take health related decisions to change their behaviour. This study of self-initiated change showed the importance of precipitation, life events, sometimes minor events, comments by other individuals and the minor part played by health concerns.

An assumption of the theory of reasoned action is that the individual has the resources, skills or the opportunities to engage in their desired action, in other words self-control. This is frequently not the case, and to address this weakness Ajzen, (1985) added a further dimension that of control, over the intended behaviour. This reflects the perceived ability of the individual to engage in the desired behaviour (Ajzen & Madden, 1986). Facilitating or inhibiting factors include both internal (skills, information) and external control factors (including opportunities and dependence on others). Perceived control combines with attitudes and perceived norms to form an intention to engage in a particular behaviour. This larger model was termed the theory of planned behaviour (Ajzen, 1985).

A criticism of the theory of reasoned action, theory of planned behaviour and also the behavioural economics model (Epstein and Saelens, 1999) is that these models do not explain why individuals make irrational decisions around food and eating (Stott and Pill, 1990) and therefore why in these instances their mind and bodies appear to be totally disconnected.

Coping and self-efficacy

The health belief model originally proposed by Rosenstock (1966) and modified by Becker (1974) has been used to predict protective health behaviour and compliance with medical advice (Gillam, 1991). The model suggests that whether or not people change their behaviour will be influenced by an evaluation of its feasibility and its benefits weighed against its costs. The model suggests that for individuals to engage in behavioural change they must have an incentive to change, they must feel threatened by their current behaviour, feel a change would be beneficial in some way and would have few adverse consequences and feel competent and able to cope with the change and to feel self-empowered enough to carry out the change.

The primary source for change within the health belief model is self-efficacy. Self-efficacy implies a mental or cognitive state of being in control (Winder, 1985). People with greater levels of self efficacy, self-belief or confidence, it is predicted, will be more likely to engage in specific behaviour, persist until they get it right, and maintain that behaviour. However, the health belief model has been widely criticised. Some of

these criticisms related to the model's lack of weighting for different factors; all indicators to preventative action, for example, are seen as equally salient.

This model may not be particularly helpful in predicting individuals who will or will not lose weight or identifying those elements that are important in influencing people to change but it does highlight the range and complexity of factors involved, including individual's coping skills and belief in themselves in their ability to achieve their stated goal.

The concepts of coping and self-efficacy may be useful in helping the results of this study be explained and interpreted. For instance individuals that cite helping factors may say their strong coping strategies could be useful in helping them to lose their weight whereas the opposite may be conversely true, if individuals say they find it hard to believe in themselves then their success at weight loss may be hindered.

Intuitive eating

Intuitive eating is a theory that could potentially explain the results in the study discussed in this thesis because of the emphasis the theory has on attending to the cues our bodies give us about hunger, which has the resonance with the concept of connectedness identified in this study. Intuitive eating is an eating style based on individuals listening to their own intrinsic cues about hunger and satiety prompting them to eat rather than responding to environmental or emotional triggers to eat (Avalos & Tylka, 2006; Faith *et al*., 2004 and Tribole & Resch, 2003). The theory of intuitive eating is represented in a number of fields. For instance, Tribole and Resch are both registered dieticians working in the clinical arena and Avalos and Tylka are based in a university psychology department.

Intuitive eating as a theory can be sub-divided into three components. Firstly, eating in response to physiological hunger signals and what the individual desires at that time (Tribole & Resch, 1995). Such individuals eat appropriately for instance after a period of not eating or eat only until they are full (Herman & Polivy, 1988 and Woody *et al*., 1981). Individuals who are prescriptive about their food and eating pattern often end up feeling deprived and preoccupied with food (Polivy & Herman,

1999 and Tribole & Resch, 1995). Such preoccupation with food persists even after restricted eating patterns have ended (Keys *et al.,* 1950).

Secondly, intuitive eaters respond to hunger and not emotional sensations to eat (Tribole & Resch, 1995). A boundary model proposed by Herman & Polivy (1983) suggested that individuals who did not diet when anxious or stressed would routinely eat less (Herman *et al.,* 1987). This is unlike individuals who routinely diet and tend to eat more when emotionally distressed or in defiance to their self-imposed dietary regime (Costanzo *et al*., 2001 and Herman *et al*., 1987).

The third component of intuitive eating is that individuals who routinely engage in intuitive eating are aware of their own internal hunger and satiety signals and trust these internal signals to guide their eating pattern (Carper *et al*., 2000 and Tribole & Resch, 1995). For instance, studies in children have shown that children will self regulate their daily intake in response to physiological hunger and satiety triggers, even if this results in each meal being highly variable (Birch *et al*., 1991). Such self-awareness is an important aspect of well being as defined by Rogers (1964) and is an intrinsic part of mindfulness (Grossman *et al*., 2004). Self-awareness also enhances an individual's ability to acknowledge their self and satisfy their needs and wants if they decide to.

Mindfulness

Mindfulness is a theory that could potentially explain the results discussed in this thesis because of the emphasis the theory has on mental and physical awareness and this has resonance with the concept of connectedness identified in this study. Mindfulness as a theory has been defined by a number of authors including Bishop *et al*., (2004); Brown & Ryan (2003) and Kabat-Zinn (1994). In this thesis the definition of mindfulness by Grossman *et al*., (2004) is utilised:

> Mindfulness is characterised by dispassionate, non-evaluative and sustained moment to moment awareness of mental states and processes. This includes continuous, immediate awareness of physical sensations, perceptions, affective states, thoughts and imagery (Grossman *et al.,* 2004:36).

This definition has been chosen because it aptly and succinctly defines mindfulness in relation to the way in which the construct of mindfulness is both open to the physical and mental experiences that the individual is undergoing. This definition of mindfulness potentially allows the opportunity of further exploration and application of mindfulness into the areas of food, eating and weight loss. The theory of mindfulness has been applied in the fields of physical, psychosomatic and psychiatric health (Grossman *et al*., 2004; Davidson *et al*., 2003; Bishop, 2002 and Kabat-Zinn, 1998). However, mindfulness has been applied in a limited way in the arena of eating disorders but even less in the field of weight loss.

The concepts of motivation, rationality and the linked concepts of control and choice, coping, self-efficacy, intuitive eating and mindfulness have been discussed in this section. The results identified and discussed in this thesis (see chapters four and five) and these identified concepts including the knowledge, attitudes and behaviour component of these concepts will be further discussed (see chapter five). This discussion will be in relation to the central concept of connectedness and conversely disconnectedness and the four themes of self-sabotage, internal conflict, control and choice identified in the results of the study discussed in this thesis (see chapter four).

Conclusion

Having considered the literature in both the research and the clinical fields of obesity and intended weight loss, a number of gaps have been identified. It appears that after considering the social, personal and health impact that obesity and the pursuit of intended weight loss has on the individual, there are only a few studies that have investigated the experience of the individual's world of obesity and intended weight loss.

Out of all the adult studies located and reviewed only a few are UK based and only a few are based in the community which is where the majority of individuals pursue their goal of intended weight loss. Only a few studies have obtained data that might inform our understanding of the experience of weight loss further. Considering the research gaps in this field, this proposed study is a British, qualitative, longitudinal

study based in the community which aims to investigate the experience of ten women trying to lose weight over a year. The use of a potential framework may be of assistance when reviewing the data obtained in this study. By conducting a qualitative UK based study designed to be set in the community arena, it is anticipated that an enhanced pool of knowledge about the experience of obesity and intended weight loss will be obtained. As Rogge *et al.,* said:

> It is unusual to hear obese people discussing what it is like for them to be overweight, and still more rare to hear them describe their weight loss failures (2004:301).

CHAPTER THREE: METHODOLOGY

Introduction

The overarching aim of the study reported in this thesis is to investigate individuals' experience of trying to lose weight. In order to address this aim, a qualitative approach was employed which involved interviewing ten overweight women on four separate occasions over the period of a year, about their intentional weight loss experiences. These interviews were then analysed and interpreted using Hycner's (1985) framework. This chapter will provide a rationale for the methods employed in the study, discuss the relative advantages and disadvantages of the methods and describe the processes and instruments used to collect the data.

A rationale for the use of a qualitative paradigm in this thesis

There has been significant debate regarding the relative merits of quantitative and qualitative approaches to research. This debate is not new or restricted solely to the arena of health promotion or education as other disciplines have also fiercely contested and purported the merits and qualities of each type of approach. Unlike quantitative research, which relies on facts and statistical tests, the foundation of qualitative research is that it is important to study the issue through the individual's eyes, their outlook and understanding, rather than through facts (Couchman & Dawson, 1995). The emphasis that qualitative research places on seeing things through the respondent's eyes has clear links with the overarching research aim of this study, namely investigating the experience of intentional weight loss.

The main arguments for the applicability of the qualitative approach to the study reported in this thesis, focuses on the potential to produce rich data and the desire to explore feelings and beliefs. The richness of the data sought in this study will emanate from exploring the subjective realities of each of the participants and the contexts in which they are trying to make sense of their weight loss experiences. As the research questions were developed, it was clear that I needed a qualitative approach to gather

rich narrative data about individuals' perceptions of their experience of weight loss. Flick (1998) argues that the research findings solely derived from quantitative data are rarely perceived or pursued in everyday life because in order to fulfil methodological standards their investigations are far too removed from the context of everyday people and their problems. The research questions of the study posed in this thesis are embedded in individuals actual experience of weight loss and have implications for how individuals might be assisted in their everyday lives to achieve their intended weight loss. Such richness is an attribute frequently assigned to qualitative research methods (Kvale, 1996 and Couchman & Dawson, 1995). For example, the exploration of feelings and beliefs is central to the aim of this research study and is underpinned by the argument that in order to understand how we can help people lose weight (and hence reduce obesity figures) we need to understand the processes that people go through when trying to lose weight. Qualitative approaches have traditionally been linked with explorations of feelings and beliefs (Harvey-Jordon & Long, 2001 and Bariball & While, 1994) and are often cited as a key strength or advantage of the qualitative approach (Robson, 2002; Patton, 2002 and Kvale, 1996).

A central facet of the qualitative paradigm is termed the interpretative paradigm (Schwandt, 1994), which is also known as the naturalistic approach (Guba & Lincoln, 1994). This approach acknowledges that objective reality is socially constructed (Robson, 2002) and human beings attach meaning to their subjective reality. Hence there may be multiple perspectives. Researchers with this worldview believe that understanding human experiences is as important as focusing on explanation, prediction and control. It was termed 'empathic understanding' by Dilthey (1833-1911) and utilised in Weber's Verstehen (Patton, 2002) approach of understanding something in its own context. This interpretavist approach lends itself ideally to qualitative research tools such as interviews utilised in this study. Another advantage of using an interpretative approach is it can generate new theories and uncover phenomena ignored by most or previous research or literature.

There has been limited research in the field of investigating individuals experiences of undergoing the weight loss process. Interpretative research uses people's subjective experiences as its starting point, as does this study. This however can be problematic as these subjective experiences are historically and contextually shaped. When

someone undertakes an interview and thus provides a narrative it is unique to that particular time, space and condition. If the interview was undertaken at a different time, with a different interviewer the respondent response could be different. In addition, the researcher who interprets the data produces his or her own version of the story told, a story that may also be different if another researcher had interpreted that data in another time situation or even different mood at that time. Rather than hide this subjective reality, using interpretative methods, this thesis aims to open up the subjective, to be transparent in how exactly the data was collected and make explicit the possible biases that can and do exist.

A justification for the use of the qualitative paradigm in this thesis

The qualitative paradigm incorporating the interpretavist construct was the dominant approach used in this thesis so that the initial knowledge and understanding that had been gained through the literature could be developed and clarified through obtaining the everyday knowledge, perceptions and narratives of the respondents being studied.

Although this paradigm is highly applicable and relevant to this thesis there are certain issues that need to be considered. When reviewing the potential strengths and weaknesses of the qualitative paradigm Candy (1991) discusses five issues, which need to be considered. These include multiple interacting factors, objectivity, the individual versus the universal, researching the whole, that research is value laden and naïve realism. They are explored in turn in relation to undertaking this research.

Multiple interacting factors

> The belief that any event or action is explainable in terms of multiple interacting, factors, events and processes. Causes and effects are mutually interdependent (Candy, 1991:432).

The qualitative/interpretative paradigm recognises the complexity of multiple interacting factors and a key aim is to understand how individuals attribute meanings to these factors and how they relate to their thoughts, feelings and behaviours. There are numerous interacting factors such as childhood, school and work experiences, their present home situation to consider just a few, which affect how individuals view

themselves and their weight (Bidgood & Buckroyd, 2005; Goodspeed Grant & Boersma, 2005 and Rogge *et al.,* 2004). The concept of multiple interacting factors ties in with the epistemological position taken for this thesis**.**

Objectivity

Candy (1991) argues that it is extremely difficult to obtain complete objectivity when human beings are being studied because they are complex, and exist in their own social world with their own views and beliefs that are a result of a complex melange of various factors such as school, home, culture and gender. The ontological position taken for this research is that objective truth is something that research should aim for but can never be fully achieved. However, research should not be seen as either subjective or objective in a dichotomist sense but rather in degrees of intersubjectivity. Therefore, the degree in which this thesis is subjective is acknowledged throughout the discussion in this thesis.

Individual versus universal

Candy (1991) and Oppenheim (1992) argue that research should be focused on the individual rather than being able to make generalisations about classes of people. This research tries to make sense of and understand the individuals views and experience of obesity and the weight loss process rather than carrying out a large survey on which generalisations could be made, it has been argued by Schofield (1993) that generalisations that say little about the situation or context have little to say about human behaviour. This research is designed to further understand individuals actual experience of undergoing an intended weight loss process and to possibly put forward theoretical propositions that others can use for instance when working with individuals who are trying to lose weight or possibly test further with more larger scale qualitative or quantitative studies.

Researching the whole

Candy (1991) argues that as the social world is composed of many realities the researcher should view each individuals experience in relation to the context in which they dwell. The qualitative/interpretative paradigm takes into account the complexities of social interactions, where the individual is placed in the social setting

and is concerned with the interaction between variables and how and when they occur. For instance, many factors have an impact on an individual's experience of their weight loss journey such as a comment from a friend or family member. Therefore it is anticipated that the longitudinal nature of the study reported in this thesis will be able to record and explore the different variables that may affect the ten women respondents on their individual weight loss journey.

Research is value laden

> The recognition of enquiry is always value laden and that such values inevitably influence the framing, focusing and conduct of research (Candy, 1991:432).

The interpretative paradigm acknowledges that research can be influenced by the researchers personal biases and idiosyncrasies. There is certainty a possibility that the research reported in this thesis will be biased by my own values. Therefore, the 'truth' presented in this thesis is not the only truth that could be constructed as the data will always be value laden, influenced and shaped by the researcher (Yates, 2003). I am a nurse and a large woman who has an interest in health promotion and helping those who wish to achieve their weight goals. As a consequence of such values, ongoing reflexive attention will be given so that this influence could be made as transparent as possible and explored in this section on reflexivity later. The Hycner (1985) format of data analysis was also utilised in an attempt to reduce possible biases and is further discussed later in this chapter.

Naïve realism

Parker (2005) highlights the dangers of naïve realism when undertaking interpretative analysis. Naïve realism is when the researcher treats the narrative that has been collected as empirical truth and thus presents it as such. Parker (2005) stresses the importance of identifying how the narrative is crafted for certain rhetorical purposes, out of certain kinds of cultural resource, for the researcher as a certain kind of audience. This is particularly important when dealing with issues such as weight and weight loss, which are so embedded in culture, social acceptance and gender in our present day society and all individuals but especially women are less acceptable in today's society if they are large (Rogge *et al.,* 2004; Sarlio-lahteenkorva, 2001 and Carryer, 2001).

A phenomenologically informed approach

The qualitative approach used in this study was informed by phenomenology. It is an appropriate approach to use when studying the experience of obesity and intentional weight loss. In this section, I will explain why I think it was appropriate for my study to be informed by phenomenology and why my study has used data gathering tools and a data analysis framework associated with the phenomenological arena.

The history of phenomenology may appear complex. Although Husserl has been acknowledged as the originator of phenomenology (Barkway, 2001; Toombs, 2001 and Crotty, 1996) and phenomenology has subsets, it is originally derived from philosophy. As Patton (1990:68) suggests phenomenology has been referred to as "a philosophy, a paradigm and a methodology and equated with qualitative methods of research". Phenomenological research focuses on the essence of the phenomenon (van Manen, 1990 and Merleau-Ponty, 1962). Schultz (1977) established phenomenology as an important perspective in social science. More recently, phenomenology has been allied with psychotherapy (Moustakas, 1988). Its usefulness in this research study is that "phenomenological research is the study of lived experience" (Oiler Boyd, 1993:126) and is useful for understanding that experience (van Manen, 1990). The phenomenological position sees the individual and his or her world as co-constructed (Maykut & Morehouse, 1994). The phenomenological viewpoint is a way to describe an individuals actual experiences without imposing prior assumptions on their reality (Holloway & Wheeler, 1996). This is vital to this study. A fundamental component of the study reported in this thesis is that the voice of the individual's experience of intentional weight loss is heard. At the core of such a methodology is a respect for the uniqueness of the human experience and data are approached with openness to whatever meanings emerge (Hycner, 1985). Such openness needs to be maintained throughout the entire research process and not just at the beginning:

> Openness is the mark of a true willingness to listen, see and understand. It involves respect, and certain humility toward the phenomenon, as well as sensitivity and flexibility (Dalhberg *et al*., 2001:97).

There is a tradition of using phenomenology in both the fields of education (Greasley & Ashworth, 2007 and Abrahamsson *et al*., 2005) and nursing/health promotion

(Bidgood & Buckroyd, 2005; Goodspeed Grant & Boersma, 2005; Rogge *et al.,* 2004; Lopez, 1997 and Santopinto, 1988). The rationales for using phenomenology in each of these fields focus on the fact that phenomenology is the methodology to use when wishing to achieve "a deeper understanding of the nature or meaning of our everyday experiences" (van Manen, 1990:9). For instance, when attempting to understand the experience of obesity "phenomenological research provides a way of bringing light to how individuals and families are aware or conscious of obesity in their life world" (Rogge *et al.,* 2004:302).

At the core of phenomenology is a respect for the uniqueness of the human experience and data are approached with openness to whatever meanings emerge (Hycner, 1985). This was certainly the intention of this research study. Phenomenology is also concerned with a completeness and depth of understanding of the phenomena (Moustakas, 1988 and Colaizzi, 1978). In the phenomenological approach, respondents are considered experts and are asked to discuss their experience from their own perspective (Munhall & Boyd, 1993) and this is a key component of the study reported in this thesis.

A phenomenologically informed approach has been integrated into this study in order to enhance the understanding of the individual's experience (van Manen, 1990 and Moustakas, 1988) of obesity and intentional weight loss. Considering the complexity and conflicts in the area of obesity, human change and intended weight loss the researcher believes that a qualitative approach informed by phenomenology would value the respondents and produce some very useful data:

> Human beings are complex beings who attribute unique meanings in their life situation…trust is the subjective expression of reality as perceived by the participant and shared by the researcher. Truth is context laden (Liehr & Marcus, 2001:256).

To date little research has been conducted into the issue of weight (Bidgood & Buckroyd, 2005 and Lopez, 1997) as seen from the perspective of the obese individual. It is anticipated that by exploring overweight individuals' accounts of their experience and dealings during their often-repeated attempts to lose weight over a year, a greater understanding of the phenomenon would be achieved.

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All the time I am seeking to understand how individuals perceive their experience of intentional weight loss, this seeking to understand the individuals' experience is the root of phenomenology.

Semi-structured interviews

The main purpose of interviews is that they are used to try and understand how people think and feel about a particular issue rather than determining strength of relationship between variables or causality of phenomena (Oppenheim, 1992) and this coincides with Candy's (1991:432) assumptions of interpretative research, where the aim is to develop an understanding of individual cases, rather than to make generalisations.

Face to face interviews have been found to provide an opportunity of modifying the researchers line of enquiry and the following up of interesting responses and identifying motives, which cannot be obtained by self-administered questionnaires (Robson, 1993). Kvale (1996) has argued that the use of interviews in research is a method of moving away from seeing human subjects as simple data that is external to individuals and towards regarding knowledge as generated between humans through conversations. It is a way of research that is seen as not just collecting data but an opportunity to find out the participants thoughts and feelings and importantly their interpretations of the subject being researched. Semi-structured interviews also provide the benefit of having a structured form of data that aids comparability of responses and the analysis of data using the Hycner (1985) format, with the flexibility of being able to follow a particular theme if this emerges during the interview.

Oppenhiem (1992) argues that one of the key tasks for undertaking an in-depth interview is to listen with the 'third ear'. That is to say, it is important to not only listen to what is being said but also what is not being said and to pick up on any gaps or silences and explore what is behind them. This links with the notion of naïve realism as described earlier where one must not just hear what is being said but to interpret what is being communicated. It was important to consider this because the respondents' may feel vulnerable when discussing such emotive issues.

Such interviewing is very adaptable and may open up other avenues or arenas to research (Britten, 1995). Furthermore, health researchers often want to further investigate a specific condition or health factor and how it impinges on the individual

and interviews allow the individual or patient to reveal this information. Interviewing gives the researcher the opportunity to further understand individuals (Fontana & Frey, 2000) and hear their voice (van Manen, 1990):

> The interview seeks to interpret the meaning of several themes in the life world of the subject. The interviewer registers and interprets the meaning of what is said and how it is said (Kvale, 1996:206).

Structured interviews would be inappropriate because the researcher is unlikely to be able to anticipate what it is like for each individual to try and lose weight and therefore is not in a position to frame very structured questions. Completely unstructured interviews would be inappropriate because they may be time ineffective and the obtained data may be difficult to analyse (Patton, 2002). The specific advantages of the semi-structured interview is that it would enable the researcher to:

a) Elicit viewpoints and ideas (Robson, 2002 and Patton, 2002). For example, "Well, I really think the only strategy is not to buy the stuff that I don't want to eat…it's under my control" (Margaret, second interview).

b) Explore the perceptions and opinions of respondents regarding complex and sensitive issues (Harvey-Jordan & Long, 2001 and Couchman & Dawson, 1995). For example, "I do find it hard. I do find it hard. I must admit" (Molly, fourth interview).

c) Be flexible-adapting questions to suit different participants needs and responses (Britten, 1995 and Talbot, 1994). I used different phrases in response to the participants needs such as "Do you feel you could tell me a little more about how you feel…?" or "Do you think you could tell me about your weight loss experience?".

d) Use questions to probe for more in-depth information, providing a significant amount of rich data (Kvale, 1996 and Couchman & Dawson, 1995). For example, from interview one I posed the question "I understand that you have decided to lose some weight. Could you explain to me what factors have led to your decision to try to lose some weight?"

e) Handle sensitive issues (Couchman & Dawson, 1995 and Barriball & While, 1994). For example, from interview two, I posed the question "How do you feel about yourself and/or your weight at the moment?"

In addition, interviews are a very common method in weight loss studies, for instance, Hurd Clarke, (2002) used semi-structured interviews in her study when she explored 22 older women's perceptions of their ideal body weight and their motivations for attempted weight loss. Each women was interviewed a number of times and the tensions behind the women's reasons for dieting was revealed by the use of such an interviewing technique. Interviews were therefore a natural but considered choice in this research study for gaining individuals perceptions about their experience of their weight loss process.

Finally, I have found that in my previous research at MSc level, in the clinical level and from reviewing other research literature, the semi-structured interview produces some unique, individualised and personal data from the respondents interviewed.

Weaknesses of semi-structured interviews

Whilst there are undoubted strengths of utilising semi-structured interviews there are also potential weaknesses. The tool of the interview is that of language and although both the interviewer and the research participant live in the same world and often share the same language and culture this can cause a dilemma. Holloway & Wheeler (2002) argue that having mutual customs or community norms may cause problems. For instance, the interviewer and respondent may belong to a similar socio-economic class but have different beliefs due to their family background or education. It is also possible that the interviewer can misinterpret the words of the interviewee or not hear what is being said due to a number of reasons including the researcher's own agenda. This can be avoided by active listening on the part of the interviewer, being aware of the potential bias and extensive preparation. This was one of the reasons I tape-recorded all of the interviews so that I could ensure that I heard the respondents and did not interpret the data in a biased way. This helped to promote credibility.

However, it has to be acknowledged that there are many barriers to acquiring credible data through interviews. For instance, one issue is how the participants might respond to such methods. Employing semi-structured interviews with a qualitative approach is

no guarantee that participants will talk to you. Some individuals are likely to talk very openly and respond to these methods and others may not do so. This is largely a matter of personality and where shy, introverted women are being interviewed, even the most skilful interviewer is unlikely to get them to enter into full conversation. It can be a challenge for the interviewer to enter the world of the interviewee and this can affect the value of the information gained. This is why I considered the impact I may have on the interviewee and the research. I considered issues such as my mode of dress and was approachable and attentive and appreciative of the respondents being involved in the research and freely giving up their time. I was also mindful of the fact that just because I am overweight does not mean that I have the same life experiences as other big people and I still need to listen intently to their story and their experience of weight loss.

Another issue is the extent to which conversations may lead to the discovery of truth about their lives. Cornell (1984) comments that people can give public or private accounts of the same situation depending to whom they are talking. The public account is the one that is viewed as socially acceptable and the private account is the one that reflects personal feelings. Private accounts may be more forthcoming where interviews are conducted at the interviewee's home, or on an equal basis. There are however, many barriers to promoting feelings of equality in the interview situation. As Cornell notes, while the interviewer and the respondent may be equal in some arenas perhaps such as gender they may be unequal in terms of class, race or education. These differences can lead the respondent to feeling a need to relate a public or acceptable account to the researcher. In the study reported in this thesis I felt that it was important that my actions, my dress, manner and body language encouraged the interviewees to feel able to offer their private accounts of their weight loss experiences.

Some have cautioned against the overuse of interviews such as Fontana & Frey who have termed our world as an "interview society" (2000:646) and the feminist researcher Oakley rather paradoxically writes "Interviewing is rather like a marriage: everyone knows what it is, an awful lot of people do it, and yet behind each closed door there is a world of secrets" (1981:41). Therefore, although it is a popular tool of data collection, the interviewing strategy needs to be clearly defined and transparent

to ensure credibility and discourage criticisms of anecdotalism (Bryman, 1988), poor technique or researcher bias.

Another potential critism of interviews is that the quality of the interviewing can be poor. Patton (2002) argues that as a significant amount of interviewing is conducted so poorly this weakens the value of the interview data obtained. Another possible criticism is as it is the interviewer who actually interprets the material of the interview this can consequently result in biased or skewed data as it is the interviewer who records and construes the sense of what the respondent says as well as other aspects such as tone or body posture (Kvale, 1996). Hence one of the reasons for using a robust data analysis process such as the Hycner format and by tape recording and transcribing the data verbatim was in order to combat the potential allegation of bias or skewed results. However, it has to be acknowledged that:

> The human instrument is the only data collection instrument that is multi-faceted enough and complex enough to capture the important elements of a human person or activity (Maykut & Morehouse, 1994:27)

Longitudinal studies

In designing this study other approaches were considered. However, in order to avoid a one dimensional and limited view of an individuals experience of intended weight loss I decided that to investigate this experience more fully it would be more appropriate to study a number of individuals over a period of time. Therefore, the context of the individuals world in which their experience occurred, could be incorporated. Very few weight loss studies have used a longitudinal approach and the studies that have utilised such an approach have often been very short lived. A longitudinal study utilises a single sample over an extended period of time therefore ongoing co-operation and good will in longitudinal research studies is vital.

There are a number of advantages of longitudinal studies, for instance, social change and evolution in an individual can be accommodated. Hence in interviewing individuals over a period of one year, who were actively trying to lose weight, I wanted to capture how they changed in that year. Denzin (1989) defined this as 'data triangulation'. Time, space and person are all inter related and relevant in a longitudinal study.

A greater amount of information can be obtained because data collection occurs over a number of occasions (Douglas, 1976). I interviewed the ten women a total of four times in this study during a year long period of time. This longitudinal approach shows how individuals change over the time period and also highlights such self-change from external influencers. It is also useful for charting individual's growth and development during the weight loss process.

The longitudinal approach gathers data contemporaneously rather than retrospectively. Therefore, avoiding the problems of selective or false memory, which is useful in this study. The longitudinal approach also enables change to be analysed at the individual micro level. Such individual data are more accurate than macro-level cross-sectional data. Sampling error is also reduced as the study remains with the same sample of ten women over the year. Such an approach also enables clear recommendations for future interventions to be made in the related spheres of health education interventions. The longitudinal approach also increases credibility in terms of spending enough time in the field, really getting to understand the lived experience (Leininger 1994).

However, there are some disadvantages with longitudinal studies which include problems of ensuring the respondents continue to take part in the study for its whole duration, (sample attrition). Respondents may drop out of the study due to a loss of interest, for instance, if they are not meeting their desired weight loss goal or if they move away from the area. This is a threat to credibility and was a consideration in this study as one respondent dropped out after the first interview, due to being moved away by the housing department, and one respondent moved after the third interview, as the tenancy on her flat was not renewed and she moved out of the area.

Instances may have changed in the participant's environment or life, which may affect them in some way, which could affect the respondents' responses. However, this can equally be seen as an advantage of a longitudinal study as weight loss is not something that happens quickly and individual's circumstances will inevitably change during their weight loss quest. However, some instances are so overwhelming as to totally change their perspective, for instance, unexpected bereavement.

Longitudinal studies are time consuming, as it takes a long time for the studies to be conducted and for the results to emerge. This may be part of the reasoning why there are so few longitudinal studies in the arena of weight loss as funding may be difficult to obtain and researchers may not desire or be able to devote time to a longitudinal study. There may also be problems over sample mortality, which heighten over time and diminish initial representativeness, such as gender balance and age of the respondents. This may be a significant issue in educational research as students finish their studies and teachers move away and teaching methods change over time.

There may also be control effects, as repeated interviewing of the same sample may influence their behaviour. This was something I was acutely aware of especially, for instance, when participants asked my opinion on various diet plans or products advertised in newspapers.

When considering longitudinal studies there may be a problem of securing participation as it involves repeated contact. However, this did not prove to be an issue in the study reported in this thesis.

In longitudinal studies significant amounts of data are often produced which may be rich at an individual level, and are typically complex to analyse. This is the main reason why I utilised the Hycner (1985) method of data analysis, which is a robust framework, to explore the complex and significant data obtained in this qualitative longitudinal study.

Only a few studies investigating the experience of weight loss have used the longitudinal approach. These include the Canadian study by Hurd Clarke (2002) who interviewed each respondent two or three times but only over the relatively short time of approximately six weeks and Johnson (1990) who undertook multiple in depth interviews over a twenty one month period. However, this is a relatively old study based in America and consisted of a convenience sample of individuals who were attending a 'weight reduction centre'. Carryer (2001) did investigate nine individuals' experiences over a three-year period but the study was designed to investigate their experiences of obesity but not their experiences of intentional weight loss. It was also based in New Zealand. Therefore, it would appear that there are no up to date, British studies in this area. It is understandable why this is the case, as there are inherent

difficulties in the longitudinal approach which have been previously discussed but the new data that such an approach would yield, and the knowledge gained which could be utilised in the health education and health promotion arena are some of the spurs behind this study. Therefore, utilising a longitudinal approach enhances the value of this study, which explores the experience of ten women trying to lose weight, at this moment in time.

The Hycner (1985) data analysis framework

Phenomenology is both a theory and a method and Hycner and other qualitative researchers have offered us different frameworks to analyse the qualitative data. After reviewing the Hycner framework it would appear that it was applicable to this study. Therefore, in this study, Hycner's (1985) format of phenomenological analysis, (see appendix 2) was utilised to analyse the significant amount of qualitative data the study produced. Hycner's method of data analysis has fifteen stages (see appendix 12). These include:

1. Verbatim transcription

2. Bracketing and phenomenological reduction

3. Listening to the interview, for a sense of the whole

4. Delineating units of general meaning

5. Delineating units of meaning relevant to the research question

6. Training independent judges to verify the units of general meaning

7. Eliminating redundancies

8. Clustering units of relevant meaning

9. Determining themes from clusters of meaning

10. Writing a summary from each individual interview

11. Return to the participant with the summary and themes

12. Modifying themes and summary

13. Identifying general and unique themes for each interview

14. Contextualisation of themes

15. Composite summary

How I utilised Hycner's (1985) method of data analysis on a sample of the transcripts is demonstrated explicitly (see appendix 12). This enables the data analysis to be transparent and credible to the reader and would enable another researcher to repeat the data analysis process I followed.

Hycner's stages of data analysis will be discussed in more detail later in this chapter where the data obtained from the semi-structured interviews is discussed.

Hycner devised his (1985) framework to elucidate the format of phenomenological data analysis. Despite the works of Colaizzi, (1973, 1978); Giorgi, (1975); Keen, (1975) and Tesch, (1980) Hycner felt that many individuals found the process of analysing qualitative data in a phenomenological manner daunting. Hence Hycner formulated a "step by step" (1985:279) process, which was intended to be simple and easy to follow. Despite this intention, researchers need to use the framework with an awareness that Hycner wrote his guidelines with reluctance, because he was concerned that "no method (including this one) can be arbitrarily imposed on a phenomenon since that would do a great injustice to the integrity of the phenomenon" (Hycner, 1999:144). He was also concerned that being so pedantic would swing the pendulum of phenomenology towards the natural sciences. Keen also shared his concern:

> Unlike other methodologies phenomenology cannot be reduced to a 'cookbook' set of instructions. It is an approach, an attitude, an investigative posture with a certain set of goals (Keen, 1975:41)

The Hycner framework has been utilised in a number of studies in the arenas of educational and health related research. Studies in the educational arena utilising the Hycner framework include Groenewald, (2004); Pattison, (2003); Warr, (2002); Koetsier & Wubbles, (1995) and Ashton & Shuldman, (1994). Studies in the health

related arena include Gallagher & Jasper, (2003); Richardson, (2002); Everall & Paulson, (2002); Tepper *et al*., (2001); Whitman *et al*., (2000); Lindsey & McGuiness, (1998) and Hafsteindottir, (1996). These studies have utilised the Hycner framework for a number of reasons, for instance, the educational study by Groenewald (2004) utilised the Hycner framework because of it's adaptability and because the data was validated by the respondents themselves thus ensuring a "validity check". This supports the rationale for why I have utilised Hycner's framework. In Warr's (2002) educational study Hycner's framework was utilised partly because it can be successfully applied to qualitative data and also because using a documented structure of analysis adds credibility to the data obtained (Warr, 2002). Ashton & Shuldham (1994) utilised the Hycner framework to allow individual variations or themes to be investigated as well as commonalities. This is vital in the study reported in this thesis, which is investigating the experience of intentional weight loss, where everyone's uniqueness will be valued. This is particularly important when considering previous arguments that not every overweight person is the same (Barron McBride, 1988).

Whitman *et al*., (2000) explored the process of acknowledging one's own sexuality to others and the Hycner framework was utilised to enable the data to be respected and to be faithful to the phenomenon of the subsequent material obtained which is a vital consideration in the study reported in this thesis. Lindsey & McGuinness (1998) argued that the Hycner framework allowed the research data to be fully explored, through the minute examination of the phenomenon.

Adaptations to the Hycner framework

A number of studies that have used Hycner's framework have adapted it in some way. For example, both Groenewald (2004) and Twisleton (2000) adapted the Hycner format by merging the stages of the framework and Groenewald (2004) simplified the fifteen stages into five phases. It also appears that Groenewald (2004) did not utilise independent judges. Lindsey *et al*., (2001) integrated Hycner's framework with frameworks offered by Patton (1987) and Huberman & Miles (1994).

Hycner (1999) himself said that his framework could be adapted by certain researchers who felt confident to bypass stages eight "clustering units of meaning" and nine "determining themes from clusters of meanings" and then advance to the

core theme which communicates the fundamental nature of that section of the interview.

I have adapted Hycner's framework of analysis to adapt to the nature of my study. As each individual is interviewed up to four times the framework was elongated to accommodate this. Unlike the original Hycner framework where each stage is completed once or possibly twice I completed each step up to four times because each respondent was interviewed four times over the year. I also ensured that each individual reviewed the interview data after every interview "to ensure the heart of the interview had been totally captured" (Hycner, 1999:154). But because so much qualitative data was available not all the data was reviewed by independent judges, a sample of three interviews from each of the four stages was reviewed. Such adaptation I believe has significantly reduced the possibility of the cookbook scenario in this study.

Strengths and weaknesses of the Hycner framework

The Hycner framework has a number of distinct strengths that allow it to be suitable for analysing qualitative data. For instance, the Hycner framework can be utilised to analyse data co-jointly with other researchers as was utilised in the Koetsier & Wubbels (1995) study, which investigated trainee teacher's initial reality shock when they began teaching. The adaptability of the Hycner framework is also a great strength (Groenewald, 2004)). This is despite Hycner's (1999) fears that imposing a method on the data would affect the phenomenon.

In the Hycner framework the validation of the data is enhanced as the interview data are reviewed by independent judges (stage six of the framework) and the researcher herself also reviews the data to ensure the findings "ring true" (Coles, 1974). In the Hycner framework, stage eleven ensures the data is reviewed by the respondent, thus ensuring a "validity check" (Groenewald, 2004). This ensures that the "heart of the interview has been totally captured" (Hycner, 1999:154).

The Hycner framework acknowledges that individual or unique themes are as important as commonalities with regard to the phenomenon being investigated. This was apparent in the Ashton & Shuldham (1994) study and in the Barron McBride

study (1988), in which data confirmed that not every person who is fat or large is the same. Consequently, this was a consideration in the study reported in this thesis.

The Hycner framework can be applied to interview qualitative data obtained from different methods such as focus groups and one to one interview data (Russell *et al.*, 2003) and also via focused interviews (Warr, 2002). Warr also acknowledged "The use of a recognised framework of analysis adds credence to the generated themes" (2002:243).

Another strength of the Hycner analysis framework, which has also been discussed in the adaptability section of this chapter is that the Hycner (1985) framework can also be integrated with other approaches and authors such as Patton (1987) and Huberman & Miles, (1994) when undertaking qualitative thematic analysis. An example of such integration is the Lindsey *et al.,* (2001) study, which combined the Hycner analysis framework with thematic analysis to explore community development.

Other instances of such integration include the exploratory educational study by Pattison (2003), which investigated the experiences of international students, combined the frameworks of Colaizzi (1978) and Hycner (1985) in order to fully understand the participants meaning. Everall & Paulson (2002) in their education study co jointly analysed their interview data utilising the frameworks of Colaizzi (1978) and Hycner (1985). It was the aim of these researchers to capture the essential qualities of the participant's experiences, which they believed would be more fully captured if they used a combination approach. In the 2001, Tepper *et al.*, study the same combining process was followed in order to allow depth of understanding to be open to whatever meanings emerged. In the Fater & Mullaney (2000) study the authors additionally listed each cluster of themes along with its formulated meaning, in order to promote auditability as advocated by Hycner, (1985). The Hycner framework can be used when a study is seeking to investigate an individuals experience such as in the Hafsteindottir (1996) study. This study investigated the individuals experience of communication whilst respirator dependent. The Hycner framework was also used in the 1995 Koetsier & Wubbels study which investigated bridging the gap between the reality shock student teachers experience in their first professional year. The ability of the Hycner approach to be combined with other frameworks shows how adaptable the framework can be for use by researchers and

also is one of its inherent strengths. Although, it is not essential as the Hycner (1985) framework can be utilised to competently analyse qualitative data in a study underpinned by a qualitative and phenomenological approach.

However, with all frameworks and methodologies there are weaknesses. For instance, the fact that the Hycner framework has fifteen distinct steps can produce an interruption of the data and can be difficult to strictly apply. This is possibly why a number of researchers such as Groenewald, (2004) and Twisleton, (2001) have merged some of the steps together. Although this could also be seen as a successful adaptation and strength and has been previously discussed. This is a process that Hycner (1999) acknowledges is acceptable if the researcher is experienced and the integrity of the data is maintained.

Alternative frameworks used in weight related studies

Researchers exploring the experience of weight have used a number of different frameworks. Goodspeed Grant & Boersma (2005) investigated the experience of being fat and utilised van Manen's (1997) framework to analyse the qualitative data. In the 2002 study by Hurd Clarke and in the 1990 study by Johnson grounded theory was utilised (Glaser & Strauss, 1967). The New Zealand study by Carryer in 2001 investigated the concept of embodied largeness using a process of thematic analysis to analyse the qualitative data. In the Santopinto (1988) study, which explored anorexia nervosa, Giorgi's (1975) framework was used to analyse the data investigating the "relentless drive to be ever thinner". However, a review of these studies revealed that in most of these studies very little reason has been given for why a particular framework is utilised.

Rationale for utilising the Hycner (1985) framework in this study

Qualitative data can be analysed phenomenologically using a number of different frameworks such as those suggested by Van Kaam, (1966); Colaizzi, (1978) and Giorgi, (1970). After in depth consideration of the strengths and weaknesses of Hycner's method of phenomenological analysis, this approach was deemed as the most appropriate for this study, for a number of reasons.

Firstly, the Hycner framework has been used successfully in a number of studies that discuss very powerful and emotive subjects such as child protection (Gallagher & Jasper, 2003) and sexuality (Whitman *et al*., 2000). The experience of intentional weight loss is an equally personal and emotive area for the individual involved. Therefore, it would appear an appropriate framework for use in this study.

Secondly, Hycner's framework allows a significant amount of subjective interview data to be analysed. As each respondent in the study was interviewed up to four times over the period of a year producing a wealth of data, such an accommodating structure was useful for this research study. Using a clear framework allows the true essence of the experience under investigation to be clearly depicted from the individual interviews. This essence is validated by the respondents own verification of their transcripts and ensures that the "heart (essence) of the interview has been totally captured" (Hycner, 1999:154).

Thirdly, Hycner's (1985) framework for analysing qualitative data is clearly depicted and as a relatively inexperienced researcher, this was useful to me in this study. Therefore, it can prove advantageous to have such a clear framework to work to assist the analysis of qualitative data:

> I have found that for many students and colleagues…they have many questions about specific steps in carrying out phenomenological analysis of data (Hycner, 1985:279).

Finally, the Hycner framework offers enhanced validity as the qualitative data produced has to "ring true" (Coles, 1974) to the researcher, be validated by the participants themselves, the so termed "reality check" by Groenewald, (2004) and also be assessed by independent judges. These three stages in the Hycner framework ensured that the data was validated and enhanced the rigour of the research.

Therefore, after intense reflection the Hycner (1985) framework was considered the most appropriate method of analysing the data in this phenomenological study investigating the experience of obesity and intentional weight loss.

Identifying the participants

The aim of this study was to investigate the experience of intended weight loss. The participants in the study have all chosen to attempt to lose weight although they may have differing primary motivators. Individual motivators can range from a desire to be healthier, slimmer or younger looking.

In order to address this aim the study proposed to interview people about their weight loss experiences. The inclusion criteria for the study were that the individual had to:

- Be over eighteen years old.

- Have recently started (in the last month) or are about to start trying to lose weight.

- Had to consider himself or herself to be overweight, i.e. at least three stone over ideal weight.

- Be a resident of the Dorset or West Hampshire area and planning to stay there for the next year, approximately.

 Exclusion criteria for the study were that the individual was:

- Under eighteen years old.

- Actively undergoing medical treatment for weight loss such as surgery.

- Receiving treatment for an eating disorder, or recently diagnosed as having an eating disorder.

- Receiving treatment for depression or other mental health conditions, or recently diagnosed as having depression. This exclusion criterion was also applied by Lopez, in her (1997) lived experience study about weight loss.

Sample size

In this study, I planned to interview 10 people about their weight loss experience. Each participant was interviewed four times over the period of a year, producing an anticipated total of forty transcripts. The reasons for choosing ten people were

because the size of the sample needed to be large enough to ensure that it was credible and trustworthy but not too large that it is unwieldy for the researcher or for the practical environment in which it is based. It was also hoped that the data from forty transcripts would provide 'saturation' where no new information or ideas emerge (Robson, 2002 and Silverman, 1993).

It is not unusual for phenomenological and qualitative interview research studies to have relatively small numbers (Parse *et al*., 1985 and Bogdan & Taylor, 1975). This is because qualitative studies are often small. Sample sizes are not determined by hard and fast rules (Patton, 2002) but by other factors such as the depth, richness of the data obtained (Patton, 2002) the duration of the interview and also what is feasible for a single researcher (Robson, 2002). A small but well-chosen sample will focus in-depth on a particular issue and produce data that should "correctly map the phenomenon in question" (Denzin & Lincoln, 1994:100) and an accepted indicator of sample size is when data redundancy or data saturation is reached and small samples of two to five individuals have been found to achieve this (Parse *et al*., 1985).

Transferability

The descriptors of generalisability, validity and reliability are positivist terms primarily associated with quantitative research whereas the terms transferability, credibility and trustworthiness are more commonly associated with qualitative-interpretative research (Lincoln & Guba, 1985). Alasuutari has suggested that perhaps 'generalisability' is the wrong word to describe what we attempt to achieve in qualitative research and is associated with a positivistic approach:

> Generalisability is…(a) word that should be reserved for surveys only. What can be generalised is how the researcher demonstrates that the analysis relates to things beyond the material at hand…extrapolation better captures the typical procedure in qualitative research (1995:156-7).

The challenges and criticisms about studies with small numbers are all about transferability. A small group such as this study presents a "truth" for this group of people studied but this may not be the "truth" for other groups of people. Therefore, studies with small numbers cannot test out theories or come to any concrete

conclusion regarding causality and may not be applicable to other populations. Jasper, (1994) stated that it could not be claimed that the experiences described by one group of participants necessarily represented the experience of everyone who undergoes a similar phenomena. After all, such qualitative research seeks to understand in depth the investigated life experiences (Ambert *et al*., 1995) and wholesale transferability from the studied population to the general population is not a significant research aim.

However, studies with small numbers such as this study is about uncovering new rather than testing out existing hypotheses. So long as the process is rigorous, which this research study was designed to be, the results are still credible for that group of people, at that time, and in that context. Rigour, in this qualitative research study aims to ensure that the data presented is faithful to the participants meaning and rich in nature (Davies & Dodd, 2002). This study can uncover the "truth" for this small group of people that larger quantitative studies cannot find out because they are testing out existing assumptions or theories.

I had originally hoped that a number of males would be included in the programme, but was unable to recruit any into the study. Other researchers have commented on the difficulty of recruiting male participants. In Cioffi (2002) only one participant of twelve was male, although other men were invited to join the study. It has also been documented in other studies (Johnson, 1990) that more females than males participate in community based programmes. This proved to be the case in this study.

Only Caucasian women from the ages of twenty-one to sixty five took part in this study. All the women were British apart from one who was from South Africa. The ten women who were interviewed for this study were not a homogenous group. Although they were all overweight and women, their backgrounds and experiences were widely disparate. Some of the differences between the women in the sample included age, class, nationality, housing, marital status, being a mother or not, number of children, grandchildren, and in their life histories and past experience, size, weight and their chosen method of weight loss and their experience of trying to lose weight.

The average age of the participants was 48, with the youngest being 21 and the eldest being 65 years old. The number of children the participants had ranged from none to six. The occupations of the participants varied, but included unemployed, retired,

nurse and hairdresser. Six respondents were owner-occupiers and four respondents were living in rented accommodation. The respondents' partners' occupations were diverse and varied from farming, the armed services, the entertainment industry, a social worker and an electrical engineer. (See Table 1).

Table 1: Detail of the demographic background of each participant

Participant	Background
Participant One	65 years old with two children. Retired along with partner. She lived in rented accommodation.
Participant Two	41 years old with no children and worked as a nurse. She was an owner-occupier.
Participant Three	21 years old with no children. She was unemployed and lived in rented accommodation.
Participant Four	36 years old with six children. She worked as a hairdresser and her partner was a social worker. She was an owner-occupier.
Participant Five	35 years old with no children. She worked as a nurse and her partner was in the entertainment business. She was an owner-occupier.
Participant Six	43 years old with five children. She traded stocks and shares and her partner was in the armed services. She was an owner-occupier.
Participant Seven	63 years old with two children. She was retired as was her partner and she lived in rented accommodation.
Participant Eight	63 years old with no children. She worked as a cook and was divorced. She lived in rented accommodation.
Participant Nine	53 years old with two children, she was a machinist and her partner was an electrical engineer. She was an

	owner-occupier.
Participant Ten	58 years old with four children. She was a hospital car driver and her partner worked in farming. She was an owner-occupier.

Sampling

Two sampling methods were utilised in this study, purposeful sampling and the snowballing technique.

Purposeful sampling

Purposeful sampling is defined by Welman & Kruger (1999) as the most important kind of non-probability sampling, to identify the primary participants. A purposeful sampling strategy was chosen for this study based on my judgement and the purpose of the research (Grieg & Taylor, 1999; Schwandt, 1997 and Babbie, 1995), which was to identify those participants who "had experiences relating to the phenomenon to be researched" (Kruger, 1988:150; Patton, 2002; Cohen *et al*., 2000 and Colaizzi, 1978). The human experience this research was designed to explore was the individuals' experience of trying to lose weight. According to Hycner (1999:156) "the phenomenon dictates the method (not vice versa) including even the type of participants":

> Purposeful sampling demands that we think critically about the parameters of the population we are interested in and we chose our sample base carefully on that basis (Silverman, 2000:104).

Therefore, the purposive sample in the study reported in this thesis consisted of an individual meeting the specific criteria, of trying to lose weight and being willing to participate in this study

The possible disadvantage of the purposeful sampling method utilised in this study is that generalisations can only be made in a very limited way about how other individuals view the process of trying to lose weight. Bowling (1997) points out that while this approach may be unable to yield results that can be applied to the wider population this approach is useful in being able to understand complex phenomena,

(e.g. weight loss) and also to generate new hypothesis and it may also yield results that confirm previous findings.

However Becker argues that:

> Sampling is a major problem for any kind of research, we can't study every case of whatever we're interested in "up to 60% of the population may be overweight" (my italics), nor should we want to. Every scientific enterprise tries to find out something that will apply to everything of a certain kind by studying a few examples, as we say, 'generalisable' to all members of that class of stuff. We need the sample to persuade people that we know something about the whole class (1998:67).

In this study, purposeful sampling was achieved by advertising and recruiting individuals who were experiencing the phenomenon under investigation, which is the experience of obesity and intentional weight loss and who fulfilled the inclusion criteria of this study. Two individuals who saw the newspaper advertisements and volunteered to take part in this study were excluded. This was because both had mental health issues and were therefore illegible. I spoke to them individually, as gently and as sympathetically as I was able to, about the reasoning why they were not suitable to take part in this study, and I believe both individuals understood the reasoning behind this decision.

Snowballing

The technique of snowballing in sampling is where individuals approach the researcher to be interviewed as their friends or colleagues have been interviewed or where respondents volunteer or suggest other individuals who may be interested in taking part in the study. Obviously such a sampling technique has its criticisms but such a sample may also be very useful and "many pieces of research…have used…such samples" (Bell *et al*., 1984:179). Indeed Hurd Clarke (2002) obtained fifteen out of her twenty-two respondents via snowball sampling and her research appears to have been written in a credible and transparent way and written up in a way that could be reproduced. Hawe *et al*., (1990) also cite it as a useful way to obtain respondents. Rogge *et al.,* (2004) used the snowballing technique and they gained almost a third of their respondents in this way. However, in this study once the

purposive sample was obtained, the snowballing technique was tried in order to increase the number of respondents taking part but with only minimal success, only one female participant was gained. Two men who were volunteered by their mothers, who were also taking part in the study, declined to be participants in the study.

Credibility and Trustworthiness

Credibility and trustworthiness have generally replaced the phrases of reliability and validity in qualitative research. However, credibility and trustworthiness are of concern to all researchers especially for researchers in the qualitative arena where the methodology utilises so called softer data collection tools. In this study the key issue in relation to credibility was the use of interviews, as the data collection tool and whether similar information would be gained from each participant, considering the individuality and uniqueness of trying to lose weight was being explored. Providing there is appropriate preparation and thought before the commencement of the interview programme and the researcher remains self-aware for the duration of the data collection and is critical during the process of data analysis, credibility should be maintained. It is also acknowledged by researchers that interviews are not exact and that they can also eliminate imbalance by their very structure. It is impossible to obtain true credibility between interviews. In a semi structured or unstructured interview each interviewee may lead you down different paths, making it difficult to match response. However, this anomaly ensures the credibility of the interview "the interviewee is able to express their true feelings about elements of the topic that have meaning to them" (Seale & Barnard, 1998:58).

Truthfulness is "interpreted as the extent to which an account accurately represents the social phenomena to which it refers" (Hammersley, 1990:57). For this study, the test of truthfulness would be whether the interviews revealed information that would truly describe the experience of obesity and intentional weight loss. Truthfulness is therefore concerned with using the right tool or approach to give a credible answer to the research questions being asked. The complaint of anecdotalism questions the truthfulness of much qualitative research:

> There is a tendency towards anecdotal approach to the use of data in relation to conclusions or explanations in qualitative research…there are grounds for disquiet

in that the representativeness or generality of these fragments is rarely addressed (Bryman, 1988:77).

In the study reported in this thesis, the claim of anecdotalism was counter-acted by clear definitions and descriptions of the philosophical underpinnings of the study and the research questions being asked; the utilisation of robust data gathering tools and data analysis tools.

The truthfulness of the data arising from the individuals was strong because different respondents repeated similar themes. This emergence of similar viewpoints from the participants about the same issue supports the notion of content validity. Although this is a positivist term, it has been adopted by qualitative researchers who take a pragmatic stance (Miles & Huberman, 1994). Although such an approach has its detractors such as Morse (1991) in this study it has been utilised with the consideration that in qualitative research validity is an evolving concept:

> Content validity…refers to the extent to which the research instrument adequately represents the topic under investigation. There should not, for example, be undue attention to one aspect of the topic in relation to the other (Reid, 1993:42).

Every question used in the semi-structured interviews was carefully worded to ensure that it would gain the information required and "correctly map the phenomenon in question" (Denzin & Lincoln, 1994:100). For instance, two of the questions asked in the second semi-structured interviews were "How do you feel about the whole process of trying to lose weight?" and "Has your chosen style of trying to lose weight affected your life?" These sample questions seek to enter the life world of the individuals undergoing the process of intentional weight loss.

Transparency is also important for establishing the truthfulness and validity of research (Lomax & Parker, 1995) as it enhances "authenticity and rigour" (Lomax, 1994a). I endeavoured to achieve this in the study by ensuring the research aims were clear, by carefully writing up the research process, data collection and method of analysis utilised. A detailed method of data analysis was undertaken in the study and this method is defined further in the chapter.

The usefulness of multiple interviewing was documented by the Canadian researcher Hurd Clarke (2002) as being very useful in enhancing the credibility of data by clarifying themes and meanings and reducing inconsistencies.

Credibility is also a key tension for any lone researcher. Therefore in order to enhance credibility individuals with an interest in weight loss such as public health workers and dietetic staff and individuals skilled in the use of research methodology such as my academic supervisor and fellow peers were asked for their comments on the research structure, design of the data collection methods and the data obtained. Similar research studies in the weight loss arena were also reviewed.

Respondent validation was also sought and after each interview, their transcripts were sent to each respondent for their comments and then discussed with them. It was anticipated that this would enhance validity and authenticity and has been used by Johnson (1990). Such a process is also known as member checking (Lincoln & Guba, 1985) and is utilised to heighten the interaction between the researcher and the participants. Cioffi (2002) also undertook a similar path by asking half of the respondents in her study to comment on the findings. Validation was also discussed with my academic supervisor.

The descriptive analysis presented in the results chapter in this thesis is written in such a way to enable the reader to gain a picture of the individuals who took part in this research. To hear their words describing the world they live in, to get a sense of what they believe and to know that the comments selected is a typical response from the data collected. This separation of the descriptive analysis from interpretation aims to increase the credibility and trustworthiness of the findings presented (Radnor, 2001).

Researcher and subject bias

Credibility and trustworthiness are important aspects of all types of research but particularly so in qualitative research which can be open to calls of researcher bias. If there is researcher bias then the results may be skewed or slanted whether intentionally or because of poor research design. Researcher bias is a consideration if the researcher is obtaining the research data, which is often the case when there is a lone researcher, so safeguards need to be in place. For instance, by ensuring that the

research process and methodology is written well and transparent, such as Hurd Clarke (2002) where the research steps were clearly written. This allows another researcher to follow the procedures in the study as could be done in the study reported in this thesis (see appendix 12). Therefore, this study could be replicated if not all the findings. By using the Hycner format to analyse the data, it was also hoped that this would reduce such potential researcher bias.

Subject bias was also an issue that was considered when designing the research tools; the researcher was concerned that the participants might want to provide the 'right' or socially perceived desirable answer to the questions asked (Coolican, 1990). To help address this issue the questions were carefully worded to ensure that they did not imply a right or best answer to give, some examples of the interview questions utilised include: "How do you feel about the last twelve weeks?" and "How do you feel about this whole process of trying to lose weight?"

Pilot studies

All research methodologies need to be judged with reference to their credibility and trustworthiness. Each has its drawbacks and advantages in theory but the only way they can be judged realistically is by examining how they work in practice in a particular piece of research. The usefulness of a pilot has been well documented (Robson, 2002 and Ashton & Shuldham, 1994). "The main purpose is to identify flaws in its design and to improve the instrument proper" (Reid, 1993:14). Each of the four interview formats were piloted with two overweight individuals although this data was not included in the final research findings. The feedback from the pilot interviews resulted in the following amendments being made. Firstly, rephrasing some of the questions so they were clearer for the respondents to understand. Secondly, such piloting reminded me to give the respondents plenty of time to respond during the interviews. Each pilot interview was piloted eight weeks before each set of interviews to allow adequate time for feedback and rewriting of the actual interview. This additional time for piloting was scheduled into the research plan.

The interview schedule

The individuals involved in this study were interviewed initially at the beginning of their weight loss journey, then three months later, then again at six months and finally at twelve months, one year from the initial interview. I believed this format with the respective intervals would obtain a fuller view of the individual's experience of weight loss.

The four interview schedules will be discussed chronologically. The questions asked at each interview will be discussed in relation to why the question was important to ask, in the light of what is already known about the experience of intentional weight loss and what gaps have been identified in the research literature. Copies of the four interview schedules are included as appendices 3,4,5 and 6 at the end of this thesis.

Interview One

Interview One was the semi-structured baseline interview. The main purpose of interview one was to obtain information about the respondents at the commencement of their weight loss journey and to set the scene. Interview one was divided into four main sections. Section one focused on obtaining socio-demographic data as recommended by Mulvihll & Quigley, (2003) and NHS CRD, (1997). These initial questions after introduction, settling in and ensuring the consent process was discussed and the consent form had been signed, included: full name, date of birth, address, home telephone number or contact number, occupation and family details such as structure.

The next section of the interview consisted of questions about the respondent's knowledge level and motivations for taking part. For example: "How did you find out about this research study?" and "What is your aim for taking part in this study?" Various studies have listed differing motivators for why individuals wish to join research studies.

On reflection, I felt that some of the respondents were a little hesitant about answering these initial queries in the interview. I considered that it might have been due to asking a number of questions concerning socio-demographic data collection before these questions. Although it may have been that the respondents were understandably

anxious as this was the first interview in the research study and the research relationship was only in its initial stages. However, none of the respondents declined to give any socio-demographic data or discussed its need for collection. Indeed its collection appeared to be accepted by the respondents as a natural part of a research study of this nature. I will discuss this issue further in the discussion chapter of this thesis when considering methodological issues.

The next section of the interview was designed to obtain the qualitative view of participants, in relation to the research gaps that have been previously identified. In order to understand more about the respondents and their experience of weight the question "What is your life history in relation to your weight?" was asked. Studies such as Bidgood & Buckroyd (2005) and Rogge *et al.,* (2004) advocated obtaining such information as it helps to contextually situate the individual. I also asked the question "I understand that you have decided to lose some weight. Could you explain to me what factors have led to your decision to try to lose some weight?" This question was supported in the literature by Hurd Clarke (2002) and both questions seek to explore the individual motivators for why the participants decided to try to lose weight.

The next section of the interview included the questions "What is your present weight loss goal?" Mulvihill & Quigley (2003) recommended the use of this type of question. I also asked "How will you measure your progress?" and "How do you feel about the process of losing weight?" both were deemed appropriate by Rogge et *al.,* (2004) and Lopez (1997). I also asked "How do you feel about your weight at the moment?"

Such studies such as Bidgood & Buckroyd (2005); Rogge *et al.,* (2004); Mulvihill & Quigley (2003) and Lopez (1997) have recommended obtaining information from the respondents about how they feel about their previous or past experiences of losing weight; hence the question, for instance, "What do you feel about your previous or past experiences of trying to lose weight? If there were any?" For instance, Bidgood & Buckroyd (2005) alleged that there was little research in this arena and the voice of the individual needed to be heard so that existing weight loss strategies could be strengthened to be more useful to the individuals trying to lose weight.

The questions "What aids/ strategies have you chosen to help you lose weight?" was deemed important by Goodspeed Grant & Boersma (2005); Bidgood & Buckroyd (2005); Mulvihill & Quigley (2003); Barker & Cooke (1992) and Johnson (1990). The question "How do you believe or perceive the strategy you have chosen will affect your life?" was felt appropriate by Bidgood & Buckroyd (2005) and Mulvihill & Quigley (2003). These questions were asked to gain further information about the process of intentional weight loss.

Bidgood & Buckroyd (2005); Goodspeed Grant & Boersma (2005); Hurd Clarke, (2002) and Barker & Cooke (1992) supported such a question "What or whom do you feel or believe will help you in your weight loss process and why do you think that?" Furthermore, the question "What or whom do you feel or believe may hamper or hinder you in your weight loss process and why do you think that?" was advocated by Bidgood & Buckroyd (2005); Goodspeed Grant & Boersma (2005) and Barker & Cooke (1992).

The interview was ended by thanking the respondents for taking part and explaining that I looked forward to seeing them again, at a mutually convenient time and location for them, in three months. I explained I would send them a copy of the transcript and summary. This confirmation of the transcripts was vital to ensure validation and was appropriate with the utilisation of the Hycner (1985) framework of data analysis. This process was followed at the end of each interview. (See Table 2 for information about how the interview questions align with the research questions).

Table 2: Alignment between interview one questions and the overall research questions.

Interview One	Related Research Questions
Questions 1-6, socio-demographic information	
Questions 7-8, motivators for being part of the study	1,

Questions 9-11, factors influencing decisions to lose weight	1,
Questions 12-13, weight loss goals and measuring progress	1,2,3,
Questions 14-16, weight loss process and the individuals beliefs	1,
Questions 17-18, weight loss strategies such as diet and lifestyle change and how it affects the individual	2,3,
Questions 19-20	1,2,3,

Interview Two

The main purpose of interview two was to continue gaining information about the respondents' experiences of their first three months of trying to lose weight. Interview Two consisted of a semi-structured format and was conducted with the respondents three months after their initial interview.

The initial part of the interview focused on greeting the participant and thanking them again for agreeing to be involved with the study. I then clarified with the respondent that their transcribed interview and summary, (stages one and eleven of Hycner's 1985 framework) was a true reflection of their feelings and viewpoint of what was discussed in the interview. Any issues not adequately represented would have been amended but this did not prove to be the case. These clarifications again took place before the third and fourth interviews and also post the fourth interview. Therefore, all the participants had the opportunity to confirm they believed the transcripts and summaries appropriately reflected their views.

The subsequent body of the interview asked questions in order to obtain the respondents viewpoints about the present process of intentional weight loss that they were involved in. "How do you feel about the last twelve weeks, about yourself and in relation to your weight?" (as recommended by Bidgood & Buckroyd 2005 and

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Mulvihill & Quigley 2003). I asked the question, "May I ask what is your present weight?" as an indicator of weight lost or gained in the early section of this interview. This was because on reflection it was evident from previous respondents comments in interview one, that their weight was an issue that the respondents wanted to discuss with me early on in the interview. This was regardless of whether they lost weight, stayed the same or gained weight. For instance, the respondents wanted to tell me what their weight was very early on in the interview. The question "How do you feel about yourself and/or your weight at the moment?" was seeking to look at how the individual viewed themselves and was suggested by Bidgood & Buckroyd (2005) and Mulvihill & Quigley (2003).

When I asked the following two questions I consciously allowed the respondents plenty of time to discuss how they felt as my reflections from interview one were that these questions were particularly evocative for the respondents. I felt that I needed therefore to give them adequate time to express their views although I was aware throughout all aspects of the interviews that I needed to be sensitive to the respondent's feelings, as the issue of weight may be potentially meaningful for all the respondents. Looking at the respondent's experience by asking "How has the experience of trying to/achieving/not achieving weight loss affected you?" was recommended by Bidgood & Buckroyd (2005); Rogge *et al.,* (2004) and Mulvihill & Quigley (2003). I also asked the respondents "How do you feel about the whole process of trying to lose weight?" as suggested in the literature by Bidgood & Buckroyd (2005); Rogge *et al.,* (2004); Mulvihill & Quigley (2003) and Lopez (1997). The available literature has suggested that the weight loss process may affect individuals, for instance, in the study by Lopez (1997) the participants in her study expressed conflict between trying to lose weight and still have a life. They also articulated their feelings of loneliness when undertaking the dieting process. It is appropriate to explore this further because potentially the experience of the dieting process may affect the individuals weight loss outcome.

The question "What strategies, tools or measurements have you used to elicit your weight change and to measure your weight change?" was recommended by Mulvihill & Quigley (2003). "Has your chosen style of trying to lose weight affected your life?" was suggested by Bidgood & Buckroyd (2005) and Mulvihill & Quigley (2003).

The need to ask a question such as "What or whom has helped you in the last twelve weeks?" was advocated by Bidgood & Buckroyd (2005); Goodspeed Grant & Boersma (2005); Hurd Clarke (2002) and Barker & Cooke (1992). Furthermore, asking: "What or whom has hindered you in the last twelve weeks?" sought to investigate the experience of weight loss and was suggested by Goodspeed Grant & Boersma (2005); Bidgood & Buckroyd (2005) and Barker & Cooke (1992).

I also asked "Is there anything else you would like to share with me about your weight change process over the last twelve weeks?" which was a question supported by Rogge *et al.,* (2004) and Lopez (1997). I also asked, "Is there anything else you would like to share or discuss with me?" This was asked to offer the respondents another opportunity to discuss anything they wished with me.

The ending of the interview was similar to the ending of the first interview. The respondents were aware that the time interval for the next interview was to be in three months. (See Table 3 for alignment between interview questions and research questions).

Table 3: Alignment between interview two questions and the overall research questions.

Interview Two	Related Research Questions
Questions 1-2, clarification about the previous transcript	1,2,3,
Questions 3-4, enquiring about the individual weight loss process, the last twelve weeks and present weight	1,2,3,
Questions 5-7 and 9, enquiring about how the individual felt about themselves, their weight loss journey and how it affected them	1,2,3,

Questions 8, weight loss strategies employed, for instance, the Atkins diet	2,
Questions 9-10, investigating anticipated hindrances and facilitators to losing weight	3,
Questions 11-12, the opportunity for the individual to share, for instance, their feelings on any aspect of their weight loss journey	1,2,3,

Interviews Three and Four

The main purpose of interviews three and four was to continue exploring the participant's experience of their weight loss journey in the later part of the year. Interview Three was conducted with the respondents six months after the initial interview. The initial part of the interview was similar to the initial part of the second interview and the questions in the main body of the interview were similar to the second interview. The ending with the respondents was also similar as the first and second interviews although the respondent's were aware that the fourth interview would be conducted twelve months after the initial interview. In a longitudinal study of this nature repeating questions is acceptable as we are seeking to obtain the respondents views of the weight loss process (Mulvihill & Quigley, 2003).

I repeated the question "Is there anything else you would like to share or discuss with me" in both interviews three and four. On reflection, I found that by using this non-weight specific question in interview two the respondents had revealed details of their lives to me that may not have been discussed if I had continued to end the interview on a weight specific question as I had done in the first interview.

Interview Four was conducted twelve months after the initial interview. The initial part of the interview and the majority of the questions in the main body of the interview were similar to the third interview. However, additional questions were

asked in this interview, in view of the longitudinal nature of the study. These included "What were the main reasons or beliefs as to why you started trying to lose weight?" as suggested by Bidgood & Buckroyd (2005); Mulvihill & Quigley (2003); Hurd Clarke (2002) and NHS CRD (1997). I also asked, "Over the last year what feelings or beliefs have motivated you to continue trying to lose weight?" After reviewing literature such as Goodspeed Grant & Boersma (2005); Bidgood & Buckroyd (2005); Mulvihill & Quigley (2003); Barker & Cooke (1992) and Johnson (1990) I considered such a question would usefully gain more information about the phenomenon being investigated.

I was consciously aware of being as open as possible to the respondents as this was the final interview. Although all the respondents were aware from the beginning of the study that we would only meet four times over the year the respondents in some of the earlier interviews but especially at the third interview had voiced their disquiet that this interview would be our last meeting. Some of the respondents were also rather saddened by this and I tried to give them every opportunity to voice this and how they felt about their weight loss process and areas that they felt affected them. The questions in the later part of interview four addressed the whole year and the last question "Is there anything else you would like to share or discuss with me " gave the respondents ample opportunity to discuss their feelings. On reflection, I felt the respondents were able to express how they felt to me in an open and supportive manner.

The ending of the fourth interview was similar to the endings of the other interviews although the respondents were aware this would be the last occasion we would formally be meeting. The respondents were informed that they would be sent a copy of their fourth transcript and summary and were aware of how they could contact me if they wished to challenge the transcripts or summary. I also assured them that they would have access to the final finished document. (See Table 4 for alignment between interview questions and research questions).

Table 4: Alignment between interview three and four questions and the overall research questions.

Interviews Three and Four	Related Research Questions
Questions 1-2, clarification about previous transcripts	1,2,3,
Questions 3-4, finding out about the twelve months in total	1,2,3,
Questions 5-7 and 9, enquiring about how the individuals felt about their weight loss journey and how it affected them	1,
Question 8, weight loss strategies employed such as dietary restraint	2,
Questions 10-11, investigating anticipated hindrances and facilitators to losing weight	1,2,3,
Questions 12-13, the opportunity for the individual to share their feelings on any aspect of their weight loss journey	1,2,3,

Recruitment and data collection

A number of strategies were utilised to recruit participants into the study. Initially, I contacted two well-known commercial organisations and asked if I could recruit participants on their premises. Although I contacted each organisation twice they declined to take part. No reason for declining was given.

As I wanted all strata of society to be aware of the study I then wrote a letter to the 62 libraries, 149 post offices and 77 supermarkets who were within the geographical area of the study, Dorset and the west of Hampshire, asking them if they would display a poster about the study and asking for participants. Both the letter and the poster are included as appendices 7 and 8. The poster itself went through many drafts, to ensure it was aesthetically pleasing and would hopefully attract enough attention. The poster consisted of a yellow background with dark red lettering, which is easy to read, and not the 'usual' black. The font size and style was chosen so it was not difficult to read. The image on the poster was chosen with care in order to arouse curiosity but not cause offence. The image of a mountain range was chosen as losing weight can seem like climbing a mountain and gaining weight is so easy, like falling down a mountain. The flag at the top was chosen to show a sense of achievement, which many individuals feel when they lose weight. The majority of establishments displayed the poster for free but approximately 15% wanted payment to display the poster, which I supplied. I also hired a post office box number from the post office so that individuals would be able to contact me by letter and I also bought a mobile phone specifically for the study. This was so the potential respondents could speak to me directly.

Despite these posters being in place for over three months there was a limited response; only two individuals contacted me. Therefore, I decided to advertise in the local paper, which covered the geographical area of the study. A small advert was placed each evening in the paper, explaining the study and asking for participants. Using this method of advertising within a few weeks, produced the majority of the respondents in the study. A copy of this advert has been included in the appendices (see appendix 9).

When a potential respondent approached me, I explained the study to them and sent them an information letter, (see appendix 10). If the respondents were still interested I arranged to meet them at a mutually convenient time and discussed the study with them further. I gave them plenty of opportunity to be frank with me and discuss any concerns they may have. I also then gave them a consent form, which offered them a further opportunity to discuss any issues, which they may have, (see appendix 11). This form was then signed and dated by the respondents and myself and then kept securely and safely. Only two potential respondents were excluded from the study due

to not being suitable as both had mental health issues. In total seven respondents were obtained via the newspaper advertising and one via the snowballing technique.

All the interviews with the exception of one, took place in the homes of the interviewee. The other respondent arranged a private area away from her own home so she would not be overheard, she informed me. All the interviews were arranged on a time and day that was acceptable to the respondent. In order to be free for this interviewing I took holiday leave from my workplace. My own safety was an issue as the appointments were in the respondent's own homes during the day and evening. Therefore, I contacted a responsible person to say I was going to undertake an interview and I also confirmed with them when I had conducted the interview and had left the respondents property. This was a safety precaution that proved unnecessary because everyone treated me openly and warmly and genuinely wished to speak to me.

I felt that the initial impressions that the interviewees gained about me was important because of my desire to achieve a non-hierarchical relationship with them. I felt that both my appearance and manner were important in developing this relationship. In terms of appearance, most of the women I interviewed were 'working class' and because they were being interviewed in their own homes I felt it was appropriate to dress comfortably but not too formally. An apparently middle class researcher complete with suit and briefcase I felt would establish an immediate distinction between the respondents and myself and not adequately represent myself when in fact I am a clinical nurse conducting a research study. I felt that being too formally dressed would not be helpful in terms of conversational flow. In terms of manner too, I felt it was important to identify the similarities between the respondents and myself. Thus on arriving at the house I tired to be friendly and informal and establish a rapport and to perhaps make some comments about the area or the house. In fact, I found this occurred naturally. In this way, I attempted to show that I had some experiences in common with each respondent and also to try to create a friendly atmosphere that would be conducive to the flow of information in the interview. Other researchers such as Roberts & Ashley (1999) and Parker (1994) have also interviewed research participants in their own home. I was invariably offered a drink upon arrival and I took this opportunity to sit and chat in general and also to give some more

information about the research before starting the interview. I told all the women that I was a student at Southampton University undertaking a research study investigating the individual's experience of losing weight. I also told them anything they told me was strictly confidential as any information the respondents gave me was kept securely and when it was discussed or reported the information was anonymzed. This explanation appeared to be satisfactory and seldom were more questions asked about the research before the interview although the respondents often instigated discussion about the research following the interview.

After the initial chat and explanation about the research I commenced the interview. I asked the respondents first if they minded the interview being tape recorded, as I would be unable to write down everything they said, and no one made any objections to this, the interview concentrated on questions contained in each interview schedule. The interview schedules from one to four have been included in the appendices. I tried to approach these questions in a conversational manner rather than following the interview schedule in a rigid format.

I tried to create an atmosphere that was open and uncritical so that the respondents were free to come out with seemingly irrational ideas or less socially acceptable responses. This issue of creating the right rapport is especially important when interviewing such sensitive issues as an individuals weight and how they feel about themselves. As Oppenheim (1992) points out, if the interviewer acts surprised or if their body language such as a raised eyebrow manifests this, it could cause the respondent to close up or modify their future response, only by maintaining a receptive and non judgemental attitude can one hope to gain insights of which respondents believe may be 'self incriminating' but which may nevertheless guide their behaviour. I found that in general I was able to achieve the type of interviewing style that I had intended, obviously this was more successful in some cases than in others but in the main the women I interviewed seemed to respond positively to the informal approach and they appeared to be very open with the information they gave to me.

I anticipated that there might be a problem getting women to talk openly about some of the personal areas of their lives especially in relation to their feelings about their weight and their actions to try and lose their weight. However, I found this was not a

problem. Many of the women appeared to welcome this opportunity to talk about themselves, their weight and their weight loss strategies. Some of the women were initially more reticent but I was invariably able to draw them out on this subject. However, all of the women discussed their experiences of trying to lose weight quite candidly. The fact that such information was given freely and openly perhaps demonstrated the appropriateness of the data collection tool chosen for this study. The interviews lasted on average, one and a half hours, although some lasted considerably longer than this.

I felt that the differences between myself and the respondents that might have mitigated against the acquisition of credible and trustworthy data were reduced by my actions. I also had similarities with the respondents such as being a woman who had experienced weight concerns and had tried differing techniques to lose weight. Collins (1990) argues that in order to make legitimate knowledge claims researchers should 'have' lived or experienced their material in some fashion.

There were two sets of problems that I did encounter: one relates to factors within the interview relationship between the respondents and myself and the other factor relates to factors outside of this relationship, which impinge on it. The first set of problems that caused some interviews to be less successful than others, as I interpreted it, was when I could not get interviewees to talk openly and at length about the topics under discussion. This happened with one respondent, who despite being keen to take part in the study, on the day of the interview needed considerable prompting to answer the questions. I found out that the reason for this was that another personal matter distracted the interviewee. Although I offered to stop the interview, the interviewee insisted on carrying on. Another respondent responded in a slightly hesitant way at each of the four interviews, although she had also confirmed she was keen to take part and be involved in the study.

In retrospect, I felt that given the majority of respondents did talk at length that one or two shorter interviews were inevitable and probably more due to the personality of the respondent rather than my perceived lack of expertise at interviewing. Reflecting on the one participant that responded in a slightly stilted manner when I observed how she spoke to family members it became apparent that compared to how she spoke to her relatives she was positively effusive with me!

The second set of problems relates to that of other people impinging on the interview situation. This has the potential to make the interview less successful than it might otherwise have been. When the interviews are taking place in a person's home there is always the possibility that other family members or indeed visitors might be present. Such a presence would mean that the respondent could give a less open or honest account than she would if she were on her own. Obviously, the best solution to this problem is to ask the respondent if it is possible to conduct the interview on her own. However, this is not always possible either for reasons of space or because it is difficult for the interviewer to make that request. Additionally, even when it is possible to carry out an interview without someone else present in the room the mere presence of others in the house may be enough to inhibit a respondent's account for fear of being overheard. This is likely to be particularly so where there is a power relationship between the respondent and the person present in the home or in the house, such as in the case of a partner or a parent. In one instance, when a husband was present, he was hustled by the respondent into the kitchen and was not seen or heard for the duration of the interview. I shouted goodbye to him at the end of the interview when I left, to which he responded. The respondent appeared to speak to me in a similar manner as she did in the other interviews when her husband was not present. Where this power relationship exists but in reverse, such as with the respondent's children being present, for example, the problems are of a different nature but still have the potential to make the interview less successful than it might have been. Hence the problems are more ones of disruption and interruption that can mitigate against a good interview. However, on the one instance when a baby was present this was not an issue at all, in fact, the respondent was very frank with me when the baby was present and spoke to me in the same way as in her other interviews.

During the study one respondent dropped out after the first interview. She was the youngest respondent in the study and she was living with her boyfriend in temporary accommodation. When I tried to interview her at three months as planned, despite phone calls to her mobile which was no longer operative and a visit to where she had lived I was unable to see her. Another respondent was also lost at the fourth interview stage. When I tried to contact her, I was told by the new occupant that her tenancy had not been renewed and no forwarding address was available. This is a hazard of this

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type of community based data collection. On the one hand I had to acknowledge that if either of the respondents had wished to contact me, I had a phone number they could have contacted me on, but on the other hand, I am not aware of the circumstances of their move so they may have been unwilling or unable to communicate with me. Mulvihill & Quigley (2003) have recommended that data be collected on individuals who drop out of weight loss studies however, despite my attempts; this was not possible in this study.

At each interview, I thanked each respondent for freely giving their time and welcoming me into their homes and I acknowledged how valuable their participation was. Respondent co-operation is important in any study and in order to assist future researchers and as a courtesy the respondents will also be formally thanked and in order to ensure transparency a copy of this thesis will be made available to them.

The researcher's ethical position

In this qualitative study about obesity and intentional weight loss there were a number of ethical issues to consider and these were addressed throughout the study. The whole area of ethics caused me considerable anxiety as I sit both in the field of research and in the clinical arena. Therefore, in order to maintain an appropriate ethical stance and to ensure that there was no conflict of interests my ethical approach was informed by researchers and institutions such as Heath *et al*., (2007); British Educational Research Association (2004); University of Southampton, School of Education, Ethics Review Checklist (2004); Cohen *et al*., (2000); Oppenheim (1992); Sapsford & Abbott (1992) and Reynolds (1979).

I endeavoured to act in an ethical way throughout this study. This included acting in a non-exploitative, non-hierarchal and reciprocal manner as far as possible in all my interactions with the respondents in this study. During the research I considered the effects my actions may have on the ten women involved and I tried to preserve their humanity and act in an ethical manner (Cohen *et al*., 2000). Acting in such a way has been termed an appropriate "obligation" by the Social Research Association (2003).

An illustration of the ethical code utilised in this research and adapted from Reynolds (1979) has been included in the appendices, (see appendix 13). An advantage of using such a code is that:

> A code of ethical practice makes researchers aware of their obligations to their subjects (respondents) and to those problem areas where there is a consensus about what is acceptable and what is not (Cohen *et al*., 2000:71).

The University of Southampton's ethical guidelines were followed in this study and in addition, this research was conducted in line with the 'Revised Ethical Guidelines for Educational Research' (Bera, 2004).

Throughout this research study I believed that the ethical principles of informed consent, confidentiality, anonymity and right to privacy as far as possible should be upheld and maintained at all times.

Informed consent

In social sciences it is vital that the research participants have agreed to be involved totally voluntarily and equally important is their right to withdraw from the study if they wish to. This is stipulated by the British Educational Research Association (2004). No coercion must be utilised by the researchers and the respondents' agreement should be based on complete and open information being given to them (Bidgood & Buckroyd, 2005; RESPECT, 2004; Code of Practice for Socio-Economic Research, Frankfort-Nachmias and Nachmias, 1992 and Reynolds, 1979). Denzin & Lincoln term informed consent as being "carefully and truthfully informed" (2005:715). Heath *et al*., (2007:403) believed that informed consent was "central to ethical research practice" which was the aim in this research study.

In order to address this issue in my study all respondents were volunteers in the study after responding to advertisements to be part of the study. Rogge *et al.,* (2004) also advertised for participants in their study. After fully informing the respondents about the study I obtained written consent from all the individuals involved in the study. I explained the nature and duration of the study and gave them the opportunity to ask any questions they may have. All the respondents were informed that they could

withdraw from the study at any time they wished. Copies of the information sheets and written consent are included in the appendices.

Confidentiality

Confidentiality ensures the participants right to privacy because although the researchers are aware of who the participants are the connection between the participants and the data is not made public. Hopkins (1985) argued that as often research is conducted in a small, localised arena there could be inherent difficulties in maintaining the respondents confidentiality. However, this study was based over a wide geographical arena, so such difficulties are less likely to apply. This also served to lessen the possibility that the respondents would know one another.

In order to ensure confidentiality I undertook the following measures. Firstly, when discussing the respondent's data with my supervisor, or with others such as the independent judges, the respondent's names or unique identifiers were never revealed (Cohen *et al*., 2000). However, removing all unique identifiers produces a research tension as how can the study be replicated (Smith, 1990) if the interview subjects cannot be identified. To address this issue in this study, transparency and the format of the study has been well documented. The use of pseudonyms as suggested by Lee (1993) was implemented and all the respondents chose their own pseudonyms in this study. However, the privacy of the respondents considering the sensitivity of the topic was of paramount concern for the researcher. Such actions were also taken to ensure anonymity for the respondents, from others but obviously not myself as I interviewed the respondents.

Secondly, appropriate data storage also enhances the participant's confidentiality. When considering how to store the research data the guidelines for data storage (2004) from the British Educational Research Association was considered, as was the 1984 Data Protection Act. All data was kept in the researchers home, as no other facility was available. Each piece of data was labelled and then stored chronologically in a locked container on a shelf in a lockable cupboard. Copies were kept on a computer hard drive, password protected, on disk and hard copies were kept in a secure, boxed metal container. When the study is completed all data will be

maintained safely and securely for a defined period of time to ensure auditability and then destroyed.

Anonymity

Anonymity is only ensured when the participant cannot be identified in any way and is faceless to the researcher (Patton, 2002 and Cohen *et al.,* 2000). This is possible in some research but not some studies such as Hurd Clarke (2002) and Bidgood & Buckroyd (2005). It was also not possible in this study when the participants were qualitatively interviewed face to face with myself over a number of occasions over a year. However, the respondents' confidentiality was ensured by the methods previously discussed in the prior section of this chapter.

Transparency and ethics

In order to enhance an ethical and transparent way of working the research findings were made accessible to the respondents (Hycner, 1985 and Stanley & Wise, 1983) by showing each respondent their previous interview transcript and encouraging the respondent to discuss or challenge the transcript if needed. Methods such as this have been used by other recent research for instance; in the Cioffi (2002) study half of the respondents were asked to comment on the qualitative data produced. Although Ashworth (1993:15) argues otherwise:

> Participant validation is flawed nevertheless since the 'atmosphere of safety' that would allow the individual to lower his or her defences, cease 'presentation' and act in open candour (if this is possible) is hardly likely to be achieved in the research encounter.

Although Ashworth supports participant validation he warns against taking such validations at complete face value seriously as it may be in the participants best interests to protect their socially presented selves. Cornell (1984) concurs on this point. Nevertheless, I would argue that transparency in research is a vital part of ethical and honest working and for instance, empowering respondents to have access to their own transcripts and summaries is appropriate for an ethical approach and indeed is one of the stages in the Hycner (1985) framework.

Professional ethics

An additional ethical consideration for this research is that I am a practicing nurse and health visitor who would need to uphold professional obligations when researching with the participants. Sufficient guidelines are available including the 'The Code of Professional Practice' (1984) in which ethical practice is recommended and this will be upheld in this research. An example of this is Clause 1 of the Code, which states that each registered nurse, midwife and health visitor shall "Act always in such a way to promote and safeguard the well being and interests of patients and clients".

It also has to be considered that researchers in health are very often professionals in their own right and there may be a power imbalance. "Health professionals are experts in care, informed about many health and illness issues and have their own perception of the phenomenon" (Holloway & Wheeler, 2002:88). Although, the participants only knew me in my role as a student researcher undertaking a community based study in intentional weight loss and that I was a student at Southampton University. I did however; inform them that I was a community practitioner based in a local primary care trust.

Health "researchers by virtue of their professional expertise and skill in interviewing are in a position of some power, however much they attempt to achieve a relationship of equality with the participant" (Holloway & Wheeler, 2002:88). This power imbalance may influence what patients will reveal to health researchers as they may be concerned what the consequences may be or fear how they are being judged by the health researchers (Holloway & Wheeler, 2002). The ethical implications of such interviews need to be well documented and discussed with the participants prior to such studies to emphasise their rights. However, many participants in research studies wish to have their view put forward for a variety of reasons including altruism, for instance, to improve the care of future patients. "Researchers can empower patients and colleagues by listening to their perspective and giving voice to their concerns" (Holloway & Wheeler, 2002:88). This should also be the concern of researchers in whatever field they are.

As I work for a National Health Service Primary Care Trust, I sought clarification from the local research ethics committee to see if formal ethics committee approval

was needed. As the research did not involve National Health Service patients or staff, none of the research was conducted in National Health Service venues and the study was conducted in my own time, formal ethics approval was not required.

Transcribing and analysing the semi-structured interviews

All interviews were transcribed for a number of reasons. Firstly, to ensure that the voice of the respondent could be heard, something that Kiesinger (1998:92) indicates as important:

> Transcribing also allowed me to hear Abbie's voice over and over again, and as a consequence, I grew to feel closer to her experience. Repeated listening reconnected me with the emotionality of her plight.

Secondly, verbatim transcription of the interviews ensured that no data was lost (Gilbert, 1993). Verbatim transcription has also been recommended by Cohen *et al.*, (2000); Baillie, (1996); Field & Morse, (1985) and Omery, (1983). Other researchers in the field of weight loss such as Bidgood & Buckroyd, (2005); Goodspeed Grant & Boersma, (2005); Rogge *et al.,* (2004); Ziebland *et al.*, (2002) and Soderberg *et al.*, (1999) also transcribed their interviews verbatim.

In this research data analysis was not an isolated activity but an ongoing process commencing as soon as the first part of the data was obtained at the first semi-structured interview. An "important feature of qualitative data is the close connection between data collection and data analysis" (Holloway & Wheeler, 1996:9). Due to previous reading the researcher was aware of the possibility of data overload (Robson, 1993 and Faust, 1982) and the implications of first impressions (Miles & Huberman, 1994). For these reasons data analysis was started early on in the research process and a robust methodology for analysis, Hycner's (1985) framework was utilised.

Hycner's method of analysis has fifteen stages (see appendix 12). These include:

1. Verbatim transcription

2. Bracketing and phenomenological reduction

3. Listening to the interview for a sense of the whole, as does Colaizzi, (1978) and Giorgi, (1985a).

4. Delineating units of general meaning.

5. Delineating units of meaning relevant to the research question.

6. Training independent judges to verify units of relevant meaning.

7. Eliminating redundancies.

8. Clustering units of relevant meaning.

- Example A: 1 Loss of self-control. (Code Red, second interview).

- Example A: 2 Lack of will power. (Code Red, second interview).

- Example B: 1 Am I abnormal? (Molly, second interview).

- Example B: 2 Am I like normal? (Molly, second interview).

- Example C: I have to lie to them a little. (Louisa, third interview).

9. Determining themes from clusters of meaning.

- Example A: Lack of individual control and will power (could be two themes but currently merged into one theme at present).

- Example B: Questioning normalcy of self.

- Example C: Locus of control (in relation to authority figures-primary health care staff).

10. Writing a summary from each individual interview.

11. Return to the participant with the summary and themes. Colaizzi (1978) also recommends a final validation be achieved by returning to the participant. I adapted Hycner's (1985) framework to accommodate the longitudinal nature of the study by revisiting each participant with the summary and themes after each interview.

12. Modifying themes and summary.

13. Identifying general and unique themes for each interview.

14. Contextualisation of themes.

15. Composite summary.

Similarities and the respondent's meanings were noted and considered as the new data was analysed. The new data was analysed in a themed approach considering each of the research questions posed and remaining true to the phenomenon (Knaack, 1984).

Whilst working through the data I was careful not to remove the data from its context (Miles & Huberman, 1994). During the data analysis using the Hycner format, careful deliberation took place to consider the whole experience in its context (see appendix 12). However, phenomenological analysis is a little like admiring a butterfly, we can look at it and admire it but if we hold it by its wings they begin to deteriorate, analysis needs to be done in such a way that the data is as complete as possible.

The researcher's position

It is important to state that I am a nurse and a health visitor working in a local primary care trust and I have an interest in public health. I work in a number of arenas to assist individuals to achieve their desired goals including weight loss. I am also a part time student at Southampton University undertaking this research study. I am also a large woman. This is something that I have found difficult to write down for apprehension of the social censure and possible discrimination that myself and consequently this research may have to endure in a social environment where being large has certain usually discriminatory, social and cultural connotations.

I am aware therefore that my background may provide a potential bias for undertaking research in this arena. Therefore I have had to continually monitor my thoughts and interpretations; aspiring not to expect to see, or even want to see, my perception in terms of the experience of weight loss. I also had to be aware that inquiry does not mean looking for solutions (Kabat-Zinn, 2008); something that nurses and health professionals are usually seeking to achieve. Although, I was conscious that if the data in this study illuminated some of the research gaps previously identified I would

believe that the research study had achieved some of the stated goals. I have also tried to undertake a thorough literature review and use a transparent and robust research methodology to collect the data and also used a clear strategy, the Hycner format to analyse the collected data.

After considering the different ideological discourses available I would probably position myself within the progressive/public health and pro-education and libertarian discourse (Lawrence, 2004, Francis, 1999 and Labonte, 1998) as I believe in the benefits of taught and self education and I believe in individuals being, on the whole, free to choose their own lifestyle and way of living.

When considering my views about previous research, I would say I value both qualitative and quantitative research providing that there is both methodological rigour and transparency, the caveat being it all depends on what the research questions are, as to what methods or mixture of methods should be used. I also need to say that although I have used both approaches before I would say that I am probably more experienced in a practical sense with the qualitative approach and qualitative tools of data collection.

The importance of reflexivity

Reflexivity was described by Mead (1934:134) as "the turning back of experience of the individual upon her or himself" and by Delamont, (1991:8) as "a social scientific variety of self consciousness" It is a complex concept that takes many forms. The relationship between social constructionism and reflexivity are integral to accounts of social epistemology (Soderqvist, 1991). Operation within such a paradigm requires researchers, to the extent of their ability to analyse and display publicly their history, values and assumptions, as well as their inter relationships with participants (Schwandt, 1994). This is something I have tried to demonstrate in this research study.

As the interpretative approach relies heavily on the individual researchers interpretations, it is important for the researcher to describe where he or she is in their own field, where they are positioned for example in a political sense and what are their opinions of past research. It is from this stance that the researcher becomes more

aware of where they are writing from and alerts the reader to possible biases that the researcher has (Cohen *et al*., 2000). Exposing the researcher in this way may help to make the subjective more objective. A complete objectivity and neutrality are almost impossible to achieve (Holloway & Wheeler, 2002) and "even if preconceptions and bias are acknowledged, they are not always easily abandoned" (Robson, 2002:173) and the values of the researcher can become an integral part of the research (Smith, 1983).

Flick (1998) describes the importance of taking the researcher's communication with the field as an explicit part of the knowledge and data from the research rather than excluding it as an intervening variable. It is the subjectiveness of the researcher and of the individual being studied, which are integral to the research process and findings. The researcher should reflect on their actions, feelings, impressions and irritations and intuition so they in their own right form part of the analysis and interpretation of the research. Peshkin (1988) argues that researchers, not withstanding the research problem they are investigating or the methodologies used, should systemically identify their own subjectivity throughout the research process. The rationale for undertaking this approach is that the researcher becomes more aware of how their subjectivity shapes the inquiry and outcome. This process can be recorded and then exposed to the reader(s) so that it is evident and transparent where the self and the subject become joined.

Therefore, I maintained a research diary for the five years that I undertook the research. After each article I read, each supervision session, each interaction with a respondent I would reflect on my thoughts and feelings. This diary provided an opportunity for me to learn about my personal qualities that connect with the research study, the experience of weight loss. These were then incorporated into the research findings to provide a more accurate picture of how these conclusions were drawn. As Peshkin states "one's subjectivity is like a garment that cannot be removed" (1988:17). So throughout this thesis I hope to describe in effect what clothes I am wearing so that any affect this may have on the conclusions drawn is transparent to the reader(s). For instance, I have revealed to the readers of this thesis that I am a large women, who has had her own experiences due to size, but I have tried to put

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these aside in this study, and assume that not all fat people are the same (Barron McBride, 1988).

Conclusion

This chapter has discussed the methodology that was used to investigate the research questions posed in this study. The overarching research aim this study seeks to address is: What is the experience of intentional weight loss. The associated research questions of this study are:

- What feelings or beliefs motivate individuals to start trying to lose weight and to continue trying to lose weight?

- What strategies do individuals employ to try to lose weight and what decisions, feelings or beliefs underpin or influence these strategies?

- What factors help or hinder individuals in their attempts to lose weight?

In this study, I intend to utilise a phenomenologically informed qualitative approach. The research data gathering tools have included a series of semi-structured interviews taking place with a purposive sample over the duration of a year. This purposive sample was recruited by advertising and a snowballing technique. The qualitative data collated was analysed using the framework advocated by Hycner (1985) and for elucidation exemplars have been included in this chapter and also in appendix 12. The strengths and weaknesses of the tools and framework utilised in this study and the structure of the research plan and the design of the study have been fully discussed in this chapter.

On reflection, such strategies I believe are the most appropriate to allow the voice of the respondents who are undertaking a journey of intentional weight loss to be heard. The proposed research methods in this study have raised particular issues in relation to sample size, generalisability, reliability and validity, subject and researcher bias, and ethical considerations such as the researcher's ethical position, informed consent, and aspects of confidentiality, anonymity, professional ethics and reflexivity. In the subsequent chapter of this thesis further analysis of the qualitative data obtained and the results of this study will be reported.

CHAPTER FOUR: RESULTS

Introduction

The intention of this chapter is to present the collected data in order to allow the research questions posed to be explored. The overarching research aim of this study was to explore: What is the experience of intentional weight loss. The associated research questions of this study were:

- What feelings or beliefs motivate individuals to start trying to lose weight and to continue trying to lose weight?
- What strategies do individuals employ to try to lose weight and what decisions, feelings or beliefs underpin or influence these strategies?
- What factors help or hinder individuals in their attempts to lose weight?

Therefore, in this chapter I will initially present the ten women in the study in the form of vignettes. Each vignette introduces each participant and gives an overview of their general background and weight loss history. Secondly, the four primary themes of self-sabotage, internal conflict, control and choice which have been drawn from the qualitative data using the Hycner (1985) analysis framework, will be identified and illustrated through examples drawn from the interviews. Thirdly, the central concept and identified themes will be discussed in relation to the women in the study. Fourthly, three case studies will be introduced that serve as exemplars of different dimensions of a central concept, identified in the data analysis, as connectedness. Fifthly, the differences and similarities between the women in the study will be discussed in relation to how they felt about their weight loss experience, their motivators for weight loss and the weight loss strategies they employed. The conclusion gives an overview of this chapter and sets the scene for the final chapter in this thesis.

Vignettes

The use of vignettes has been purposefully chosen in order to set the scene for the reader about the participants involved in the research study. The vignettes of the participants are presented in alphabetical order purely for clarity and the participants themselves primarily chose the pseudonyms used. The ten participants are: Beth, Code Red, Karen, Kate, Louisa, Lucy, Margaret, Molly, Pat and Peggy.

Beth is a practicing nurse in her early thirties. She is married and has no children. Beth has been concerned about her weight for a considerable number of years and at her heaviest she weighed twelve and a half stone. Beth would like to be slimmer for a number of reasons including looking better in her clothes. Beth says she finds it easier to restrain her eating when at work but can succumb to temptation when at her mother in laws who is a good cook she says and always produces delicious cakes. At the beginning of her weight loss journey, which was the twelve months of the study, Beth struggled to lose weight and then maintain the lost weight. Part way through her journey, however, Beth started to consistently lose weight and maintain the weight she lost and eventually she reduced her weight to eleven stone one pound.

Code Red is a self-employed forty three year old entrepreneur. Code Red is a busy mother with five children and a number of pets. Code Red says she has tried every diet, exercise regime and weight loss strategy there is, at least once and is always on the lookout for the newest, easiest way to lose weight. Code Red has wanted to lose weight for a number of years. At her heaviest Code Red weighed twelve stone ten pounds. Although Code Red has lost weight, these episodes of weight loss are often followed by weight gain. Code Red has an image of herself being much slimmer which she has yet to achieve. Throughout the year, Code Red's weight fluctuated. A period of weight loss would inevitably be followed by a period of weight gain. Code Red's weight at the end of her yearlong journey was five pounds heavier than her original starting weight.

Karen is a forty one year old nurse who has always been overweight. She says her favourite picture of herself was taken when she was about eighteen months old and

she was feeding her chickens. She describes herself as just a bit chubby then. She now describes herself as huge. At her heaviest, she was seventeen stone ten pounds. She is always trying to lose weight but also enjoys eating and finds any social occasion she attends revolves around food. She wants to lose her weight to be more active and also to be a role model for her brother's children. She does not want them to be fat like her. She would also like to wear the clothes that she fancies; not what she can get that fits her. Initially her weight fluctuated but part way through the year Karen started to consistently lose weight and she eventually reduced to fourteen stone four pounds.

Kate is a sixty five year old retired woman who has spent the last twenty-five years plus working as a carer. As a child, Kate said she lived in the countryside and enjoyed riding her ponies and she was always very thin. She started putting weight on when she was about fourteen, which she described as being horrible. She became progressively bigger and by the time she was twenty, Kate was about eleven stone. At her heaviest Kate weighed eighteen stone ten pounds. Kate has always tried hard to keep her weight down but never wins she says. Kate would like to lose weight because of her age and to improve her mobility and to be able buy the clothes she likes. Kate would like to be a size ten and at her largest, she was a size twenty-eight (dress sizes). Throughout the year, Kate's weight fluctuated and she did lose almost a stone but by the end of the year, Kate weighed just one pound less than her original starting weight.

Louisa is in her early sixties and works as a cook. Louisa lives with her husband in a rented apartment. Louisa says she has tried different ways to lose weight in the past. At the start of the year Louisa weighed fifteen stone. Her aim, Louisa says is to lose about four stone and if she could get to a size fourteen Louisa says she would be happy. Louisa feels that her husband is disappointed about her weight gain because she says when she met him she was a "lovely" eight stone. Throughout the year Louisa did try to lose weight without any success and by the end of the year Louisa had gained almost another stone in weight.

Lucy is twenty-one and unemployed, although she is delivering magazines. Lucy is currently living with her boyfriend in rented accommodation. She has had concerns about her weight for the last couple of years and these appear to have stemmed, she

feels, from when her lifestyle changed and she left home. She has two younger, slimmer sisters to whom she compares herself. Some years ago Lucy was a paid model with a model figure and that is what Lucy says she wants to get back to. At the time of participation in the study, Lucy was between eleven and twelve stone. Lucy, however, did not participate in the study for the full twelve months.

Margaret teaches machine knitting and also helps her husband in his business. Margaret is married and in her fifties. She has two grown up sons, both involved in computers and her husband has his own business. Margaret states that none of them are interested in her weight and she has no family nearby to support her, as she is originally from the north of England. Margaret wants to lose a considerable amount of weight although she says she has no set time scale in mind for her weight loss. However, it is her intention to definitely lose her unwanted weight especially from certain parts of her body, which Margaret says she definitely dislikes. Margaret at her heaviest, weighed one hundred and twenty kilos, (eighteen stone twelve pounds) which during the year she consistently reduced to one hundred and three point six kilos, (losing approximately two and a half stone). Margaret was the only individual who used kilos to discuss her weight.

Molly is in her mid thirties and is married for the second time. She has in total six children, which does mean she has a very busy household. Molly also works as a part time hairdresser. Molly wants to lose a significant amount of body weight and reduce her dress size. Molly says her weight does get her down and she becomes fed up; although it does not affect her too much, in what she does. Molly says she would like to look better. Molly also has a family wedding coming up which she says she wants to look good for and to be able to wear some nice clothes. Molly at her heaviest weighed fifteen stone eleven pounds and at the beginning of the year, her weight initially fluctuated. However, Molly reached a turning point and then she consistently lost her weight; reducing her weight eventually to thirteen stone five pounds.

Pat is a former nurse in her late fifties and she works as a car ambulance driver. Pat is married and has her own children as well as fostering children, some for many years. Pat would like to lose some weight and would like to be a comfortable dress size eighteen she says. Pat has tried different ways to lose weight in the past but this time

she has decided to use the 'Slimming World' plan. At her heaviest Pat weighed seventeen stone twelve pounds and throughout the year Pat consistently lost weight. There were two exceptions to this consistency, a family holiday abroad and Christmas. However, Pat did lose those pounds gained and eventually reduced her weight to sixteen stone and one pound.

Peggy is in her early sixties and has two grown up sons. Peggy is retired and during the study moved to be near one of her sons who has since relocated to the north of England for work reasons. Peggy would like to lose four stone and has lost significant amounts of weight in the past; but Peggy said she wasn't prepared to do what was necessary to maintain that weight loss. Peggy said she is looking for the way to lose weight that takes away her desire to eat. At her heaviest Peggy weighed about fourteen and a half stone, she thought. Throughout the nine months that Peggy belonged to the study, before moving out of the area, Peggy's weight continuously fluctuated but she was seven pounds heavier at her last (third) interview.

Throughout the thesis, the respondents' self-reported weight, losses or gains have been recorded. I did not attempt to validate their claims, as I did not feel it was appropriate in a study of this nature. Instead, I acknowledged and accepted at face value what the women said as truthful. The fact that the women reported a variety of both losses and gains validates the appropriateness of this acceptance of their self-reported weight status.

Emerging themes

Following careful analysis of the qualitative data, using the Hycner (1985) data analysis framework (see appendix 12), four key themes emerged from the data: self-sabotage, internal conflict, control and rational choice. Two of these themes; control and rational choice, have been previously identified in chapter two of this thesis. The Hycner framework by its very process captures the voices of the respondent throughout its various stages and determines the various themes both general and unique to the participants. These emergent themes of self-sabotage, internal conflict, control and choice feed into the overarching theme, which has been identified as connectedness or disconnectedness. (See Figure 1).

Self-Sabotage and Internal Conflict

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        │            Connectedness/              │
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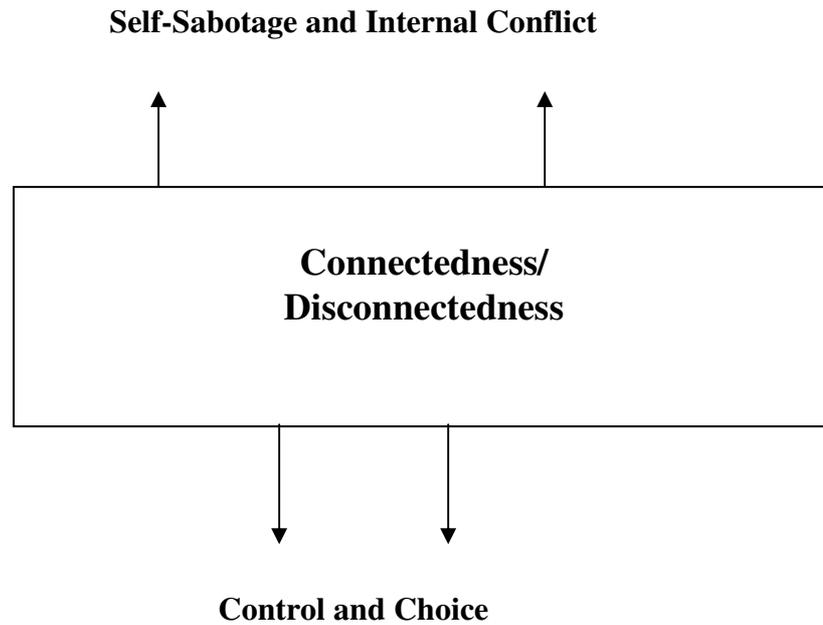
Control and Choice

Figure 1: Emergent Themes

Before expanding on this overarching theme, I will now define and illustrate each of the four contributing themes of self-sabotage, internal conflict, control and choice.

Self-sabotage

The first theme that was identified through analysis of the data was that of self-sabotage (see appendix 12, stages 8 and 9 which demonstrate the actions conducted to discover the theme of self-sabotage). Self-sabotage is doing something (usually binging or overeating) that undoes the weight loss that the individual has already achieved. Six of the individuals in this study discussed and cited a variety of examples of self-sabotage. For some the self-sabotage was constant throughout the twelve months, for others self-sabotage was occasional and not repeated. Some women were consciously aware of their self-sabotage, others were not.

Awareness of self-sabotage

Some individuals such as Louisa and Beth refer explicitly to self-sabotage or self-destruction. They are aware that their actions are potentially harmful to them and are

not helping them to lose weight but are in fact achieving the opposite of undesired weight gain:

It is very interesting because you realise that you are self-destructing, that what you are doing is not doing you any good, as I said (Louisa, fourth interview).

Louisa also described her weight loss as a self-sabotaging journey:

It's like when you reach a crossroads and you think I'll go left, you go left and it's the wrong road you know, so what do you do? (Louisa, first interview).

Louisa continued self-sabotaging throughout the whole weight loss period and gained weight. This was unlike Beth who by the third and fourth interviews had managed to reduce any self-sabotaging actions and was now consistently losing weight:

I had a couple of weeks; I have this sort of self-destruct thing. I had it a couple of weeks before I went away. I've not got it now this thing where because I am trying to stop myself from having naughty things the opposite happens (Beth, second interview).

Non-understanding of self-sabotage

There were occasions where individuals appear not to explicitly acknowledge that they are self-sabotaging, or if they do, do not understand the reasons why they undertake these actions. An example here would be Beth:

I am actually buying bars of chocolate. I don't really want them but there is something about because I am not allowed it, it's like, I don't know, it's like I am actually fighting myself. It's a very, very odd and I do go through these little phases where you know I am on the way to…I'll stop and I'll buy croissants and I will do really stupid things and I will eat food I don't really want and I will have naughty things just to show that I can to myself. It's a very, very odd thing and I will and so I went through a couple of weeks like that. Like I say I went through

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that slightly self-destruct couple of weeks when I was eating whatever (Beth, second interview).

Self-sabotaging actions

One example of self-sabotaging would be Kate. Although she follows a regime of dietary restriction reasonably successfully during the day, in the evening, she finds her resolve lessens and her actions surrounding her food consumption then becomes self-sabotaging:

> There hasn't been a lot of change only going down and going back up again and every day I am going to start the next day and do it right. But I do, do it all right and when, when dinnertime comes I don't do it right. That's what happens every day (Kate, second interview).

Such instances of self-sabotage remained constant throughout Kate's entire weight loss journey and consequently Kate lost little weight:

> I suppose when I get hungry instead of doing my diet I think what else can I eat, and I eat something else (Kate, second interview).

Molly also discusses instances of repeated self-sabotage in relation to her food consumption following often significant exercise. Molly was a competitive swimmer as a teenager and has maintained that ability in the water:

> I go there a lot. I go and do one hundred lengths (laps in the swimming pool) without ever thinking about it. I do it all the time, you go swimming, oh I feel great! You know you come out and feel great, by the evening you'll have a mars bar and then you have just lost everything you have just done. You've just replaced what you've done, you know (Molly, first interview).

Spoiling things

Other individuals, such as Margaret talk of spoiling or making a mess of things:

Well, the three tins of chocolates that get brought at Christmas, that didn't help at all, just looking at them I gave in one night (Margaret, third interview).

In Margaret's case, this instance of self-sabotage was an isolated incident, which happened at Christmas time. Holiday periods such as Christmas and holidays were a difficult time for a number of respondents who found it difficult to stay focused.

A small number of participants, Louisa, Molly and Peggy considered that weight loss was more important than spoiling their own health. In fact undertaking potentially self-sabotaging or damaging health behaviour strategies (smoking) were chosen if the individual considered it helped them to slim:

My husband has started smoking again, which I am very tempted to do; I really am tempted (to help her lose weight). (Louisa, first interview).

So, I have started smoking again. I know that it is bad but for my own personal well being, I would much prefer to smoke and to be slim than to be fat. Sad aren't I. It's vanity you know and how you look. Yes, it sounds awful to say, but it is vanity. I would rather people look at me looking good and allow my body to deteriorate inside with smoking (Molly, second interview).

Don't worry about health, you could be dead tomorrow. If someone said to me, would you like to be healthy or slim? It would be nice to be both but then I would choose to be slim (Peggy, first interview).

Self-sabotaging thoughts

Other individuals such as Code Red and Molly discuss instances of self-sabotaging thoughts, which influence their actions:

It's just like being two people. When I wake up positive I am the most positive person you will ever meet and nothing gets in my way. But it's something stupid like a piece of cheesecake that will knock me right off my perch. But seven pounds in two weeks was pretty good going and I know a lot of it will be fluid but

I was really pleased with it, like 'cos they've got this graph and you can see it go down and I get this little star and I thought yes and that was on Friday and on the Saturday I had just completely well bollixed it all up for want of a better word. Not had the cheesecake, it just makes you think well you shouldn't have had any, but if I hadn't had any, I wouldn't have needed to go out and buy another one and it was the mandarin one, you know, ahh. I just love the taste of it and the crunch and I ate the whole thing and afterwards I didn't feel guilty, I just felt a complete bloody failure and then I think ahh well stuff it; I might as well have another one and it's that silly attitude that's stopping me from doing what I want to do (Code Red, second interview).

Code Red, throughout the year of the study, consistently indulges in self-sabotaging actions and consequently gained weight. Molly links these self-sabotaging thoughts to herself as well as her weight as this extract from her second transcription demonstrates:

Am I abnormal? Maybe I don't deserve to be slim, but I don't know why? Whatever attention I receive I spoil anyway (Molly, second interview).

Internal conflict

Another theme that is strongly evident in the participants' responses is instances of internal conflict (see appendix 12, stages 8 and 9 which demonstrate the actions conducted to discover the theme of internal conflict). This internal conflict is identified through what I will call contradictory dialogue, where in the same breath, sentence or conversation an individual talks about two or more actions, aims, beliefs, ideas or views which appear to be in conflict with one another. The individual can therefore appear to be contradicting themselves, or in a state of flux, swinging backwards and forwards between different ideas or beliefs. This internal conflict can result in individuals acting in contradictory ways, which serves to hamper weight loss.

Contradictory actions

Although Lucy is aware of what foods are healthy and wants to lose weight, her actual food consumption is contradictory to her aim of weight loss:

> I love my yoghurts. I am a yoghurt girl. I don't like the taste of water, whatsoever; I don't often have fruit whatsoever. I've got fruit in the fridge now. I just don't eat it. It's all for my boyfriend. It doesn't interest me at all; all that interests me is the fat food, food what's tasty (Lucy, first interview).

Contradictory aims and goals

Some women, such as Beth, in reflecting on current weight loss achievements compared to past successes or failures reveal how over time they can have very different or contradictory views about specific weight loss aims, goals or targets. This can reveal an internal conflict in terms of struggling to set goals which if achieved will result in both weight loss and the happiness and satisfaction that their goal has been achieved:

> Well, it has just gone back up. When I saw you last time, I was eleven and a half stone but now that half stone is back on again, so basically I haven't lost. But I was really pleased up until the holiday although I hadn't lost any more; I had maintained the eleven and a half. Not happy, definitely not happy because I felt better being half a stone lighter. So I am not happy, I think what I have learnt over the years of wanting to lose weight since I was, well since I was an adult, I wanted to lose weight. I have never been happy. I wasn't happy at ten stone but I would die to be ten stone now, isn't it stupid (Beth, second interview).

Peggy also reveals a number of conflicting aims she has about her own weight loss targets. Although she says she is weighing the heaviest now she has ever been and wants to lose weight, in the same breath she says staying the same weight would be acceptable to her. Peggy then continues that despite other people saying she should be slimmer Peggy feels this heavier weight may be her ideal weight:

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I have never been as heavy as I am now. I would like to try to lose weight but emmm it just depends on how things are, if you lose weight, to stay the same, as I ever would be, would be good. Oh, I don't know about it! Well, because it's always in your head, you know, you can't get away from it, you know people saying, oh you should be slimmer, you know perhaps this is my ideal weight (Peggy, first interview).

Contradictory beliefs

Peggy discussed contradictory beliefs about going back to a weight loss product that she had used in the past. Peggy's belief structure was contradictory because ironically, when she had previously used the product she found the experience unpleasant due to the side effects and consequently she wasn't able to use them for very long anyway. This had resulted in her losing little weight and yet Peggy is advocating using this strategy again as "the only way for me" despite its previous limitations:

I am always trying to lose weight, always trying to find, I am always looking for that way that I can lose weight. Some sort of appetite suppressant that would be the only way with me, you know, so that I don't want to eat but that sent you up the wall because you thought you were meeting yourself coming back. I couldn't keep them going very long, from what I can remember (Peggy, first interview).

Contradictory self-dialogue

The interview data of Beth, Code Red and Kate shows evidence of contradictory self-dialogue. For instance, Beth contradicts herself in the same conversation about whether she should accept herself the size she is. She swings to having to take action, back to not doing anything about her weight gain. Kate, in a similar fashion wants to be twelve stone but in the same breath feels this isn't a possibility for her:

I think that's the choice and I think you either give up and say I'm going to be the way I am. Maybe get bigger and I don't care, and I'm going to be flabby and I'm not going to be toned and I'm not going to like the way I look in the mirror when I take my clothes off, and that's it, and I'll just accept myself for who I am. It

depends on what I do. Then you see these programmes with these big women who accept themselves as being big and I think that's great. If that's what they want to do, but I'm not ready to give up on it yet, but at the same time I think that eventually I've either got to bite on the bullet and eventually move to a way I can get on with it or I've got to give up on it (Beth, third interview).

A primary reason for Kate wanting to lose weight is to have a second knee operation. For her first operation, Kate was fourteen stone, which was considered a safe and acceptable weight to undergo potentially dangerous surgery. Prior to her second operation, Kate is now heavier than fourteen stone, but has set herself the goal of getting to twelve stone before the operation:

> I would like to be about twelve stone for the operation. But I think it is you know, a little bit impossible. When I had my last operation, which is the same one, I was fourteen stone then and I felt that I was too heavy at that time to cope with myself (Kate, first interview).

This goal seems to ignore or contradict Kate's prior experience, and sets her up for an internal conflict whereby twelve stone seems impossible to achieve, particularly as she doesn't like dieting:

> But I diet, I eat, I diet, I eat…well you know everything you want to eat or if you do eat it, nice dinners and that, I like you are thinking all the time I shouldn't be eating this…I don't really like dieting but I know I've got to do it now (Kate, first interview).

Louisa also displays instances of contradictory self-dialogue when discussing what she calls her dual personality and her actions around weight loss:

> Anyway, to cut a long story short he (husband) brought this along with some other products and he said maybe this will help. But it doesn't seem to help; as soon as I get something like that, I seem to have a dual personality. One part of my brain is saying oh yes! Yes! This is it, you can do it! And the other part of my brain says is it worth the hassle? Why bother? You know, so I am fighting a constant battle

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within myself. It hasn't helped at all. I seem to have this dual personality. I want to and yet it is too much hassle because basically I am a lazy person... I go at things like a bull at a gate and then I lose interest you know I've been like that all my life. It is just this total frustration with myself, and knowing that if I set my mind to it I can really do it but I am too bone idle to really set my mind to it and stick to it (Louisa, second interview).

Contradictory thinking

Beth shows evidence of contradictory thinking because despite saying she wants to lose weight she also admits to not trying to lose weight. Beth does not even weigh herself very much because the scales show she is not losing weight, which is not surprising as she is not presently, despite her stated aims, trying to lose weight:

It's very frustrating. It is very frustrating. I think it is very frustrating because I am not; I am not making the effort. Well, I have got these scales next door that I occasionally get on, and there's scales at work that I occasionally get on but when they don't tell me what I want to know I've not done anything much (Beth, second interview).

However, instances of contradictory thinking lessen in Beth's later transcripts as she loses her weight in the latter part of the year of the study.

Self-awareness of contradiction

Code Red commented on how contradictory she felt she was after reading her own transcripts:

No, the only thing you do that is funny, it is ever so funny to read it back, it is ever so funny what you say and I am so contradictory when I look back at certain things. I said that, did I really? So, it is good to read back, it is a good reference…It is a good reference because you can look back and think I did say I tried that (Code Red, third interview).

Control

After analysing all the data, it would appear that control is a significant issue that the women have to grapple with during the process of trying to lose weight (see appendix 12, stages 8 and 9 which demonstrate the actions conducted to discover the theme of control). There is a number of elements to control: being in control or rather as is often demonstrated by the respondents, being out of control and being controlled by external factors such as beliefs about genetics and foodstuffs.

All or nothing

The following quote is an example of how the pendulum of control swings from very much in control to being firmly out of control. Karen terms this as the "all or nothing" mentality:

> I am going to be as good as possible, no cheating, no snacks, no breaking off the diet. It is very difficult because I am very much an all or nothing person either I am so good people will say "my god aren't you good" or I will just eat everything (and dieting or life control or weight control isn't like that). What you need to do if you go off it, is what you need to do is get right back on again (Karen, first interview).

In this bracketed extract, Karen associates life control with weight control as though in her own mind the two are synomous one with the other.

Being out of control

Louisa also discussed being out of control with her food intake and also her feelings in relation to food:

> Scared, scared of failing you know. That's the whole thing. I am sort of frightened of starting something and failing again…I just can't stick at anything. I've tried going to 'Slimming World' and you know where they lie to you and say you can eat as much as you like of certain foods. It's a lie, because I can't stop eating and I

just don't lose weight even if I stick to the right format that they give you. What they mean is you are supposed to eat one plate of food. I can sit and eat three or four plates of food and still be hungry after you know, ten minutes later (Louisa, first interview).

Beliefs about genetics

Some of the women believed in there being a fatalistic aspect to their weight, which involved heredity or genetics. This they believed might affect the control they have over their weight as it may be influenced by these other external factors:

My mother is in her sixties and is very overweight. My brother has been overweight as well over his life time at various periods and my grandfather was a big man despite never having butter on anything (Karen, first interview).

My weight has been a long-term problem. I think the whole thing is (Margaret, first interview).

My mum was big, my sons are big now. I've got uncles, aunts and cousins they're big so there is more to it than what you just put in your mouth. My Nan during the war was a big lady (rationing). My eldest grandchild she is tending to be, but his mum she's big as well as my son so but even if (Peggy's grandson) is not big as a child when he gets bigger, older, he will put on weight (Peggy, first interview).

Controlling aspect of food

Lucy and Margaret demonstrate in their quotes the controlling aspect of food. For instance, Lucy discussed "fat food" and Margaret talks about "peppermint" and "stacks of toast". Margaret uses the word "drowning" to demonstrate her potential to succumb to tempting toast:

All that interests me is fat food, food what's tasty. You get addicted to them (Lucy, first interview).

Having a baby crying at night was not on, so they used to feed me undiluted gripe water which is basically sugared water with dill, extract of dill and peppermint, lots of peppermint, even today peppermints they are, you know, the after eight mints, show me a box of them and you've got an empty one (Margaret, first interview).

Just the thought of stacks of fresh toast (laughing) with butter and marmite, you know I am drowning (laughing). See the temptation. It is like an addiction, in fact some people it really is as though I mean some people is as though. I mean it is the same sort of level as a heroin addiction and they just cannot get away from the desire to have high carbohydrate food, pizza and pasta and potatoes and…(Margaret, fourth interview).

Although Molly acknowledges this external control she questions where it comes from, even potentially herself:

I don't know that I could do that. I would be fine but I don't know if it is psychologically or is it something inside me that says something or I don't know? No, not deprived but then psychologically yes. I don't seem to be able to do it (control myself). It's just a craving for chocolate. It just creeps in absolutely. I eat too much though whatever there is (Molly, first interview).

Addiction

Louisa discusses the global issues of addiction and debates what she feels is the limited support an overweight person is given both by society and health professionals to help them lose the weight they wish to:

Basically it looks as though the NHS is prepared to help drug addicts, alcoholics. They even help you stop smoking but when it comes to weight, they don't. I mean you know, all those addictions are the same as eating is an addiction; the help is definitely not there. I mean they are prepared to send you to someone who is a dietician, but that is not what you need; you need someone a little bit more than a dietician. I think you need more counselling…we all need help. I mean I have

tried all the diets…I have tried them all and nothing seems to work because you seem to crave the things you shouldn't have. You feel good while you are eating it, the same as an alcoholic feels good when they drink, you know and a drug addict when they have their fix of heroin or whatever they have but afterwards…(Louisa, fourth interview).

The concept of addiction to food is highlighted by a number of respondents including Louisa, Lucy, Margaret and Molly. Such addiction they say emphasises how difficult it is to resist eating certain foodstuffs, usually high in fat and sugar, an anathema to the foodstuffs they perceive as useful for dieting. Margaret discusses such addiction in terms of other people and Louisa discussed links with the more global issues of control. The consequence of such addiction, for the women, is a loss of control.

When discussing her chosen weight loss strategy of 'Sole Source' Molly discussed how much control she felt she had. However, this would appear to be contradictory because in one respect this strategy does not give the participants any choice at all because conventional food is totally excluded from their diet. Molly does not acknowledge this at all. If food is removed from the diet, how can Molly be exhibiting control at all? The supporters of such a strategy say removing conventional food from the equation assists the individual to rebalance and recover from their food issues especially in relation to control and excess consumption, (Clinical Information Brochure, Lighter Life, 2008).

Control is a big word in weight, it really is. You know it has become more and more clear over the years, you know yourself, how much control you really have and when you are doing something like 'Sole Source' you are completely in control, completely (Molly, fourth interview).

Choice

Another theme that appears prominent in the data obtained from the respondents is the issue of choice, which in this thesis is defined as free and rational choice (see appendix 12, stages 8 and 9 which demonstrate the actions conducted to discover the

theme of choice). The women discussed their choices around foodstuffs, fatalistic beliefs and strategies for losing weight.

Choice of foodstuffs

Kate and Peggy acknowledge that choosing to eat products to help them slim is what they want to do but neither of them like the consequences of eating that way or would choose naturally to eat such products and feel as though their choices are curtailed. This results in internal conflict as they are acting in a way they do not wish to, despite their intended aims of substantial weight loss:

> I think that the best thing to do is try and live on salads, fruit, vegetables. Don't have any cheese, don't have any butter and if you go without bread, well and biscuits you are on to a winner. That is very restrictive but if you have a lot of fat to get rid of that is the way, you have to do it. I think if you can get enough off it will be good, dieting is boring you know but I suppose you've got to put up with it if you want to lose some weight (Kate, first interview).

> (Dieting). Well, it is just so boring and awful. I just find it boring and awful and I mean all the things they do not want you to eat I like. I am not a salad person. I like sweets, chocolate, cream, cakes, biscuits, crisps. I like everything, not eating the sweeties, not eating the crisps, not eating the biscuits, not eating the cakes and not having the cream, not a lot left is there, boring diet (Peggy, first interview).

Magical or quick fix remedies

The following quote by Peggy highlights her desire for magical or quick fix remedies. Peggy chooses to believe that these magical remedies may help her to lose weight. In the quote below, by referring to the use of a bacon slicer on herself to lose weight there is an interesting play on words. Does Peggy for instance, see herself as food or is she still thinking of food when considering her weight loss?:

> I am always trying to lose weight. I am always looking for the way that I can lose weight and I know that the only way I can lose weight is by having some sort of

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appetite suppressant and that would be the only way for me, so that I don't want to eat. I am just looking for the secret bullet, chocolate patch, they have smoking patches. I'd take tablets if they (GP) would give them to me. I have asked but you have to show you can lose weight to start with, which is daft but never mind. I would like to be ten stone tomorrow, that's what I'd like. Not unless they put me on a bacon slicer. I don't want a difficult way. I want an easy way. Oh, I'd like to be, you know, about five stone slimmer. But you know that's wishful thinking. I keep watching things on the television, have you been seeing them? You know and I thought that's what I could do with. I could do with a big sugar daddy who will pay (Peggy, first interview).

Connectedness and disconnectedness

After analysing the qualitative data, the themes that emerged were self-sabotage, internal conflict, control and choice. From these themes, what emerges is an overarching theme or central concept of human connectedness. That is the individual being connected with their mind and body, internal dialogue and self-actions. This, in a harmonious manner is the essence of being connected. The individual's mind and body are in synchronisation and are working better in a united manner to achieve their desired ideal. Connectedness is linked to being in control and making the right choices and therefore not self-sabotaging or being in conflict with self, aims or actions.

Beth tries to define being connected and struggles to articulate its essence, ultimately defining it as "will power". Beth is identified as being more connected during the latter part of the study:

This might be, you know, I always felt that this might be. I should have the capacity to do it. I have thought about it now, and I have had enough tries but I am hoping that I have got the, the will power, its nothing else (Beth, fourth interview).

Karen defines connection as being ultimately self responsible for your own actions in relation to your weight loss and making that implicit decision to lose weight. Karen becomes connected in the early part of the study:

> Well, I think in the end it has been myself because you have to decide to do it, and you have to decide to go on the diet, or follow the food plan or change you're lifestyle and you have to do it. It's not if anyone helps you, it is how you interpret that help (Karen, second interview).

Pat defines being connected as being "motivated" and "mentally focused". Pat says she is aware of her capabilities as she has done it before and even sets the exact day of the commencement of her weight loss. Pat was identified as being connected from the early part of the study:

> When I can get my head round it. Just getting yourself motivated and really setting yourself and doing what your mind wants you to do, you know. Just suddenly like this weekend, I thought right this is it. Monday I am going to start. I've got my head round it now. I've got it sorted out and made the decisions. I have just got mentally focused on it now and I have done it before (Pat, first interview).

Disconnectedness would appear to be the reverse of being connected. When an individual is disconnected from their mind and body, their thoughts and actions are at variance. They often show instances of reduced control and make choices in opposition to their desired stated aims. What the respondents reveal is how disconnected they often appear to be; firstly, in their mind, internal dialogue for instance in the form of contradictory thinking and secondly, in their body, self-sabotage for example appears to be a series of actions that are employed usually unconsciously to reduce the individuals chances of achieving their goal.

Code Red defines herself as "stuck" and "scrambled" again. Her disconnection in this second interview is evident and such disconnection remains constant for Code Red throughout the whole period of the yearlong study:

I am always trying to lose weight and I have been trying to lose weight for the last twelve years. It is just an ongoing thing. It's the sticking that I find the hardest. I am really fed up being this way. I am stuck. So, I am scrambled again (Code Red, second interview).

Code Red's disconnectedness is evident as she discusses her relationship with food as:

It's wired in my head (Code Red, second interview).

Louisa is not "happy" in herself or about having to diet. Although she has a plan she feels can work Louisa also says she cannot do anything. Louisa's disconnection remains constant throughout the whole year of the study:

I am not happy but I am going to give it a go. I will be, I am trying to be. I have no carbohydrate days and they do work. Which makes you feel worse about yourself being big, because I cannot do anything about it (Louisa, second interview).

Molly's disconnection is evident in this following quote. Only a small deviation, a "couple of chocolate buttons", is enough to promote Molly's self-punishing and negative thoughts about herself. However, Molly did not remain fixed in this disconnected state for the whole year. Molly became connected by the latter part of the year and lost a considerable amount of weight:

I haven't eaten loads but I've had a couple of chocolate buttons and in my mind that's naughty and I am bad and I am not going to lose weight now. I've had a couple of lapses. I am punishing myself for some reason. I am not allowed to have that. I am not allowed to look like that; it's the only thing I can come up with. Am I abnormal? Maybe I don't deserve to be slim but I don't know why? I want to be able to live a life of normalness (Molly, second interview).

It would appear that the ten respondents in this thesis were situated in one of three categories of human connectedness. These three categories were: fully connected, partially connected and primarily disconnected.

Two respondents Margaret and Pat appear to be totally connected. However, there were subtle differences between the two respondents. Margaret constantly lost weight throughout the whole year of the study and she perceived her weight loss journey as an enjoyable experience. Although, this was the exception and not the rule, in that the other women did not find it an enjoyable experience. Margaret remained focused on her goal throughout her whole weight loss journey. Pat also remained focused, apart from two exceptions when she appears to disconnect albeit only very briefly when circumstances became too difficult for her to continue on her weight loss journey. However, she quickly refocused herself. However, Pat stated she did not enjoy her experience of trying to lose weight.

Three respondents Beth, Karen and Molly appeared to be partially connected. All of these respondents at some juncture of their weight loss journey became focused. Beth and Molly by the last interview and Karen by the second interview in their weight loss journey. After becoming connected, their weight loss became constant.

Five of the respondents, Code Red, Louisa, Lucy, Kate and Peggy appeared to be totally disconnected throughout the whole period of trying to lose weight. This was despite their constant affirmations that they really wished to lose weight.

It would appear that being connected seemed to be linked with successful weight loss whereas being disconnected would appear to be linked with unsuccessful weight loss. For example, in the connected category, Margaret lost 16.4kg, which is approximately two and a half stone and Pat lost almost two stone. In the partially connected category before being fully connected, any weight lost by Beth, Karen and Molly was easily regained but when they were connected, all lost weight. Beth lost a total of one stone six pounds, Karen lost three stone and seven pounds and Molly lost two stone six pounds. However, the respondents in the disconnected category, Code Red, Lucy, Louisa, Kate and Peggy, despite saying at times that they definitely wanted to lose weight, showed little weight loss. Kate had lost a pound but Code Red had gained five pounds by the end of the year. Peggy had gained almost seven pounds and in total, Louisa had put on almost a stone during the year of being involved with the study.

However, it has to be stated that there is no supposition that individuals are fixed permanently in each category but may be able to move from one to the other, as in the case of Beth, Molly and Karen and even back again.

Case studies

For clarification and illumination and to discuss the central concept of connectedness further, three detailed case studies of Code Red, Molly and Pat will be discussed. Code Red presents as primarily disconnected, Molly presents throughout the longitudinal study as partially connected or moving between the different positions and Pat presents as fully connected.

Code Red: an illustration of disconnectedness

Code Red is a self-employed forty three year old entrepreneur. Code Red is a busy mother with five children and a number of pets. Code Red says she has tried every diet; exercise regime and weight loss strategy there is at least once and is always on the lookout for the newest, easiest way to lose weight. Code Red has wanted to lose weight for a number of years. At her heaviest, Code Red weighed twelve stone ten pounds. Although Code Red has lost weight, these episodes of weight loss are often followed by weight gain. Code Red has an image of herself being much slimmer which she has yet to achieve.

The use of Code Red as a pseudonym by this individual needs consideration. It is very unusual to use and has associations with the military such as high alert and also danger. Recently, it has become known as a computer threat. Code Red was released as a computer worm in 2001 and it is also the name of a German thrash metal band's album. When all the other individuals were asked to choose a pseudonym for themselves, they all chose other female first names. It is possible that the pseudonym Code Red has particular meaning or significance for the person concerned, which may be related to how she feels about her weight or weight loss such as being in danger.

Code Red's fourth interview transcript has been included in the appendices (see appendix 14). This transcript has been included as an example of the qualitative interview data that was obtained from the respondents during the duration of this study.

Throughout the year, Code Red's weight has continuously fluctuated, despite a variety of weight loss strategies being utilised. Although, Code Red was adamant that she wanted to lose weight, Code Red's weight at the end of her yearlong journey was five pounds heavier than her original starting weight. It would appear that Code Red remained in a disconnected state throughout her whole yearlong process of trying to lose weight. The following discussion of the themes that were revealed during the qualitative interviews and the supporting quotes that are used would appear to validate this supposition.

The first theme identified in the interview transcripts of self-sabotaging thoughts and actions are clearly present in the interview transcripts from Code Red. For example, although Code Red acknowledges the usefulness of the rose theory, which was a particular metaphor, that someone had told her about, she does not apply it to her food consumption and dieting strategy. She voices thoughts and actions that mitigate against her successfulness of losing weight, which is her stated intention:

> Somebody gave me a really lovely theory, the other day. She said to me if you were given a bunch of roses and one of them died, would you throw the whole bunch in the bin? I said no. She said you would take out the bad rose and that is how you have to look at your food, if you have a bad day so what, start again tomorrow. You see when I have a bad day I think that's it then I am doomed so I might as well carry on. But I can't understand where that attitude comes from because it is a rebel, it is almost like mm mm mm. All right then I will have three donuts no I won't I'll have four. Then afterwards I'll just feel like what did I do that for? Who am I rebelling against? (Code Red, first interview).

The second theme identified in the interview transcripts was that of internal conflict, which resulted in the respondents, revealing instances of contradictory thoughts and actions. Code Red showed clear evidence of her internal conflict with her

contradictory thinking and actions. Code Red advocates using a potentially dangerous strategy that she, from past experience, has found it difficult to comply with:

So, I'll have a big glass of that and then take that and take half a tablet in the morning and half later because I can't take a whole one because I have the most evil headaches. Because they are what you call it? They were banned, Attenuate Dospan. They haven't done anything for me. It didn't make me whiz around the house at all. It's the headache I get with them. They are evil. But that's because I don't drink the water. Between eight and ten glasses of water and I can't even drink two glasses of water. I can't. I find it difficult. I used to be able to drink water. I used to be able to drink water. I used to be able to drink loads (Code Red, first interview).

Code Red advocates eating sensibly then discusses all the extreme options she has tried, all without success:

I do, I know, but I still want that fast result that I want. That's three others that I did. There's 'Herbal Life'. I didn't lose anything only five hundred quid. That's expensive rubbish. I have done 'Slim Fast'. That made me feel so sick. I mean there's if I was going to say everyone right forget every slimming club you have ever been to. Do not diet. They don't work. It may work for one week, or two weeks or three weeks but then you stop. It is almost like oh! I'll carry on eating like I used to. No, you've got to change the way you eat. It is the only way you will ever do it. It is forever. I think you have to seriously look at the way you're eating (Code Red, first interview).

Code Red even acknowledged this contradiction herself when discussing her reading of her own interview transcripts, which I offered to her as part of the Hycner data analysis framework. However, in her quote there is yet another contradiction of which Code Red seems to be unaware of, as if she is unconnected and blind to herself:

No, not really, it just makes me laugh when I read it back. I seem to say ten positive things and then I say twenty un-positive things but I had I don't know, it's not a revelation but I have woken up to myself (Code Red, third interview).

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The third theme identified in the interview transcripts was that of control in terms of self-control and actions. Code Red demonstrated evidence of rigid, almost obsessional control of her eating pattern and her fitness regime:

> What I have done sporty wise, I have really cracked on. I went to…the other week and I was looking in the shop window and I think that I told you last time that I really like kick boxing. I saw this sign and my son had kept nagging me about going kick boxing and I saw this sign and the guy apart from being to die for, absolutely gorgeous, he was just on my wave length. So I do Monday, I do circuits with him. Wednesdays I do kick boxing and Fridays he comes here and I have personal training hour with him, kick boxing and exercises and Friday nights I have kick boxing again but I have been doing that for the last six or seven weeks and I can really see the toning look. I am not happy with the muscles but their there, that's from the punching but I do feel really good doing it (Code Red, second interview).

Kick boxing was a sport that Code Red wished to try and she was encouraged by her elder son to participate in kick boxing. Code Red saw the advert and took it as a "sign" that she should use it as a strategy to help her lose weight. Although Code Red was very enthusiastic and committed initially, despite the time and expense, Code Red after a number of weeks stopped kick boxing, citing the way it made her look as one of the reasons for no longer participating.

Code Red also swung widely in the opposite direction where she appeared to have no control whatsoever in relation to her food consumption. Her use of the word "slippery" indicates a loss of control but almost as though it is a game she is being conspired against to lose. "Overkill" is also a dramatic word to use in relation to her behaviours surrounding food and yet this word has impact because it indicates how strongly food arouses Code Red:

> All it took was one flipping cheesecake and I was back down the slippery slope. I really have to get my head round it. It is almost like maybe I don't want to lose it because I haven't got that will power. And yet I am really fed up with being this way but food just has that, it wins, chocolate, don't even go there. I could kill for

chocolate. Overkill in everything I do there is no moderation, my cholesterol is a bit high but I also do blame that on 'Slimming World' because you can have bacon, eggs, loads of you know, you can have as many as you want. So I was having some weeks about fifteen eggs…and 'Weight Watchers' about the same really…I ran out of points after a while, so stupid! One day I had about seventy sins. Weird. I'll do things like I know bread's not good and I've not had bread for ages and suddenly I'll have a piece of toast and I'll have four pieces of toast and then the next day I'll have a sandwich with bread and more bread so I overload on everything. It's like I'll kick the backside out of things. If I try something like the 'Weight Watcher's' biscuits, I know that you are only supposed to have two but I'll have eight because I think their 'Weight Watcher's' and I could have more (Code Red, second interview).

The fourth theme of choice identified in the interview transcripts appears to be closely linked with control and parallels can be drawn from one to the other. For instance, Code Red who did not achieve her desired weight loss had issues in choosing foodstuffs that were appropriate for weight loss:

I could eat anything. It is almost like I turn into a rebel. It must be hormonal because I am like I'll have what I want. I am going to have that. No, in fact I will have three donuts, ha, ha, ha but the only person I am really upsetting is myself, so I can't quite understand that theory, because I can be really good for two weeks and then it all goes to pot and chocolate don't even go there. I could kill for chocolate (Code Red, first interview).

Code Red was insistent throughout the duration of the study that she wished to lose weight. However, Code Red demonstrates repeated instances of self-sabotage and internal conflict. Code Red also found it difficult to take control of herself or her food consumption or choose appropriately to enable weight loss to occur. Despite her verbal insistence that she wanted to lose weight throughout her weight loss journey Code Red had gained five pounds by the end of her weight loss journey. It can therefore be concluded that Code Red was persistently in a disconnected state for the whole duration of the yearlong study.

Molly: an illustration of partial connectedness

Molly is in her mid thirties and married for the second time. She has in total six children, which does mean she has a very busy household. Molly also works as a part time hairdresser. Molly definitely wants to lose a significant amount of body weight and reduce her dress size. Molly says her weight goes up and down and she becomes fed up although her weight does not affect her too much, in what she physically does. Molly says she would like to look better and Molly also has a family wedding coming up which she says she wants to look good for and to be able to wear some nice clothes. Molly at her heaviest weighed fifteen stone eleven pounds. Molly's weight loss journey fluctuated including periods of weight loss and gain particularly in the first six months. However, Molly reached a turning point in the eighth month of the year. Molly commenced a food supplement programme, the 'Cambridge Diet' and very quickly lost a significant amount of weight, two stone six pounds. Molly maintained this loss for the duration of the research programme.

It would appear that Molly was initially in a disconnected state, which she changed to being in a connected state in the later part of the year. The following discussion of the themes that were revealed during the qualitative interviews with Molly and the supporting quotes that are used would appear to validate this supposition.

The first theme identified in the interview transcripts of self-sabotaging thoughts and actions are more prominently present when Molly is trying to lose weight at the beginning of the year, (see interview two transcript). Whereas the reduction of such thoughts and actions appears to correspond with Molly losing her weight as the year progresses, (see interview three transcript):

> Am I abnormal? I thought am I just the only person like that then? Maybe I don't deserve to be slim, but I don't know why (Molly, second interview).

> I don't know if I could do that, I would be fine, but I don't know whether it is psychological or it is something within me that says I need something or I don't know, I don't know. I don't know, psychologically I wish I could get into my own consciousness. I don't know why I do it, it's almost like spoiling everything I have

just done because you work so hard to lose it, you lose it you know, if you lose it quickly great but keeping it there, keeping motivated, keeping strong with it. I just don't seem to have that ability for some reason, it's almost like I want to be fat but I don't want to be fat, you know (Molly, second interview).

It was almost impossibility before. For some reason, you have to have your head entirely there, focused. I went to the 'Lighter Life session'. I was focused. It was only the money that stopped me as I said I booked the appointment for 'Lighter Life' and then I was really keen, motivated. But the finances couldn't do it. But even in the time I was supposed to have started it, I went to the 'Cambridge Diet' as an alternative and I thought sod it! It's half as much. It's still a lot but it's half as much and it's worth it, so actually losing the weight, easy! It's an easy way to lose weight! (Molly, third interview).

The second theme identified in the interview transcripts was that of internal conflict, which resulted in some respondents, revealing instances of contradictory thoughts and actions. Molly did demonstrate some instances of contradictory thinking and actions, (see interview two transcript). As these contradictions lessened, (see interview four transcript) Molly began to lose her weight in a continuous manner:

No, because I know what to eat and not what to eat. I know when to eat. I know, I pretty much know what to do to lose weight. My problem is keeping it there and keeping motivated and keeping my brain in tune with it. It's almost like I punish myself. I lose weight and it's almost like you're not allowed to lose weight, you've got to put it back on again. I don't know, it's almost like because of the yo yoing I lose weight and I feel great and it's almost like no! You can't do that! You've got to put it back on again (Molly, second interview).

It was almost impossibility before. For some reason, you have to have your head entirely there, focused. When I went to the 'Lighter Life' session, I was focused. It was only the money that stopped me as I said I booked the appointment for 'Lighter Life' and I was really keen, motivated but the finances couldn't do it, but even in the time I was supposed to have started, I went to the 'Cambridge Diet' as an alternative and I thought sod it! It's half as much, it's still a lot but it's half as

much and it's worth it so actually losing the weight, easy! It's an easy way to lose weight. It's keeping it off, so that's sort of January when I started it so that took me through to February, and then we are now in the middle of July. I have been in that four pound bracket since then, so (Molly, fourth interview).

The third theme identified in the interview transcripts was that of control. Molly, however, differed from Code Red in the control aspect because although Molly had issues in relation to self-control at the beginning of her weight loss programme, (see interview one transcript). Molly's control appeared to increase throughout the year in correlation with her weight loss, (see interview four transcript):

Just try and eat healthily. After doing all, the different diets you know what to eat and how to eat, what not to eat and when to eat, and things like that. You know what to do, it's just doing it. I don't seem to be able to do it. It's just a craving for chocolate; it just creeps in, I absolutely eat too much and it just leads onto the next thing. When I am on my own that's it, I just munch through whatever there is. I don't know if I could do that I would be fine, but I don't know whether it is psychological or it is something within me that says I need something, or I don't know (Molly, first transcript).

It was almost impossibility before, for some reason you have to have your head entirely there, focused…I was focused…I went to the 'Cambridge (Diet)' as an alternative (Molly, fourth interview).

Molly here is discussing pre connection and post connection, although using her own words. She identifies how difficult it is to achieve her goals when she was not connected but uses the word "focused" to indicate how she feels when she is connected.

The fourth theme that was identified from the interview transcripts was that of choice. Molly who lost weight eventually displayed a successful strategy of choice, the 'Cambridge diet', which was closely linked with control and termed 'Sole Source':

But I opted for second best which is 'Cambridge' and I did the 'Cambridge Diet' and it's fantastic, but I don't know if it is the healthiest way to lose weight and the best way to lose weight but the motivation is the best thing because you lose weight so quickly. I do find it hard. I do find it hard. I must admit because you are constantly aware of what you are eating. 'Sole Source' is fantastic because you lose, lose, lose (Molly, fourth interview).

During the time Molly was using the 'Cambridge Diet' although she was working through on her own she said she found the process itself very easy, as the quick weight loss was very motivating. Molly said although her 'Cambridge Diet' counsellor was very nice she didn't find her very helpful. Molly appeared to be very motivated and connected at this stage to her weight loss goal and drove herself forward to lose her weight with minimal input from others including her family and friends and the 'Cambridge Diet' counsellor whom she had expected to have been more helpful.

Molly said she was determined to lose weight throughout the whole duration of the study. However, in the first six to eight months of the year Molly demonstrates instances of self-sabotage, internal conflict, loss of control and poor choice. This is when Molly is in a disconnected state and her weight yo yo's. However, in the latter months of the study the instances of self-sabotage, internal conflict, loss of control and poor choice significantly lessen. This is when Molly appears to become connected. Molly uses the term "focused" to explain her connected state and proceeds to lose two stone six pounds in the latter months of her weight loss journey.

Pat: an illustration of connectedness

Pat is a former nurse in her late fifties and she works as a car ambulance driver. Pat is married and has her own children as well as fostering children, some for many years. Pat would like to lose some weight and would like to be a comfortable dress size, eighteen. Pat has tried different ways to lose weight in the past but Pat has now decided what strategy she is going to use, to lose the weight she wants to this time. At her heaviest Pat weighed seventeen stone twelve pounds and throughout the year Pat consistently lost weight.

Pat was adamant that she was going to lose weight. Apart from putting on a small amount of weight when she went on a family holiday and at Christmas, Pat consistently lost weight and stuck to her weekly regime of being weighed. She also consistently tried to follow a 'Slimming World' programme and eventually reduced her weight to sixteen stone one pound.

It would appear that Pat was in a connected state for the whole duration of the year. Pat demonstrated her connected state by not repeatedly indulging in instances of self-sabotaging actions, internal conflict or making poor choices or demonstrating limited control.

The first theme that was identified in a majority of the interview transcripts was that of self-sabotage, thoughts and actions. Pat, however, throughout the year, demonstrated very limited self-sabotaging thoughts and actions and on the whole consistently tried to lose weight and did consistently lose weight:

Well, I shall weigh myself every week. I tend to be very, very good in the week, you know, very strict in the week and then at weekends you know, I have the odd sort of treat whatever, and then I shall go back on it, Mondays. So, I think back on track again on Monday. I shall eat differently from everyone else. I shall stick to 'Slimming World', the green and the red days, which is just like the 'Hay Diet'. It has worked before. Once I start going I can keep losing a couple of pounds a week, which is quite good. Well, usually in the first week I lose about six pounds, yea in the first week really when I can get my head round it, just getting yourself motivated, and really setting yourself, and doing what your mind wants you to do, you know (Pat, first interview).

However, exceptions would appear to be during a family holiday abroad and Christmas. Although defined by societal expectations as usually happy times these caused Pat to have concerns:

It's gone completely. Nothing happened at all. No, we went away to France and the whole food thing was just horrendous out there. For breakfast we were offered, croissants, baguettes, ham, cheese, it was set for breakfast, so that was

that. And then for the evening meal we came back and we had like chicken in a sauce with, um, like potatoes and there was no other vegetables or anything and you asked like, you know, could we, you know, could we have fruit or something for no, non, non, no and it was very difficult. We went out to eat at lunchtime because from then it's just gone completely. I was ill, kidney infections and I just couldn't, haven't got back on track. It's just gone completely out of the window basically (Pat, third interview).

The second theme identified in the interview transcripts was that of internal conflict. Internal conflict was evident in the majority of the respondent's transcripts, with a number showing examples of contradictory thoughts and actions. However, throughout the year Pat showed limited instances of contradictory thoughts and actions. Overall, she did not appear to be contradicted in her own way but had a clear goal and worked consistently towards achieving her own weight loss goal:

I am going to the gym three times a week and I have joined 'Slimming World'. I have lost 4.5lbs, 4, 3.5, 1.5, 4, 2, and I put on 3.5 on my hols, 4, 3, 2, 2 pounds a week since I have been going (Slimming World) (Pat, fourth interview).

The third theme identified in the interview transcripts were issues surrounding control. Pat however, on the whole demonstrated self-control in her actions and dietary restraint throughout the whole process of trying to lose weight. In the following quote, Pat highlights her controlled intake of food for the day:

Because today for instance, bite sized shreddies with milk for breakfast with two glasses of juice or water…then halfway through the morning I had a banana… then at lunchtime I had whole grain bread spread with a bit of waistline mayonnaise, lettuce, tomato, cucumber, spring onions with a bit of marmite on, in between two slices of bread, a peach…then mid afternoon, I had half a dozen strawberries with some vanilla yoghurt on. And then for my tea tonight I had salad with slices of ham and that's it. It's all spaced out you know (Pat, first interview).

The fourth and final theme identified in the interview transcripts were issues surrounding choice, which affected the respondents weight loss goals. Pat

appropriately and consistently chose her foodstuffs to complement her weight loss strategy despite the demands of a very hectic lifestyle and long hours at work. Choosing these appropriate food products did allow Pat to achieve a significant amount of weight loss throughout the year:

> So I've really just got to prepare something that I can eat on the move or you know, sort of finger food or sandwiches and things that I can eat going along, and things to eat when I stop and I am waiting for someone as well. I usually eat fruit and stuff. We don't eat chips for a start. We don't eat junk food. We eat proper meals with meat and veg, and you know, not pre whatsit meals. I mean I make loads of bolognaise and put it in the freezer things like that, so it is all you know home made food there is no fish fingers, you know, so we can sit down to a roast without the potatoes just meat and veg (Pat, first interview).

Pat states she was determined to lose her weight and be "a comfortable size 18". Throughout the yearlong weight loss journey Pat remained connected. Pat uses the term "when I can get my head round it" and "just getting yourself motivated". Throughout the yearlong duration of the study Pat consistently displayed very few instances of self-sabotage, internal conflict, limited control or poor choice in relation to her diet strategy. Despite two instances of a few pounds weight gain over Christmas and a family holiday abroad Pat consistently lost weight. It could be argued that an individual not dieting over those periods would not be aware of such small gains. Pat remained connected throughout her weight loss journey and reached her goal of "a comfortable size 18".

Discussion

From the data presented so far, what emerges is a sense that what differentiates these ten women in terms of their weight loss experience is the extent to which they are connected or disconnected. Before I move on in chapter five to try to further explain and understand this concept of connectedness it would be useful to try to conceptualise a little further the differences and similarities between the ten women. In order to do this I will examine the following issues. Firstly, similarities and

differences in the women's feelings about their weight loss experience. Secondly, similarities and differences in the women's motivators for losing weight and thirdly, the similarities and differences between the weight loss strategies that the women used.

Weight loss experience

Negative experience

When discussing the similarities between the women, with one exception, the general experience of trying to lose weight was a painful and unpleasant experience for the individuals. All the respondents voiced this:

> A nightmare yea, it's on my mind a lot. It's a big part of my week, my day and everything; it's a bit worrying really (Beth, third interview).

> It's hard work. It's hard work trying to lose weight. It's horrible. I desperately, desperately want to lose weight and it's not happening, so it has that reverse effect and then it gets me down (Molly, third interview).

> It's very hard; it's very hard, it is just so hard (Kate, third interview).

Although there was one exception Margaret, even those individuals who successfully lost weight such as Karen and Pat viewed the whole weight loss process negatively:

> A nightmare. A nightmare, there is no other word for it (despite consistently losing weight). A nightmare, yea basically if I felt that I could sit down and eat a meal you know a meal like everyone else, like meat and two veg, you know, I mean I don't even ask for a sweet, but and stay the same I would be really happy about that. But the fact that I have to really you know, give up everything that I really enjoy, you know, just to lose a few pounds or stay the same, it's very depressing isn't it (Pat, third interview).

Well, it is just such a lot of wasted time isn't it, and effort and energy that really you could spend doing something else. Well, it's dreadful isn't it? It's soo boring, you can't eat any of the foods you like, I mean my favourite food in the world is a cheese sandwich but that is just loaded with calories after all it isn't just the cheese and the bread is it. It is the mayonnaise and the butter you have as well and so that can have enough calories equivalent to a whole meal really. Every time whenever you are on a diet you are always invited out to places for dinner, for functions and you inevitably go on holidays, so really I would say I am dreading it really. I think I will cut out all social occasions because you know social occasions revolve around food, to me they do anyway. I certainly won't go out for dinner with friends (Karen, first interview).

It has to be noted that these comments are from Karen's earlier transcripts, before her significant weight loss.

However, those individuals who didn't achieve their weight loss goals viewed their ongoing weight loss experience in more extreme negative terms:

Sick to death of it. I am sick to death of it (Code Red, third interview).

It is very, very hard to be very good; you know you can do this. It is just so hard, the diet is very restrictive but if you have a lot of fat to get rid off, that is the way you have to do it. Dieting is boring; you've got to put up with it if you want to lose some weight. I think the best thing to do is try and live on salads, fruits, vegetables, don't have any cheese, don't have any butter and if you can go without bread well and biscuits, I think you are on a winner (Kate, first interview).

Extremely, frustrating, really, really frustrating (Louisa, third interview).

It is very hard, very hard (Lucy, first interview).

It does, it takes over your life (dieting) nothing, nothing else matters. I just think it takes over your life and nothing else counts. It is just so boring and awful. I just

find it boring and awful and I mean all the things they don't want you to eat, I like (Peggy, first interview).

Positive experience

However, one individual Margaret didn't find the weight loss process so taxing. In fact, Margaret viewed her whole weight loss process positively throughout the year:

I have really come to the conclusion that it will only be positive. It's not really an increase in energy but an increase in general well being, there is quite a difference in mental attitude too. On 'Atkins' (diet) I find that I am a far more cheerful bod. Well, having done a stone in a month I think really there are hard ways and there are easy ways to lose a stone and it was very easy. It really was just not an effort but it is one of those things where you begin to think there is a conspiracy theory, why has nobody told me how easy it is to do? I need to cut out dense carbohydrate. All I do is replace sugars and starches with salad. Oh perfectly happy and the other day I ran up the stairs and I thought what are you doing. I can feel thinness here, (points to self) lifting my mood and giving me more energy. I can remember some of the diets I tried in the past oh dear, it made you feel so tense, so anxious, just generally not well and they did not keep you in that happy equilibrium but I do feel that I am getting there. I have got to do it you know and I have to say this is the level at which it is sensible and easy to lose weight. Fine, really, I have this awful sensation it is all too easy, so much effort has been put in. There is the whole weight loss industry, somebody, somewhere ought to say it's the carbs dear. Stop eating the carbs and the weight will just go away with no effort whatsoever. I have really abandoned, the what you call, the official dieting with the capital dieting attitude, just have it as a lifestyle rather than it being an interval in my life when I am losing weight. Well, good in a way, there is always that sort of feeling that you feel you are getting away with something, well the attitude. It is an effort; you've got to punish your body into thinness, that isn't happening. Onwards and downwards, it is definitely going to be a long process but I am going to die thin (laughing). Well I think that the only thing I want to emphasise is that it has been easy it's not something that I want to, oh gosh I want to get this over with. I am simply on a trend which will eventually bring me down

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slowly and gradually to where I should be and hope well, it is such a shame that I had to get to this age, in order to find out how to lose weight with such ease and tranquillity. No screaming, no slamming doors, no banging pots (Margaret, third interview).

Margaret's comment indicates a global connection between mind and body and may be an important issue to consider when discussing Margaret's attitude to her weight loss experience. Her actions are part of her lifestyle, which help her to lose weight rather than being an isolated arena in her life when she is trying to lose weight:

I have really abandoned the, what you call, the official dieting with the capital dieting attitude, just have it as a lifestyle, rather than it being an interval in my life when I am losing weight (Margaret, third interview).

Mood

A similarity between all the women was that their weight affected their mood in one of two ways if they were losing weight or had lost weight they were happier:

Oh, perfectly happy and the other day I ran up the stairs and I thought what are you doing? (Laughs). It is not a lot of weight that I have lost but errm it does show. I, I do think that somehow on 'Atkins' it is the, it does make you feel more cheerful; it does make you feel more cheerful (Margaret, second interview).

I did five weeks 'Sole Source' and I did nothing else other than and I lost pretty much a stone and a half in those five weeks and just the people comment on how good you look and, and I felt so sprightly and just lots of energy even just a stone ooh! Your clothes are, and since then it has just been getting better and better. I am going to do it. It is amazing how it affects your life, amazing, to get weight off amazing, but now I have got the summer holidays and I just think ooo! (Molly, fourth interview).

However, if the women were not losing the weight they desired or felt they were too large the women's mood was more sombre:

Not happy, definitely not happy. I think over the years of wanting to lose weight since I was, well since I was an adult I wanted to lose weight. I have never been happy but the thing that bothers me the most is when I was ten stone I always had a big bottom, that's fine. But I had a flat stomach and now I have a stomach and people keep asking me if I am pregnant. I am going to break someone's nose. I've got this fat stomach and I really hate it. I really hate it. I think if I could just get rid of it, I would be happy (Beth, second interview).

I am really fed up being this way. I am stuck, so I am scrambled again. I hate being this weight, it's vile. I can't stand seeing photographs. I am all right with the head but if I see the body, body photographs I am like Yuk! Disgusting! I get really narked with them so obviously at the back of my head I don't like what I see (Code Red, second interview).

Awful. I wasn't very happy about that. I do feel too fat. I feel fat. I feel quite disheartened. I feel terrible about myself. Terrible (Karen, first interview).

I feel very fat, very depressed. I felt very fat, very depressed about it. I don't like it. I really don't like it (Kate, first interview).

It kind of pulls you down doesn't it? The weight is just putting me down. Crap. I feel really bad. I just get upset. I'm fed up with myself. I don't like myself; I am too big, too high, I get annoyed with myself (Lucy, first interview).

I am not happy about my weight. It is not restricting me there (physically) but mentally it does, because I feel I am missing out. I hate myself at the moment. I am doing ok because I am losing it, but when it turns and it starts going back on, I hate myself with such a passion. It upsets me to such a degree where I find myself going back to bed and I get really moody and cross, really, really cross because I have let it happen again. You know, I don't want it to happen again. I want to be able to live a life of normalness (Molly, second interview).

In relation to my weight, I feel just as bad as I did previously I really do. It has affected me quite badly. I could have gone with my husband to South Africa to the

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wedding (daughter's) but I opted not to because I am so embarrassed about how large I have got. They all remember me as a thin eight stone little person and now I am fifteen stone. Just double the weight and you can see, you can see it there and you can see it there. It's all like cellulite, it looks horrible…I don't particularly like myself, yes, honestly you know, it is affecting me as much as if I could find some formulae that would work I would give it free to every single person in my situation. I wouldn't charge them a penny, honest to goodness (Louisa, second interview).

It would appear that being larger than she desired significantly affected not only Louisa's mood but also caused her to take the rather drastic decision of not attending her daughter's wedding because of how she felt about her size.

Motivation for losing weight

The women discussed in this thesis have a number of motivators for wishing to lose weight. Some of the motivators for weight loss remained constant with the women and other motivators were present at different times of the women's weight loss journey. The women were not homogeneous therefore although some had similar reasons for weight loss other women had differing reasons. The motivations for weight loss can be classed broadly into three categories: the present negative impact of being this size on the individuals, health reasons for weight loss and the perceived advantages of weight loss.

The present negative impact of being this size

All of the respondents wishing to lose weight found being their present size uncomfortable to them for a number of reasons including physically and psychologically and wished to become slimmer.

Clothing was an issue for some of the respondents discussed in this thesis. As all the respondents were women, this may have been potentially anticipated:

Not being able to get into my clothes…I always looked bad in clothes…so like oh god, you know, whatever you wear (Beth, fourth interview).

I cannot find the clothes, the outfits to fit me (Karen, first interview).

I know that I have got some very nice clothes but I have to get quite a lot of weight off before then (to be able to wear them) (Kate, first interview).

A number of respondents felt that being larger than they wished to be negatively affected their emotional health status:

I suppose I've ended up seeing myself in a bit of a negative way because of it. You see…you perceive yourself as a bit of a failure (being big). Beth, third interview.

I feel very fat, very depressed about it (Kate, first interview).

Because I am overweight, I want to get rid of some of it, I am tired, and I suppose you get fed up sometimes (Kate, fourth interview).

It has affected me quite badly (Louisa, second interview).

I just don't like the way I look…it kind of pulls you down doesn't it (Lucy, first interview).

Some respondents were concerned how their size may affect how individuals in their life perceived them:

You worry that your husband is not finding you as attractive as he used to…he is only human and I understand that…it's a human thing, you find people more attractive when they are more attractive (Beth, fourth interview).

It's my husband, I see the disappointment in his eyes when he looks at me you know, he says he still loves me as much you know but I don't feel he does and of

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course he does love me but you know I feel he is disappointed (Louisa, first interview).

I could see the disappointment in my husband's eyes and my children, you know, every time they looked at me. They could see me gaining weight and I could see them getting more disappointed (Louisa, fourth interview).

You know, I have loads of my friends say you've put so much weight on, you're big. I've had loads of people like saying horrible things, oh your big…sometimes my mum tells me to lose some weight. It's not nice, not at all (Lucy, first interview).

Some respondents wished to lose weight because they felt their present weight was affecting their mobility:

I don't feel very active. I've got grandchildren and where I used to be able to run round with them, play games with them, do all sorts of things. I can't do it now (Louisa, first interview).

I did a lot of things I don't do now (when she was thinner). I had far more energy. I mean now I go to bed exhausted. I wake up even more exhausted than when I went to bed (Louisa, fourth interview).

Health reasons for weight loss

Some individuals wished to lose weight because they felt their present weight was impinging on their lifestyle or because they perceived future risks to their health if they stayed the present weight.

Present health concerns:

I have been having lots of problems with my knee…I've got a bad back and a bad knee now (Beth, second interview).

I do have problems with my joints; it runs in the family with arthritis (Margaret, first interview).

I've got quite bad arthritis…so I need to keep it down (weight) for that if nothing else really. I've got it in my knees and my hands as well but my knees is the worst. I can cope with the rest but my knees get quite painful, going upstairs as well (Pat, first interview).

Future health concerns:

My blood pressure was also so high it was a one hundred and sixty over a hundred. I thought I would be more likely to have a heart attack or a stroke so I suppose fear of something to do with my health (Karen, first interview).

It is no good being fat either. I don't think if you don't eat exactly what you should eat will do you as much harm as what all this overweight will do. I already have high blood pressure. You can have a stroke though it and heart disease (Kate, first interview).

Because of my knees (awaiting surgery) (Pat, fourth interview).

The perceived advantages of weight loss

The women discussed in this thesis divulged a plethora of advantages for losing weight. These can be broadly classed into; benefits to health and being physically more able, feeling better about self, the perceived impact on others and wearing different clothes.

Benefits to health and being physically more able:

I would like to go back to horse riding and I know I am too big for that (currently) (Karen, first interview).

I would love to be able to swim and dance better (Kate, first interview).

Lifting my mood and giving me much more energy (Margaret, second interview).

(Weight loss helps?) Yes it does, for the knees (Pat, first interview).

Feeling emotionally better about self:

You feel much more positive (Beth, fourth interview).

So that I would look better, feel better, be more myself and so that clothes would fit so that I felt more like the same as everyone else and not different because I was overweight. To feel that I belonged and that I wasn't different from everyone else because I was overweight (Karen, fourth interview).

Lifting my mood and giving me more energy (Margaret, second interview).

I feel good…I sort of want to be back in that nice zone (Molly, first interview).

Perceived impact on others:

I don't feel happy about myself and although I feel happy in my marriage and I am sure he is not going to walk out on me and find some pretty young thing, I always think oh god (fear of losing husband lessened with weight loss). (Beth, second interview).

When I met my husband, I was a "lovely eight stone". (This is where Louisa wishes to get back to for her husband as much as herself so she will not see the look of disappointment in her husband's and also her children's eyes) (Louisa, first interview)

Feel good for him (husband) (Molly, first interview).

Wearing different clothes:

> My clothes were getting a bit looser and I was feeling a bit better about myself (Beth, third interview).

> When I am thinner, I will have nice clothes (Karen, first interview).

> So that my clothes would fit…to be able to wear fashionable clothes that I want rather than frumpy clothes (Karen, fourth interview).

> You can walk into a clothes shop and buy something that fits, and feel better about yourself and feel better in a swimming costume and in the gym, feel better in what I am wearing, it's looks again, it's vanity. You know I love being slimmer (Molly, second interview).

> I need to lose weight, all those clothes you can't get into (in the wardrobe) (Pat, first interview).

Weight loss strategies

The women's use of the weight loss strategies appears to have been broadly divided into two main categories; individuals who utilised multiple strategies and individuals who primarily used one strategy. What differentiates these women in their weight loss journey however, is the extent to which they are connected. However, this connectedness does not appear to be related to the specific weight loss strategies or methods that they utilised. In fact, it appears that the strategy itself seems to have little impact on their weight loss rather what is of importance is how connected the women appear to be.

Multiple strategy use:

Multiple strategies were utilised throughout the study by a number of respondents; Code Red, Kate, Louisa, Lucy and Peggy. Beth, Karen and Molly initially used

multiple strategies but part way through their weight loss journey these respondents decided to use one strategy.

Code Red, Kate, Louisa, Lucy and Peggy who continued using multiple strategies for the duration of the study either lost very little weight or gained weight. Code Red utilised an immense number of strategies throughout the year to help her lose weight. Some helped with initial weight loss but no strategy proved effective long term. Some of the strategies Code Red employed included 'Slimming World', tablets from the 'Slimming Centre', the use of a NHS dietician, a pedometer, 'Weight Watchers', exercise, a personal trainer, kick boxing, swimming, calorie restriction, damage limitation, food restriction, food substitution and Hoodia:

> It has been totally utterly upside down. I have probably tried more things this year than I have tried all together, it has been one, two, oh five or six different things I have tried and none of those worked. Ha, ha but I have got another one now, which is I sat and looked at the Internet the other night, and I thought what shall I do now? I have just cancelled my 'Weight Watchers', before that it had been 'Slimming World' so I cancelled that, then I tried 'Fit Bug', have you heard of 'Fit Bug?' That's where they give you so many steps to do each day and they sort of text and email you and you wear this pedometer thing. I just got fed up with them telling me I hadn't walked enough so it annoyed me (laughs) so I switched it off. That was that, so I sat there and I thought there must be something that I can take that's like the slimming tablets, because the slimming tablets, I really do get hungry, that's the best of it, especially in the evening, I pick and I'm really like what shall I have now and that's when I do my damage (Code Red, fourth interview).

At the end of the study, Code Red weighed five pounds heavier than her original starting weight. However, as has been previously discussed in this chapter throughout her weight loss journey Code Red continuously indulged in self-sabotaging thoughts and actions, high levels of internal conflict, reduced levels of control and poor choice. These demonstrated her internal disconnection, which ultimately resulted in weight gain rather than Code Red's desired weight loss.

Kate used different strategies to promote her weight loss throughout the yearlong duration of the study. However, none proved effective long term. Some of the strategies Kate employed included eating less, eating the 'right' foodstuffs, dieting, exercising and the 'Cambridge Diet':

> Well obviously, you've got to eat less and I've got to try and eat the right food. I would like to do more exercise but at the moment, I am not able to. So I just have to do as best as I can and hope that as much as possible will come off (Kate, first interview).

At the end of the year, Kate weighed one pound less that her original weight at commencement of her weight loss journey. Kate throughout her weight loss journey demonstrated continuous instances of self-sabotaging thoughts and actions, significant levels of internal conflict, poor levels of control and poor choices. These instances have been previously demonstrated in this chapter and showed evidence of her being internally disconnected which resulted in Kate's pound loss over the year rather than her desired goal of a weight loss of over six stone.

Louisa used a number of different strategies throughout the year to help her lose weight and also discussed others. Some of the strategies Louisa employed included exercise, Hoodia, 'Slimming World', diet soup, no carbohydrate days and restriction of intake. Louisa also discussed potentially using hypnotism or surgery:

> I am now just trying to eat normal, health foods. Cutting out all the starches at the moment as that is my big downfall. Starches you know, you can have a lot of it on the 'Slimming World' plan but I just seem to, once I start eating it I can't stop…by not having any at all (starches), that works better than having a little bit, so just this last week I haven't eaten any starches at all. No bread, no butter, pastas, rice, potatoes, all that is, I have just cut out completely (Louisa, third interview).

> I spoke to my husband and I said I would like to go to, have hypnotism done (Louisa, third interview).

At the end of the year, Louisa weighed almost another stone heavier than her original starting weight. Throughout the year, Louisa, displayed instances of self-sabotaging thoughts and actions with high levels of conflict and reduced levels of control and poor choices. Such instances have been previously demonstrated in this chapter and display her internal disconnection. This ultimately resulted in weight gain rather than Louisa achieving her desired goal of being a "lovely eight stone".

Lucy utilised a number of strategies to help her lose weight, during the time she was part of the study. However, no strategy proved to be effective for Lucy. Lucy's implemented weight loss strategies included exercising such as bike riding or going to the gym, dietary and calorific restriction, eating low fat food products and trying to drink more water:

> Diet stuff, diet stuff like, I tend to eat a lot of low fat yoghurts, like low fat, a lot of them and vegetables. I just eat it in packets. I eat a lot of them (Lucy, first interview).

When she left the study Lucy weighed more than her original starting weight. As has been previously shown in this chapter Lucy demonstrated instances of self-sabotaging thoughts and actions, high levels of internal conflict and poor control and choice. However, as Lucy left the study early any prediction of her eventual weight loss in the yearlong period of the study would be difficult. It is possible to conclude however, that while Lucy participated in the study discussed in this thesis she was in a disconnected state.

Peggy used various strategies to assist her weight loss during the yearlong period of the study. Although none were successful in the long term. Some of the strategies Peggy utilised included dietary restriction, changing her shopping habits and increasing her exercise levels. Peggy also discussed strategies such as medication, surgery and magical or quick fix remedies:

> I am always trying to lose weight. Always looking to find, I am always looking for the way that I can lose weight. And I know that the only way I can lose weight is by having some sort of appetite suppressant, that would be the only way with

me, you know, so that I don't want to eat…I am just looking for the secret bullet…I have got to have something to take my appetite away (Peggy, first interview).

At the end of the year Peggy weighed seven pounds more than her original weight at the commencement of her weight loss journey. Peggy, throughout the yearlong study, demonstrated repeated instances of self sabotaging thoughts and actions, very high levels of internal conflict, poor levels of control and inadequate choices in relation to her desired weight loss. Such instances have been previously established in this chapter and show evidence of Peggy's internal disconnection, which ultimately resulted in weight gain rather than Peggy's desired weight loss.

The weight of Beth, Karen and Molly fluctuated whilst they initially used multiple strategies. However, after settling on one strategy they commenced and maintained weight loss.

Beth initially utilised a number of strategies at the beginning of the year to assist her weight loss ideals. These strategies included dietary restriction, changing her eating pattern and timing of meals. Beth also tried a variety of exercise techniques all with very little success:

It's not been good (weight loss) for lots of reasons. Lots of excuses mainly (Beth, second interview).

However, in the later part of the study Beth reached a turning point and utilised only one strategy, that of intuitive eating. Beth consistently lost weight following this self-connection and implementation of strategy:

I managed to lose some weight which was nice and it was just really being a little bit more careful with my eating…at home I was eating much better, still having loads of fruit, loads of fruit at work in fact I was better at work I will give myself that…I thought wow! I have actually lost some weight and today I am eleven stone one pound (Beth, fourth interview).

At the end of the study, Beth had lost one stone and six pounds. At the beginning of her weight loss journey Beth had demonstrated instances of self-sabotaging thoughts and actions, internal conflict and poor levels of control and choice around foodstuffs as has been previously established in this chapter. However, when Beth reached her turning point she consistently lost weight and utilised only one strategy, intuitive eating. Her self-connection at this juncture of her weight loss journey was evident.

Karen initially used a variety of strategies to achieve her weight loss goals including no carbohydrate in her diet, dietary restriction and increasing her exercise levels. However, none proved consistently effective. However, midway through the yearlong study Karen self connected and chose a strategy useful for herself:

> Well because I am so big and I desperately want to lose weight, I am looking at using a food supplement. I am going to go for 'Lighter Life' or the 'Cambridge Diet'. My problem is the motivation to do that I think and I think I have spent a lot of thoughts about why I wanted to lose weight but why have I not been able to achieve it? That's why I am going to go for this sort of mechanism for me because I think it is helpful for me and it will help me (Karen, second interview).

At the end of the year, Karen was three stone and six pounds less than her original weight at the start of the study. Although Karen initially demonstrated instances of self-sabotaging thoughts and actions, significant levels of internal conflict and poor control and choice decisions in relation to food, midway through the year Karen reached a turning point. She appeared to reconnect with herself and chose an effective weight loss strategy. From that point Karen consistently lost weight for the rest of the year.

Molly initially utilised a variety of strategies to support her weight loss wish. These strategies included swimming, going to the gym, drinking vegetable juices, eating healthily, smoking, having regular weekly weigh in's at the surgery and dietary restriction:

> I will go and weigh myself…because I was a competitive swimmer when I was younger, you see, I have never lost that. I can get into the pool and you know

people get out and say they've done ten lengths, which is a warm up, I go there a lot. I go and do one hundred lengths without even thinking about it…I am actually doing this it is called 'Alpha Light' it's a formula…It's not working…it's not realistic for my lifestyle, it's just not. I know I could change my lifestyle to fit in but I've got six children (Molly, first interview).

However, in the latter part of the year Molly self-connected with herself and chose a strategy that enabled her to successfully lose weight:

You have to have your head entirely there, focused…I went to the 'Cambridge (Diet') as an alternative…I opted for second best which is 'Cambridge (Diet') and I did the 'Cambridge Diet' and it's fantastic. I don't know if it is the healthiest way to lose weight and the best way to lose weight but the motivation is the best thing because you lose weight so quickly (Molly, fourth interview).

By the end of the year, Molly was two stone six pounds less than her initial starting weight. Although as has been previously demonstrated in this chapter Molly exhibited examples of self-sabotaging thoughts and actions, high levels of internal conflict and poor choices and control in relation to food, when Molly re-connected with herself in the latter part of the year, Molly consistently lost weight and chose an appropriate weight loss strategy for herself.

Singular strategy use:

Two respondents; Margaret and Pat consistently utilised one strategy for weight loss throughout the duration of the study and steadily lost weight. Margaret primarily used one strategy to help her lose weight. Margaret used the 'Atkins Diet' for the duration of her weight loss journey:

'Atkins' really isn't high protein you know. I am eating, if there is chop for me it is the same sized chop for everyone else…well, having done a stone in a month I think really there are hard ways and there are easy ways to lose a stone and it ('Atkins') was very easy. It really was just not an effort but it is one of those

things where you begin to think there is a conspiracy theory, why has nobody told me how easy it is to do (Margaret, fourth interview).

The 'Atkins Diet' proved successful for Margaret because she constantly lost weight during the yearlong study. Margaret demonstrated very few instances of self-sabotaging thoughts and actions or internal conflict. Margaret demonstrated good control and choices in relation to her food consumption and lifestyle:

Well I really think the only strategy is not to buy the stuff that I don't want to eat. I do things like if I buy a loaf of bread I keep it in the freezer and only bring out the amount of slices that somebody wants at the time...it's under my control (Margaret, second interview).

Margaret appeared connected for her whole weight loss journey and lost approximately two and a half stone. Margaret said she had lost her weight with apparent "ease".

Pat also primarily used one strategy to assist her weight loss over the year and that was the 'Slimming World' plan:

Which is 'Slimming World' which I quite, which I quite like following their regime as it were, because I am quite happy with that (Pat, first interview).

This strategy proved useful for Pat and she consistently lost weight during her weight loss journey. Pat, overall, displayed very few instances of self-sabotaging thoughts and actions or internal conflict. One of the very few instances was at Christmas and when on a family holiday abroad. Pat routinely demonstrated good control and choice in relation to the foodstuffs she consumed:

It's fine. I have porridge in the morning, a big bowl of porridge, the 'Jordan's' porridge. It's more wholesome, you know you get scotch porridge oats then Jordan's is more wholesome than scotch porridge oats. So I have a bowl of porridge in the morning and then mid morning I have a banana and an apple and lunchtime I have, I was having a sandwich but I have cut that out and I have

cottage cheese with pineapple in a lunch box and a banana mid afternoon. And I'll have a salad with chicken or fish or something in the evening. That's it really (Pat, second interview).

Pat appeared self connected for the duration of the study and lost one stone eleven pounds and reached her desired dress size of an eighteen. As Pat was over six foot tall and wore a size ten shoe Pat felt this was an appropriate size for a woman her stature.

The respondents were divided broadly into two main categories; individuals who used multiple strategies for weight loss and individuals who primarily utilised one strategy. The respondents who lost weight; Beth, Karen, Margaret, Molly and Pat all used different strategies from each other including; 'Atkins Diet', 'Cambridge Diet', Intuitive Eating, 'Lighter Life', restriction of intake, and 'Slimming World'. It would appear that the strategy the respondents employed did not seem to be a relevant factor in their weight loss. The fact that these individuals were connected appears to be the predisposing factor for their weight loss.

Conclusion

In this chapter, the women's weight loss experiences have been more fully explored. Their qualitative data was obtained over the period of one year by a series of qualitative in-depth interviews. Their experience has been presented in this chapter in the form of vignettes of the women taking part in the study and presenting the identified themes drawn from the interview transcripts. The themes of self-sabotage, internal conflict, control and choice were identified utilising the Hycner (1985) framework. The central concept of connectedness and its opposite of disconnectedness are introduced in relation to the women in the study and the three case studies of Code Red, Molly and Pat.

Throughout this chapter the experience of the women's weight loss journey has been explored and the posed research questions have been answered. This has included obtaining more information about the potentially new concept of connection and disconnection in relation to weight loss. Finally, the differences and similarities

between all the women have been discussed. This included their weight loss experience and how on the whole, trying to lose weight was perceived negatively by the respondents and also how their moods were affected by their weight. The similarities and differences in the respondents about their motivators for weight loss and the weight loss strategies they employed were also discussed. Finally, the findings in relation to the research questions posed in this study were summarised.

In the next chapter of this thesis, chapter five, we will discuss these findings more fully including the conceptualisation of connectedness and disconnectedness in order to examine, explain, and understand the women's individual experiences of weight loss.

CHAPTER FIVE: DISCUSSION AND CONCLUSIONS

Introduction

In the final chapter of this thesis, I will provide an overview of the findings in relation to the posed research questions. This will also include how the findings link to the previous research discussed in chapter two and throughout the thesis. I will discuss the results in relation to the models and theories considered in this research study. I will reflect upon the methods utilised in this thesis. I will discuss the potential contribution to the research arena this study has produced. I will also discuss the implications of this qualitative study in the clinical and educational arenas and further potential research and recommendations. Finally, I will discuss my personal reflections on the research journey and conclusions.

Overview of findings

The findings from this thesis are discussed in relation to the previously posed research questions and also the findings from previous research studies. The overarching research aim of this study was to explore the experience of intentional weight loss. The associated questions of this study are:

- What feelings or beliefs motivate individuals to start trying to lose weight and continue trying to lose weight?
- What strategies do individuals employ to try to lose weight and what decisions, feelings or beliefs underpin or influence these strategies?
- What factors help or hinder individuals in their attempts to lose weight?

What feelings or beliefs motivate individuals to start trying to lose weight and continue trying to lose weight?

All the respondents viewed being their present size in a negative light and listed a number of reasons for why they desired to lose weight (see chapter four, pages 161 to 164). These reasons included; firstly, difficulty getting the clothes they wanted (see

chapter four, pages 161 and 162). Secondly, the negative impact on their emotional health (see chapter four, page 163). Thirdly, how the respondents believed other individuals perceived them, primarily in a negative way (see chapter four, pages 161). Finally, some respondents wished to lose weight to improve their physical capabilities (see chapter four, page 163). Some of these comments were also voiced in previous studies such as Bidgood & Buckroyd (2005); Goodspeed Grant & Boersma (2005); Rogge *et al.,* (2004); Carryer (2001); Barker & Cooke (1992); Johnson (1990) and Rand & Macgregor (1990). For example, Bidgood & Buckroyd (2005) reported that a number of respondents' felt that their lives were being blighted by how others viewed them:

> If you're waiting to be served, you can be overlooked…big as you are you are invisible. People make snide comments to each other in lifts. In passing, they will stare.

Although there are some evident similarities between the previous studies reviewed and the study discussed in this thesis some differences are evident. This includes voiced health concerns. A number of the respondents' in this study cited health reasons for their desire to lose weight. These fell broadly into two arenas; firstly, the individuals who wished to lose weight because their present weight was having a negative impact on their present health status such as pain or arthritis, (see Margaret and Pat in chapter four, pages 163 and 164). Secondly, there were those individuals who had health fears about the future due to their size (see chapter four, page 164). These fears included for instance, possibly having a stroke or a heart attack. Both Karen and Kate voiced these as future health concerns. Although it may be pertinent to add here that both Karen and Kate have experience in the health care sector so both may have increased knowledge about the impact of weight on health status. Only two previously reviewed studies Hurd Clarke (2002) and Roberts & Ashley (1999) have a significant number of respondents citing health as a primary motivator for weight loss. This may be because in the Hurd Clarke (2002) study all the respondents were older women who may have been more aware of their own health. The respondents in the Roberts & Ashley (1999) study were aware that the researchers were their own doctors and this may have influenced their health related responses.

In the literature previously reviewed, a substantial number of the studies revealed how the respondents perceived they were negatively viewed by others in society. The quotes from Herndon (2002:121); Carryer (2001:94) and Rand & Macgregor (1990:1392) are particularly pertinent (see chapter two). However, in the study discussed in this thesis only three respondents voiced being perceived by others in a negative way. Indeed the other seven respondents such as Code Red felt the comments from others about themselves were not worth acting upon.

All of the respondents felt there were distinct advantages to losing weight. These perceived advantages motivated the women in this study in deciding to lose weight and in maintaining their desire to continue trying to lose weight. These included some definite advantages to the individual's health and being physically more able (see chapter four, pages 164 and 165). Only three of the respondents felt losing weight would have a positive impact on how others viewed them (see chapter four, page 165). Most of the respondents felt that weight loss meant that they would be able to buy the clothes they wanted to (see chapter four, page 166). Some of these comments had been previously voiced in other studies such as Bidgood & Buckroyd (2005); Goodspeed Grant & Boersma (2005); Rogge *et al.,* (2004); Carryer (2001); Barker & Cooke (1992); Johnson (1990) and Rand & Macgregor (1990) (see chapter two, page 46). For example, Barker & Cooke (1992:119) reported:

> Vanity and appearance were cited, particularly by the women, as the key motivators for losing weight. A successful diet was 'reflected' in the mirror and commented upon favourably by friends.

Bidgood & Buckroyd (2005:228) reported, "all participants wanted to achieve long term weight loss".

What strategies do individuals employ to try to lose weight and what decisions, feelings or beliefs underpin or influence these strategies?

The use of strategies by the respondents in this research study was varied. Although the use of strategies was diverse, the respondents fell broadly into two main groupings, multiple strategy use and singular strategy use. There were also three

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respondents who moved from utilising multiple strategies to a single strategy whilst participating in the study.

In the first group, five of the respondents in the study; Code Red, Kate, Louisa, Lucy and Peggy used a number of strategies to achieve weight loss throughout the year. None of these respondents lost the weight they wished to lose. Their strategies were diverse but broadly speaking reflected the strategies identified in chapter two: self-help, dieting and non-dieting. Examples of self-help strategies adopted by the women in this group included utilising meal supplements such as "Slim Fast" and utilising Hoodia as an additive (see pages 29 and 30). Examples of dietary restriction strategies included elimination of carbohydrate from their diets and eating lower fat foodstuffs (see pages 26 to 28). Non-dieting approaches were also utilised such as increasing exercise levels (see pages 32 to 33).

In the singular strategy group, only two respondents, Margaret and Pat, utilised just one weight loss strategy each for the duration of the study. They both lost a significant amount of weight throughout the year. Pat used the "Slimming World" plan consistently throughout her whole period of weight loss. Whereas, Margaret used the "Atkins" diet plan strategy for the yearlong period of the study. The "Atkins" diet advocates eliminating a significant amount of carbohydrate from the diet and advises increasing the individual's protein intake. In chapter two the "Atkins" plan was defined as a diet and the "Slimming World" plan was defined as a commercial self-help group (see pages 31 to 32).

Sitting in between those two groups are Beth, Molly and Karen who initially used a variety of weight loss strategies. However, at some point in the twelve months those three respondents reached an epiphany or turning point, after which it seems they chose one single appropriate weight loss strategy for themselves and subsequently lost weight consistently. These three individuals chose their strategy at different points in their weight loss journey. Beth achieved her weight loss by utilising an intuitive eating style. Intuitive eating includes eating in response to hunger signals and not environmental cues (Tribole & Resch, 2003). This style of eating is in contrast to Karen and Molly who both used a rigid pattern and utilised meal replacements to

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achieve their weight loss. Karen used "Lighter Life" and then "Cambridge Diet" products whilst Molly used "Cambridge Diet" products.

The second part of the posed research question considers what decisions, feelings or beliefs underpin or influence the strategies chosen by the respondents. Those individuals who were more successful in losing weight and more connected chose strategies they believed would be workable and useful for them in their weight loss endeavours. For instance, both Karen and Margaret chose a strategy they felt would be workable in their lifestyle and successful for them. Karen wanted a strategy where she did not have to spend great periods of time preparing her food to lose weight. Margaret wanted a strategy she would be able to use for a long period (see chapter four pages 159 and 160). Beth utilised a strategy, which she felt she could cope with in her everyday life, and was workable for her, considering her time restrictions of working fulltime, having a number of hobbies and running a home (see chapter four, page 171). Molly chose a strategy which she felt helped her to be in control of her weight loss process because she felt her lack of self control often contributed to her excess eating, which contributed to her weight gain (see chapter four, page 137). Pat chose her strategy because of her past experience with it and her knowledge and confidence in the strategy (see chapter four, pages 154 and 155).

In contrast, it would appear that the individuals who did not achieve their weight loss goals used fluctuating and often competing multiple strategies. Some strategies it appears were often chosen on impulse and in a haphazard way by the respondents. This type of strategy use often depicted an individual who appeared to not be connected. Code Red, for instance utilised strategies as diverse as "Slimming World", slimming tablets, an NHS dietician, a pedometer, "Weight Watchers" and enhancing exercise levels (see chapter four, page 167). Kate utilised a number of strategies such as dietary restriction, eating the "right" foodstuffs, exercising and the "Cambridge Diet" (see chapter four, page 168). Louisa also used multiple strategies including exercise, Hoodia, "Slimming World", diet soup and no carbohydrate days (see chapter four, pages 168 and 169). Lucy and Peggy also used a number of strategies to assist with their desired weight loss all without success (see chapter four, pages 169 and 170).

What factors help or hinder individuals in their attempts to lose weight?

The factors that appeared to help or hinder the respondents in this study included being connected or disconnected, displaying self-sabotaging thoughts and actions, experiencing internal conflict or not and issues around control and choice. Although in essence it was how the respondents managed these influencing factors or not which determined whether self-sabotage, internal conflict, control and choice affected their weight loss efforts either in a positive or a negative way.

The helping factors, which assisted the individuals in this study to lose weight, included being connected and not self-sabotaging or exhibiting internal conflict. The individuals who exerted more control and choice around food and eating decisions also appeared to lose weight. However, the concept of connectedness would appear to have the greatest positive influence on whether the respondents in this study lost their weight or not. From the outset of the study Margaret and Pat were consistently connected. Part way through the study Beth, Karen and Molly became connected. Connection was inferred or referred to in a number of different ways by the respondents. This has included connection being termed "willpower" by Beth (see chapter four, page 140) and "motivated and mentally focused" by Pat (see chapter four, pages 136 and 141). Once connected all the individuals displayed limited instances of internal conflict and acted in a way consistent to losing weight in issues surrounding control and choice. In the research previously reviewed and discussed in chapter two, the concept of connection does not appear to have been identified. Therefore the concept of connection would appear to add something new which has the potential with further research to enrich our understanding of why some individuals are successful at losing weight and other individuals are not.

The primary hindering factors identified in this study included demonstrating instances of self sabotaging thoughts, dialogue and actions, instances of internal conflict and making decisions around control and choice which conflicted with individuals' stated desires to lose weight. Instances of self-sabotage are evident in the transcripts of Code Red, Kate, Louisa, Lucy and Peggy who did not achieve their weight loss desires and also other individuals' "pre connection" such as Beth. This includes individuals actually discussing their own awareness of their self-sabotage

and acts of self-sabotage which the respondents also termed as spoiling things (see chapter four, pages 128 and 129). Self-sabotaging health actions and self-sabotaging thoughts were also evident (see chapter four, pages 126 and 130). Internal conflict is clearly evident in the respondents' transcripts as a hindrance to their weight loss efforts. This includes individuals demonstrating internal conflict in their actions, aims and goals, beliefs, self-dialogue and thinking (see chapter four pages 130 to 134).

In the research previously reviewed and discussed in chapter two, the themes of self-sabotage and internal conflict were not identified. Therefore, these themes would appear to be novel data adding to our knowledge about individuals' weight loss experience. The other two themes of control and choice discussed in this thesis have been previously identified by other studies such as Bidgood & Buckroyd (2005); Goodspeed Grant & Boersma (2005); Lopez, (1997); Barker & Cooke (1992) and Johnson (1990) (see chapter two, pages 46 and 47). However, possibly the qualitative and longitudinal nature of this study has allowed the complexity and layers of the issues surrounding control and choice in relation to weight loss to be explored further. This is because the respondents were enabled, due to the time span of the study, to return to these themes if they wished to and further discuss how these themes affected them throughout their weight loss process. In relation to control, this includes Karen's "all or nothing" concept of control, being out of control, the respondent's fatalistic beliefs about weight, which may affect their control, the controlling aspect of food and external control and addiction (see chapter four, pages 135 to 138).

These hindering factors of self-sabotage, internal conflict, inappropriate individual decisions around control and choice culminated in the individuals being disconnected and struggling to lose weight.

A discussion of the results in relation to the models and theories previously discussed in the literature review

In this next section I will discuss the extent to which the models and theories discussed in chapter two help to explain the women's weight loss experience and to illuminate the concept of connectedness and the themes of self-sabotage, internal

conflict, control and choice. It is possible that no one model or theory will completely explain the findings in this study but potentially a combination of the models and theories may usefully help to explain the women's weight loss experience.

Behavioural learning theory

Behavioural learning theory has been applied to the role of eating and weight in the form of the behavioural economics model (Epstein & Saelens, 1999). In this approach all behaviour in relation to food, eating and weight control are termed as benefits and costs. The differing value individuals place on food is acknowledged in behavioural learning theory. Benefits (known as re-inforcers) influence individuals' behaviour.

Food re-inforcers do differ between individuals. For instance, obese individuals gain more reinforcing value from food than non-obese individuals (Epstein & Salaens, 1999). For instance, a number of respondents in this study cited the value and meaning of food to them:

> I just love the taste of it and the crunch and I ate the whole thing and afterwards I didn't feel guilty (Code Red, second interview).

> All that interests me is the fat food, food what's tasty (Lucy, first interview).

People who are dieting are also likely to be more impulsive in obtaining food re-inforcers (Herman & Mack, 1975). Consequently, such individuals are less likely to be able to control themselves:

> It's a lie, because I can't stop eating and I just don't lose weight (Louisa, first interview).

> Just the thought of stacks of fresh toast (laughing) with butter and marmite, you know I am drowning (laughing) (Margaret, fourth interview).

Although with research it may be possible to enhance the value of low re-inforcing foods, the behavioural learning theory may be limited by the fact that it is unlikely that individuals will conduct a complete, accurate or rational cost benefit analysis before every eating decision.

The health action model

The health action model (Schwarzer, 2001) is helpful in explaining certain aspects of the women's behaviour during their weight loss experience. In the health action model, at the motivational stage, a minimal trigger such as threat or concern can lead to an individual considering change. In this instance initiating a weight loss programme. The respondents disclosed a number of triggers to their weight loss:

> You worry that your husband is not finding you as attractive as he used to…he is only human and I understand that…it's a human thing, you find people more attractive when they are more attractive (Beth, fourth interview).

> I cannot find the clothes, the outfits to fit me (Karen, first interview).

> I don't feel very active. I've got grandchildren and where I used to be able to run around with them, play games with them, do all sorts of things. I can't do that now (Louisa, first interview).

> I just don't like the way I look…it kind of pulls you down doesn't it (Lucy, first interview).

The health action model does help to further expand on the themes of control and choice. The term drive is used in the health action model (Tones, 1994) to describe strong motivating factors including hunger which can affect control and choice of actions and foodstuffs:

> Control is a big word in weight, it really is (Molly, fourth interview).

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It's just craving for chocolate, it just creeps in absolutely. I eat too much though whatever there is (Molly, first interview).

The term drive is also used to describe motivations, which can become drives such as addiction. The respondents discuss how the concept of addiction affects them:

I have tried them all and nothing seems to work because you seem to crave the things you shouldn't have. You feel good while you are eating it, the same as an alcoholic feels good when they drink (Louisa, fourth interview).

All that interests me is fat food, food what's tasty. You get addicted to them (Lucy, first interview).

See the temptation. It is like an addiction (Margaret, fourth interview).

The concept of relapse is an identified issue in the health action model and evidence of relapse can be seen in this study through examples of what I have called self-sabotage:

Well, the three tins of chocolates that get bought at Christmas, that didn't help at all, just looking at them I gave in one night (Margaret, third interview).

The health action model (Schwarzer, 2001) argues that the context in which the change is attempted will influence the outcome. Actions are not just the result of cognitions, but are influenced by the perceived and actual environment (normative aspect of the model). Changes, which are supported by the social and structural environment, are more likely to be maintained than those which are not. For instance, it was difficult for Margaret to resist the three tins of chocolates on display in the house. Although it was Christmas time the chocolates could have been placed in the owner's bedroom rather than the living areas to assist Margaret trying to lose weight.

An individuals' own belief system as identified in the health action model plays a distinct role as these comments relating to self-sabotage illustrate. Code Red discusses her own sense of failure and Molly questions whether she deserves to be slim:

I just felt a complete bloody failure and then I think ahh well stuff it; I might as well have another one and it's that silly attitude that is stopping me from doing what I want to do (Code Red, second interview).

Am I abnormal? Maybe I don't deserve to be slim, but I don't know why? Whatever attention I receive I spoil anyway (Molly, second interview).

The normative system such as knowledge and skills as well as the belief system identified in the health action model can all have a part to play. This combination of factors may lead to an individual being connected. The following quotes provide examples of the respondents' self-beliefs. The quotes from Karen, Kate and Pat also demonstrate their knowledge levels in the following quotes:

This might be you know, I always felt that this might be. I should have the capacity to do it. I have thought about it now, and I have had enough tries but I am hoping that I have got the, the will power, it's nothing else (Beth, fourth interview).

Well, I think in the end it has been myself because you have to decide to do it, and you have to decide to go on the diet, or follow the food plan or change you're lifestyle and you have to do it. It's not if anyone helps you, it's how you interpret that help (Karen, second interview).

It is no good being fat either. I don't think if you don't eat exactly what you should eat will do you as much harm as what all this overweight will do. I already have high blood pressure. You can have a stroke through it and heart disease (Kate, first interview).

I've got quite bad arthritis…so I need to keep it down (weight) for that (Pat, first interview).

The converse is also true and limited self belief may affect an individual's ability to lose weight and also potentially to the individuals being disconnected:

I just felt a complete bloody failure and then I think ahh well stuff it! (Code Red, second interview).

Schwarzer (2001) argues that self-efficacy judgements determine the amount of effort and perseverance invested in the new behaviour. It does appear that individuals who appeared to be connected and believed in themselves achieved their weight loss goals:

This might be you know, I always felt this might be. I should have the capacity to do it. I have thought about it now (Beth, fourth interview).

Well, I think in the end it has been myself because you have to decide to do it, and you have to decide to go on the diet, or follow the food plan or change you're lifestyle and you have to do it. It's not if anyone helps you, it's how you interpret that help (Karen, second interview).

Well, I shall weigh myself every week. I tend to be very, very good in the week…Once I start going I can keep losing a couple of pounds a week, which is quite good. Well, usually in the first week I lose about six pounds, yea in the first week really when I can get my head round it, just getting yourself motivated and really setting yourself, and doing what your mind wants you to do, you know (Pat, first interview).

The health action model defines the importance of life skills such as belief in self and self-control. When the respondents demonstrated aspects of internal conflict such as contradictory aims and goals, beliefs, self- dialogue and motivation they were unsuccessful at their weight loss goals. For instance, Beth's and Peggy's dialogue displayed examples of contradiction and Louisa's demonstrated life skills in relation to her aims and beliefs were contradictory. For instance, Louisa displayed contradictory aspects of self-control:

I think that's the choice and I think you either give up and say I am going to be the way I am. Maybe get bigger and I don't care and I'm going to be flabby and I'm not going to be toned and I'm not going to like the way I look in the mirror when I take my clothes off, and that's it, and I'll just accept myself for who I am. It

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depends on what I do. Then you see these programmes with these big women who accept themselves as being big and I think that's great. If that's what they want to do, but I am not ready to give up on it yet, but at the same time I think that eventually I've either got to bite on the bullet and eventually move to a way I can get on with it or I've got to give up on it (Beth, third interview).

Anyway, to cut a long story short he (husband) brought this along with some other products and he said maybe this will help. But it doesn't seem to help; as soon as I get something like that, I seem to have a dual personality. One part of my brain is saying oh yes! Yes! This is it, you can do it. And the other part of my brain says is it worth the hassle? Why bother? You know, so I am fighting a constant battle within myself. It hasn't helped at all. I seem to have this dual personality. I want to and yet it is too much hassle because basically I am a lazy person…I go at things like a bull at a gate and then I lose interest you know. I've been like that all my life. It is just this total frustration with myself, and I know that if I set my mind to it, I can really do it but I am too bone idle to really set my mind to it and stick to it (Louisa, second interview).

I have never been as heavy as I am now. I would like to try to lose weight but emmm it just depends on how things are, if you lose weight, to stay the same, as I ever would be, would be good. Oh, I don't know about it! Well, because its always in your head, you know you can't get away from it, you know people saying, oh you should be slimmer, you know perhaps this is my ideal weight (Peggy, first interview).

I am always trying to lose weight, always trying to find, I am always looking for that way that I can lose weight. Some sort of appetite suppressant that would be the only way with me, you know, so that I don't want to eat but that sent you up the wall because you thought you were meeting yourself coming back. I couldn't keep them going for very long, from what I can remember (Peggy, first interview).

The health action model has helped to illuminate the concept of connectedness and relapse and the themes of self-sabotage, internal conflict, control and choice.

The health belief model

The health belief model was designed and modified by Becker (1974) to predict an individual's ability to follow health advice to fulfil health-promoting strategies, such as eating healthily to reduce the risks of cancer or to eat in a way to lose weight or avoid weight gain. This model suggests that for individuals to engage in behavioural change they must have an incentive to change, they must feel threatened by their current behaviour and feel susceptible to the disease or disorder. This perceived susceptibility was identified by the respondents' concerns about their present and future health due to their weight:

> I have been having lots of problems with my knee…I've got a bad back and a bad knee now (Beth, second interview).

> I've got really bad arthritis…so I need to keep it down (weight) for that if nothing else really. I've got it in my knees and my hands as well but my knees is the worst. I can cope with the rest but my knees get quite painful, going upstairs (Pat, first interview).

> My blood pressure was also so high it was one hundred and sixty over a hundred. I thought I would be more likely to have a heart attack or a stroke so I suppose fear of something to do with my health (Karen, first interview).

> It is no good being fat either. I don't think if you don't eat exactly what you should eat will do you as much harm as what all this overweight will do. I already have high blood pressure. You can have a stroke through it and heart disease (Kate, first interview).

> I do have problems with my joints; it runs in the family with arthritis (Margaret, first interview).

According to the health belief model individuals must feel a change would be beneficial in some way and would have few adverse consequences and feel competent and able to cope with the change and feel self-empowered enough to carry out the

change. This was demonstrated by Pat who felt confident in her ability to change and follow a weight loss programme:

> Well, I shall weigh myself every week. I tend to be very, very good in the week…Once I start going I can keep losing a couple of pounds a week, which is quite good. Well, usually in the first week I lose about six pounds, yea in the first week really when I can get my head round it, just getting yourself motivated and really setting yourself, and doing what your mind want you to do, you know (Pat, first interview).

The primary source for change within the health belief model is self-efficacy. Self-efficacy implies a mental or cognitive state of being in control (Winder, 1985). People with greater levels of self-efficacy, self-belief or confidence, it is predicted, will be more likely to engage in specific behaviour, persist until they get it right, and maintain that behaviour. Believing in oneself and consequently being connected has been demonstrated by some of the respondents:

> This might be, you know, I always felt that this might be. I should have the capacity to do it. I have thought about it now and I have had enough tries but I am hoping that I have got the willpower, it's nothing else (Beth, fourth interview).

> Well, I think it the end it has been myself because you have to decide to do it, and you have to decide to go on the diet, or follow the food plan or change you're lifestyle and you have to do it. It's not if anyone helps you, it is how you interpret that help (Karen, second interview).

An important aspect of the health belief model has been its identification of the perceived barriers to taking action. This is evident in some of the respondents when they are acting in a disconnected manner such as Code Red who seems blocked in her weight loss process and Louisa who feels her actions are futile:

> I am always trying to lose weight and I have been trying to lose weight for the last twelve years. It is just an ongoing thing. It's the sticking that I find the hardest. I

am really fed up being this way. I am stuck. So I am scrambled again (Code Red, second interview).

I am not happy but I am going to give it a go. I have no carbohydrate days and they do work, which makes you feel worse about yourself being big, because I cannot do anything about it (Louisa, second interview).

These perceived barriers were also evident when the respondents discussed their awareness of their self-sabotage, control issues around food and self-contradiction:

I would like to be about twelve stone for the operation. But I think it is you know, a little bit impossible. When I had my last operation, which is the same one, I was fourteen stone then and I felt that I was too heavy at that time to cope with myself (Kate, first interview).

But I diet, I eat, I diet, I eat…well you know everything you want to eat or if you do eat it, nice dinners and that, I like you are thinking, all the time I shouldn't be eating this…I don't really like dieting but I know I've got to do it now (Kate first interview).

It is very interesting because you realise that you are self-destructing, that what you are doing is not doing you any good, as I said (Louisa, first interview).

It's like when you reach a crossroads and you think I'll go left, you go left and it's the wrong road you know, so what do you do? (Louisa, first interview).

All that interests me is fat food, food what's tasty. You get addicted to them (Lucy, first interview).

Having a baby crying at night, was not on, so they used to feed me undiluted gripe water which is basically sugared water with dill, extract of dill and peppermint, lots of peppermint, even today peppermints they are, you know, the after eight mints, show me a box of them and you've got an empty one (Margaret, first interview).

I don't know that I could do that. I would be fine but I don't know if it is psychologically or it is something inside me that says something or I don't know? No, not deprived but then psychologically yes. I don't seem to be able to do it (control myself). Its just a craving for chocolate, it just creeps in absolutely. I eat too much though whatever there is (Molly, first interview).

The health belief model does highlight the range and complexity of factors involved, including the individuals' coping skills and belief in themselves in their ability to achieve their stated goal.

Intuitive eating

The theory of intuitive eating consists of three components. Firstly, eating primarily in response to physiological hunger signals. From the qualitative data it would appear that only one respondent Beth ate in response to her own physiological hunger signals:

I just don't want to eat any more and like I have been having one piece of toast because I cannot eat two and then even half way through a piece of toast I am, I cannot eat this. I am feeding…I have just waited until my body has told me that it is hungry and I have only had very small things like toast or an apple or even a glass of milk and I am shocked that the weight is coming off, very surprised and very pleased (Beth, fourth interview).

Beth's quote "I have just waited until my body has told me that it is hungry" demonstrates intuitive eating (Avalos & Tylka, 2006 and Faith *et al.,* 2004). By eating intuitively, Beth was surprised to find she lost weight, but she demonstrated how connected she was to her own body signals. However, none of the other respondents regardless of whether they achieved their weight loss goals appeared to demonstrate intuitive eating and eat only in response to hunger signals. With the notable exception of Beth, all the respondents who lost weight used dietary restraint (Ogden, 2003). For instance, Pat termed her dietary restraint as green and red days:

I shall eat differently from everyone else; I shall stick to "Slimming World", the green and the red days, which is just like the hay diet (Pat, first interview).

This is in direct contradiction to what the theory of intuitive eating espouses which encourages eating in response to your physiological triggers. Consequently, the theory of intuitive eating in this respect is not helping to define the concept of connectedness further in relation to the findings in this study.

The second construct of intuitive eating is that individuals respond only to hunger signals and not emotional sensations. The respondents such as Code Red, Kate, Louisa, Lucy and Peggy who did not achieve their desired weight loss exhibited frequent instances of eating in response to emotional triggers rather than physiological cues suggesting they might be unintuitive eaters. Such instances from the data include:

Well, I dread to think because when I am sitting here on my own, I will sit and eat maybe a couple of chocolate bars, I'll have sweets and I'll have my dinner too. Because they are there…I had but I had something, it's not because I am hungry (Louisa, first interview).

Once I've had my lunch, yes, I mean not hungry, I just want to pick at it, you know what I mean. I just want something in my mouth, something that's going to be in my mouth…I am back at half past eight so I forget what I had but something and it's not because I am hungry. I am not, not really. I think a lot of it is because I live on my own (Peggy, first interview).

Such unintuitiveness adds weight to the concept of disconnectedness in these individuals.

The third facet of intuitive eating is that individuals who eat intuitively are self-aware and responsive to their own physiological body signals. Some of the respondents were self aware and connected with themselves:

I have just waited until my body has told me that it is hungry (Beth, fourth interview).

The concept of connectedness identified in this thesis has some resonance with the theory of intuitive eating for a number of reasons. When individuals eat intuitively, they are listening to their own body signals and eat when hungry and not when already full (Faith *et al.*, 2004 and Tribole & Resch, 2003). Intuitive eaters also trust their own body signals to guide how and what they eat (Carper *et al.,* 2000 and Tribole & Resch, 1995). The theory of intuitive eating demonstrates the concept of connection between mind and body in these instances. As signals are sent, interpreted correctly and acted upon appropriately:

Well, I think in the end it has been myself because you have to decide to do it, and you have to decide to go on the diet or follow the food plan or change you're lifestyle and you have to do it (Karen, second interview).

However, the majority of the respondents did not necessarily demonstrate intuitive eating, in fact, the respondent quoted above, Karen, utilised a very restrictive calorific regime to achieve her weight loss which removed any necessity or obligation for Karen to attend to her own body signals.

The knowledge, attitudes and behaviour model

Most health information is given in the form of advice and the advice is usually given in the form of facts. It has been assumed that by providing knowledge there will be a modification in attitude, which will result in behaviour change. The advice model of health education: "Knowledge, Attitudes and Behaviour" (KAB, Naidoo & Wills, 2000) is based on the idea that by increasing patients' awareness of the severity and threat of the disease (the cons) together with the benefits of complying with the recommended preventative actions (the pros) will result in a lasting behaviour change. This approach is often used in the field of primary care at the initial contact; patients are given the health information to help motivate them to lose weight or a diet sheet to take away with them. Essentially, this model proposes that patients can move from a

state of being unaware of the need to change to a state of complete compliance with the recommended actions. However, the advice approach to motivating patients is flawed. The problem with giving advice is that although there may be some short term benefits, for the most part the advice is largely ignored. A number of factors limit the strategy including the behavioural aim of the intervention, the methods used, the time given for imparting the information and the inertia of mental life (resistances) termed cognitive dissonance by Festinger (1957). The ambivalence or disinterest on either the health practitioner's or the patient's part also limits the advice strategy. This is evident from the qualitative data obtained from some of the respondents including Molly:

> No, because I know what to eat and not what to eat. I know when to eat. I know, I pretty much know what to do to lose weight. My problem is keeping it there and keeping motivated and keeping my brain in tune with it (Molly, second interview).

The central premise of the KAB model is that it assumes that a person is rational and self-aware; having what has been termed enlightened self-interest (Baranowski, 1997). There has been substantial concern, however, that most people in most situations do not exhibit what would be considered effectively 'rational' behaviour (Shafir & LeBoeuf, 2002). Individuals often do not act rationally in relation to eating; for instance, individuals do not just eat when they are hungry but are affected by societal and environmental factors, which are not specifically addressed by the KAB model. Respondents in this study displayed instances of self-sabotage and internal conflict, which is in opposition to the idea promoted by the KAB model of rational behaviour:

> I am fighting a constant battle with myself. It hasn't helped at all. I seem to have this dual personality. I want to and yet it is too much hassle because basically I am a lazy person…I go at things like a bull at a gate and then I lose interest you know I've been like that all my life. It's just this total frustration with myself and knowing that if I set my mind to it I can really do it but I am too bone idle to really set my mind to it and stick to it (Louisa, second interview).

> It's very frustrating. It is very frustrating. I think it is very frustrating because I am not, I am not making the effort. Well, I have got these scales next door that I

occasionally get on, and there's scales at work that I occasionally get on but when they don't tell me what I want to know I've not done anything much (Beth, second interview).

The educational approach is based on a set of assumptions about the relationship between knowledge and behaviour, that by increasing knowledge, there will be a change in attitudes, which may lead to changed behaviour. The amount of control and choice an individual has depends not just on knowledge but also on a number of other factors some of which the individual may have very little control over including the very real constraints that social and economic factors place on an individual's health related decision making. For instance, finances preclude Molly from her preferred weight loss strategy:

When I went to the 'Lighter Life' session, I was focused. It was only the money that stopped me as I said I booked the appointment for 'Lighter Life' and I was really keen, motivated, but the finances couldn't do it, but even in the time I was supposed to have started, I went to the 'Cambridge Diet' as an alternative and I thought sod it! It's half as much, it's still a lot but it's half as much and it's worth it so actually losing the weight, easy (Molly, fourth interview).

The KAB model by itself therefore seems to be inadequate as a means of promoting dietary change. The concepts of knowledge and attitudes need to be more clearly specified conceptually and related to other variables within the overall process of change. This would potentially improve an individual's ability to choose to change their diet. The development of knowledge and attitude scales for each decision in the eating event may be a way of providing the needed specificity. If knowledge is revealed to be a key influence on behavioural change, procedures to change knowledge need to be more clearly specified within the context of effectively promoting behavioural changes in diet. Therefore, a revised health promotion behavioural model may be required. Consequently, the impact the KAB model has on the four themes identified in this study may be limited.

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Mindfulness

The theory of mindfulness advocates individuals being more aware of moment-to-moment experiences in relation to both physiological and mental processes. In this thesis, I propose that connectedness is when mind and body are in harmony. However, being connected and self-aware appears to be an issue for some of the individuals:

> But it is the food side that doesn't seem to. It's like I go off a different track it's I don't know! It's just not easy and I always thought it was easy. It's not easy. It's taken me twelve years and I've still got this weight on and I just don't know, stuck (Code Red, second interview).

> I haven't really been trying, in my head I have but when you have it in your head you tend to go completely in the opposite direction and I wanted desperately to lose some weight (Molly, third interview).

The theory of mindfulness helps to expand the concept of connectedness further as it would appear that not being mindful and aware hinders and prevents individuals from achieving their desired goal of weight loss. However, some individuals did recognise this lack of awareness and mindfulness in themselves. In this instance, Code Red discussed her own self-contradiction, which she felt was apparent after reading her transcript:

> No the only thing you can do that is funny, it is ever so funny to read it back, it is ever so funny what you say and I am so contradictory…it is a good reference because you can look back and think I did say, I tried that! (Code Red, third interview).

There are links between the concepts of mindfulness and connectedness, which I have defined as being a synchronisation and awareness of mind and body. Bishop and colleagues aptly defined mindfulness as "a problem of regulating attention in order to bring a quality of non-elaborative awareness to current experience" (2004:234). Whilst Kabat-Zinn (1994:219) argued that "Connectedness may be what is the most fundamental about the relationship of mind to physical health" The self-connection

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that practising mindfulness appears to achieve could assist individuals when trying to lose weight.

It would appear that by acting in a mindful way respondents such as Margaret and Pat lost weight. These individuals were able to choose appropriately and demonstrated appropriate control. They did not indulge in internal conflict and did not self-sabotage. They also may have held positive beliefs. Although these factors appear to lead to connection, they may be different for each individual:

> Just getting yourself motivated and really setting yourself and doing what your mind wants you to do, you know, just suddenly like this weekend, I thought right this is it. Monday, I am going to start. I've got my head round it now. I've got it sorted out and made the decision. I have just got mentally focused on it now and I have done it before (Pat, first interview).

Therefore, being mindful appears to enhance weight loss. Further research is needed, however, to support this conclusion.

It also appears that the respondents in this study who acted in a non-mindful way such as Code Red, Kate, Louisa, Lucy and Peggy did not lose weight. These individuals indulged in self-sabotage and experienced internal conflict. They did not make appropriate/rational choices. For instance, they did not choose an effective weight loss strategy for themselves. They also did not exhibit appropriate control. For instance, by controlling their dietary intake or changing their exercise levels.

Although factors such as self-sabotage, internal conflict, control and choice may contribute to disconnection, different individuals may experience them differently. Examples of disconnection from Code Red and Louisa include:

> I am always trying to lose weight and I have been trying to lose weight for the last twelve years…I am really fed up being this way. I am stuck. So, I am scrambled again (Code Red, second interview).

I am not happy but I am going to give it a go. I will be, I am trying to be. I have no carbohydrate days and they do work. Which makes you feel worse about yourself about being big, because I cannot do anything about it (Louisa, second interview).

In relation to self-sabotage, the theory of mindfulness can offer explanation through further exploration of the phenomena termed automatic behaviour (Brown & Ryan, 2003). This is when an individual acts in a specific, non thinking and often repeated way to a specific stimulus, such as eating in response to being alone:

When I am on my own that's it, I just munch through whatever there is (Molly, first interview).

If I am on my own sat in the house I'll eat, if I am out socialising, walking around the park with my friend, or if I go to someone's house for a cup of coffee I won't sit and eat their biscuits…I don't want them to think I am a pig, so I won't have them, you know. Things like that, and you know if I go out with a friend for lunch, nine times out of ten I'll sit there with a nice healthy jacket potato and you know by the time three or four o'clock comes I'll be sitting here eating a mars bar (Molly, first interview).

Such actions have been termed as "public self-consciousness" (Brown & Ryan, 2003:823) in the field of mindfulness literature. This concern about how others view the individual further divorces the individual from eating mindfully.

In relation to choice, the theory of mindfulness offers some explanation. Although a number of researchers have defined mindfulness, the key characteristics of mindfulness consist of the individuals having sustained moment-to-moment awareness (Grossman *et al.,* 2004); being self-aware (Bishop, 2002) and being in touch with themselves as a person and being present (Kabat-Zinn, 1994). This assists individuals when making appropriate choices in relation to their weight loss because potentially it offers internal feedback, which would appear to be of importance to individuals when they are trying to lose weight:

> I am always trying to lose weight and I have been tying to lose weight for the last twelve years. It is just an ongoing thing…and it is that little rebel that is going stuff it! Eat what you want! Do what you want! She or whoever it is, is winning at the moment, because I will eat what I want but really I don't know how to get out of this cycle (Code Red, second interview).

Karen chose to restrict her social engagements as she was aware that such activities encouraged her to eat potentially in relation to emotional triggers but not it would appear physiological triggers:

> Every time whenever you are on a diet, you are always invited out to places for dinner, for functions and you also inevitably go on holiday…I think I will cut out a lot of social occasions, because you know social occasions revolve around food, to me, they do anyway (Karen, first interview).

Such awareness would potentially help to assist individuals to lose their desired weight. This is because making the right choices involves a self-awareness or mindfulness of how we respond to temptations and opportunities to stray from choosing appropriately in order to achieve weight loss. Therefore, the theory of mindfulness would appear to be useful in further explaining the results of this study.

The theories of reasoned action and planned behaviour

An assumption of the theory of reasoned action is that the individual has the resources, skills or the opportunity to engage in their desired action, in other words self-control. This was frequently not the case. This lack of self control has been demonstrated by a number of respondents:

> Scared, scared of failing you know. That's the whole thing I am sort of frightened of starting something and failing again…I just can't stick at anything (Louisa, first interview).

However, to address this weakness Ajzen (1985) added a further dimension of control, over the intended behaviour. This reflects the perceived ability of the

individual to engage in the desired behaviour (Ajzen & Madden, 1986). Facilitating or inhibiting factors include both internal (skills and information) and external control factors (including opportunities, fate, luck and dependence on others). The respondents displayed both aspects of control, Margaret demonstrated internal control and Peggy demonstrated her beliefs in external control:

> Well I think that the only strategy is not to buy the stuff that I don't want to eat. I do things like if I buy a loaf of bread I keep it in the freezer and only bring out the amount of slices that somebody wants at that time…it's under my control (Margaret, second interview).

> I am always trying to lose weight. Always looking to find, I am always looking for the way that I can lose weight. And I know that the only way I can lose weight is by having some sort of appetite suppressant, that would be the only way with me, you know, so that I don't want to eat…I am just looking for the secret bullet…I have got to have something to take my appetite away (Peggy, first interview).

Perceived control combines with attitudes and perceived norms to form an intention to engage in a particular behaviour. This larger model was termed the theory of planned behaviour (Ajzen, 1985). The limits of control and choice an individual has depends not just on knowledge but also on a number of other factors some of which the individual may have very little control over including the very real constraints that social and economic factors place on the individual's health related decision making. To feel empowered increases the chances of a person making rational choices about their food intake. Self-empowerment is:

> A set of competencies and capabilities which together with certain related personality characteristics, contribute to a relatively high degree of actual control over a given individuals' life and health (Tones & Tilford, 2001:40).

However, it has to be acknowledged that choice and ability to be empowered is sometimes limited by circumstances, such as poverty, environment and the

individual's capabilities and actions. In the field of addictions, for instance, the ability to cease smoking and the addictive behaviour may be challenging:

> It is said that the individual may be free to choose (whether he wishes to smoke). But the individual is not free; with the drug of addiction, the option is only open at the beginning (McKeown, 1979:125).

Some of the reviewed literature supports the idea of addiction surrounding the compulsion to overeat and may affect what food choices an individual makes. The respondents' words also support the concept of addiction:

> All that interests me is fat food, food what's tasty. You get addicted to them (Lucy, first interview).

> Just the thought of stacks of fresh toast (laughing) with butter and marmite, you know I am drowning (laughing). See the temptation. It is like an addiction, in fact some people it really is as though I mean some people is as though. I mean it is the same sort of level as a heroin addiction and they just cannot get away from the desire to have high carbohydrate food, pizza and pasta and potatoes and …(Margaret, fourth interview).

Both the theories of reasoned action and planned behaviour help to explain the issue of control and choice in relation to the women's weight loss experience.

Social learning theory

Bandura's (1977) social learning theory suggests that the health choices people make are related to outcome expectancies, whether an action will lead to a particular outcome, such as weight loss. Good health forms an action outcome expectancy and, if valued, a possible reward for engaging in health maintaining and promoting behaviour. It is a long-term outcome; very few health related behaviours especially trying to lose weight have an immediate and noticeable effect on health. The motivation to work towards the long term goal of good health, the appropriate height

to weight ratio, frequently competes with the plethora of short term rewards for behaving in health damaging way. For example, going off the diet to have a meal out:

> I suppose when I get hungry and instead of doing my diet I think what else can I eat, and I eat something else (Kate, second interview).

Even when good health is highly valued, lapses in behaviour can be justified through a variety of cognitive processes including denial and some form of bargaining, such as promising to eat healthier tomorrow, short term health outcomes may be much more powerful determinants of behaviour. Looking fit and being able to get into attractive clothes may be more important determinants of success in dieting than any long term health gain (Norman & Bennett, 1996):

> Not being able to get into my clothes…I always looked bad in clothes…so like oh god, you know, whatever you wear (Beth, fourth interview).

> I cannot find the clothes, the outfits to fit me (Karen, first interview).

> I know that I have got some very nice clothes but I have to get quite a lot of weight off before then (to be able to wear them) (Kate, first interview).

Bandura's (1977) work emphasises the importance of belief in oneself (self-efficacy) to achieve desired goals, for instance, losing weight. Both Karen and Pat demonstrated self-efficacy and being connected:

> Well, I think in the end it has been myself because you have to decide to do it, and you have to decide to go on the diet, or follow the food plan or change you're lifestyle and you have to do it. It's not if anyone helps you, it how you interpret that help (Karen, second interview).

> When, I can get my head round it. Just getting yourself motivated and really setting yourself and doing what your mind wants you to do, you know. Just suddenly like this weekend, I thought right this is it. Monday, I am going to start

I've got my head round it now. I've got it sorted out and made the decision. I have just got mentally focused on it now and I have done it before (Pat, first interview).

Hence, the social learning theory helps to explain the concept of connection further in the respondents who lost weight.

The transtheoretical model

The transtheoretical model proposed by Prochaska and DiClemente (1984) identified a number of stages, which individuals passed through whilst changing their behaviour. There are examples of some of the respondents being at different stages including preparation, action and relapse. For instance, the individuals who were connected demonstrated preparation and action. Examples include Pat who is preparing herself mentally for commencing weight loss and Karen who discussed her action strategy in relation to available help when discussing her weight loss:

Well, I think in the end it has been myself because you have to decide to do it, and you have to decide to go on the diet, or follow the food plan or change you're lifestyle and you have to do it. It's not if anyone helps you, it is how you interpret that help (Karen, second interview).

Just getting yourself motivated and really setting yourself and doing what your mind wants you to do, you know. Just suddenly like this weekend, I thought right this is it. Monday, I am going to start. I've got my head round it now. I've got it sorted out and made the decision. I have just got mentally focused on it now and I have done it before (Pat, first interview).

Some of the self-sabotaging actions demonstrated by the women placed them, at that time, in the relapse stage:

I am actually buying bars of chocolate. I don't really want them but there is something about because I am not allowed it, it's like, I don't know. It's like I am actually fighting myself. It's a very, very odd and I do go through these little phases where you know I am on the way to…I'll stop and I'll buy croissants and I

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will do really stupid things and I will eat food I don't really want and I will have naughty things just to show that I can to myself. It's a very, very odd thing, I will, and so I went through a couple of weeks like that. Like I say I went through that slightly self-destruct couple of weeks when I was eating whatever (Beth, second interview).

I suppose when I get hungry instead of doing my diet I think what else can I eat, and I eat something else (Kate, second interview).

Consequently, the stages of change model identifies preparation, action and relapse in the respondents' weight change behaviour and therefore further explains the central concept of connection and the theme of self-sabotage.

A reflection on the usefulness of the models and theories previously discussed to explain the results of this study

On reflection, it would appear that some of the models and theories are helpful in illuminating the central concept of connectedness and the themes of self-sabotage, internal conflict, control and choice although to varying degrees. Although, it would appear that the theories of intuitive eating and mindfulness have the strongest resonance with the concept of connectedness, the health action model, the health belief model and the social learning theory also enhance our understanding of connectedness in relation to the women's weight loss experience.

In relation to the themes of self-sabotage, internal conflict, control and choice, the health action model, health belief model and the theory of mindfulness were particularly helpful in illuminating our understanding of these themes and consequently the women's weight loss experience further. Although the majority of the models and theories such as behavioural learning theory, the health action model and the theories of reasoned action and planned behaviour added further insight to the themes of control and choice. The models of health action, knowledge, attitudes and behaviour and stages of change also enhanced our understanding of self-sabotage. Whereas the health belief and the knowledge attitude and behaviour models enhanced

our understanding of internal conflict as experienced by the women trying to lose weight in this study. The models and theories identified other aspects which were part of the women's weight loss experience such as food reinforcers identified by the behavioural learning theory. The health action model also identified issues such as triggers to action, relapse and self-belief.

However, the mindfulness theory was a little more useful in offering some insight into all the themes of self-sabotage, internal conflict, control and choice identified in the women's weight loss experience. The theory of mindfulness offers us a tool that is capable of looking beyond physiological factors to embrace a wider range of factors including social factors such as public consciousness, behavioural factors such as automatic behaviour and other factors such as non-focusing. This is because the theory of mindfulness incorporates the individuals's affective, cognitive and physiological aspects of themselves. This is potentially why mindfulness as a theory may be more helpful in explaining the data and the concept of connectedness than some of the other models and theories discussed in this thesis.

However, further research is needed in order to increase the explanatory power of mindfulness in the context of weight loss. Further research is also required into creating a model or theory that may more fully accommodate the themes of self-sabotage and internal conflict identified in this study, in relation to weight loss. Hence the discussion (see chapter five, pages 206 to 221) about the combination of educational theories and intuitive eating and mindfulness as both these theories have a strong resonance with the concept of connectedness to create a stronger structure to assist individuals in their weight loss quest.

Implications of this study

This study has produced a number of implications in a variety of arenas. This has included the field of practice and health education and also for possible future research.

Implications for the clinical and weight loss practice arena

It is anticipated that the new knowledge gained by this qualitative research will enable a more informed approach to be utilised by practitioners working to assist individuals to lose weight and also the individuals themselves who are seeking to lose weight. In this study the new concept of connection in relation to weight loss was discovered through the in-depth, qualitative longitudinal interviews with the respondents. The new knowledge gained from the data leads us to propose that being connected assists with weight loss and that disconnection appears to lead to no weight loss or even weight gain despite the individual desiring to lose weight.

Health promotion discourses around weight loss often focus on education and knowledge reflecting an assumption that armed with the correct knowledge and information about healthy eating, people will more easily lose weight. The results from this study, particularly in relation to the concept of connectedness, suggest that information alone is unlikely to be helpful unless for instance, it is accompanied by efforts to address the psychological and affective aspects linked to connectedness such as individuals' being aware of self-sabotaging thoughts and actions and internal conflict.

It has been previously discussed that a number of models and theories including the health action model and the health belief model may be usefully utilised to further explain and clarify the results found in this study including the concept of connection and the themes of self-sabotage, internal conflict, control and choice. Consequently, some of the models and theories discussed singly or in combination could therefore be implemented into a weight loss programme. However, such a multi-faceted issue (see chapter, one, pages 6 to 9) as weight loss requires a multi-dimensional approach as "one size does not fit all" (Truby *et al.,* 2006:1311, see chapter two, page 28). It would appear that currently the present strategies are not effective at halting the rise in obesity (Tsichlia & Johnstone, 2010 and Hitchcock-Noel & Pugh, 2002, see chapter one, page 18) with all the potential ramifications this brings to the individuals, their families and society as well. Therefore, other alternatives strategies and approaches may need further investigation.

It is proposed that potentially new and alternative ways of working may assist individuals in their weight loss quest. This may include incorporating the two theories of intuitive eating and mindfulness into weight loss strategies. This is not to disregard other potentially useful models such as the health action model and the health belief model but the discussion in this thesis is an opportunity to investigate other new ways of working which may potentially enhance an individual's ability to lose weight. In addition, other new ways of working may include reviewing what helps individuals to learn at a micro and meta level. For instance, how individuals reduce their intake of high fat foods and also how to consider their eating decisions in relation to their lifestyle. Other new ways may include how to enhance co-joined ways of working and to formulate new fused models of weight loss.

Although, a number of models and theories previously discussed have helped to clarify the women's experience of weight loss I propose to further investigate the two theories of intuitive eating (Tribole & Resch, 2003) and mindfulness (Grossman *et al.,* 2004) as they have been rarely used to help us to understand how to enhance weight loss, and so are worthy of further investigation.

Intuitive Eating

The theory of intuitive eating advocates that when individuals listen to their own bodies and eat intuitively and not in response to emotional or situational cues, they are less likely to be overweight (Avalos & Tylka, 2006; Tylka, 2006; Hawks *et al.,* 2004 and Schwartz, 1996). The benefits of intuitive eating have been shown to extend outwards. For instance, in one community based study with thirty chronic female dieters, intuitive eating resulted in significant health benefits, including, for example, an improvement in cholesterol and blood pressure levels for all the participants involved. These behavioural health benefits were still present at a two-year follow up (Bacon *et al*., 2005). However, there are many instances in today's society when individuals are discouraged from listening to their own body signals. This may include habits, family learning and socialisation. For instance, children eating foodstuffs that are not desired and when they are not hungry:

Participants vividly recalled the feelings of dislike, anger, resentment and

boredom which accompanied eating experiences in the family. Children often feel powerless in a situation where they are forced to eat foods (Lupton, 1996:55).

Children can also feel adults hold a high degree of authority over their food choices (Robinson, 2000) although this may be lessened if the children are older and receive pocket money (Blinkhorn *et al.*, 2003). An instance of how individuals may be discouraged from eating intuitively is when parents attempt to control their children's ability to innately balance their food intake. This can result in the beginnings of dietary restraint and weight gain. Such parental action also teaches the children to lessen their intuitive eating skills and respond more positively to external cues of when and what to eat (Birch *et al.*, 2003; Birch & Fisher, 2000 and Carper *et al.*, 2000). Such children are more likely to have a higher body mass than children whose parents have not imposed restrictions on their feeding styles (Faith *et al.*, 2004).

This inability of some individuals to hear what their body is telling them, whether they are hungry or sated has been termed "biological indifference" by Polivy and Herman (1987). In the zone of biological indifference, there are no clear hunger or satiety cues. "This zone is so wide for the chronic dieter that instead of eating based on internal eating cues, food thoughts and judgements prevail and tell the dieter what to do" (Tribole & Resch, 2003:68). Such dietary regulation and restrictions discourage the individual trying to lose weight from listening intuitively to cues about hunger or satiety.

This is evident from some of the quotes from the respondents who displayed both self-sabotage and internal conflict. For instance, Molly displays such indifference in the early stages of her weight loss process which has been termed disconnection in this thesis:

> Just try and eat healthily. After doing all the different diets you know what to eat and how to eat, what not to eat and when to eat and things like that. You know what to do, it's just doing it. I don't seem to be able to do it. It's just a craving for chocolate; it just creeps in. I absolutely eat too much and it just leads onto the next thing (Molly, second interview).

Molly states she knows what to eat whilst simultaneously acknowledging she self-sabotages with chocolate and is in conflict with herself. Molly consequently appears to be unconnected and does not display intuitive eating.

Two studies Tylka (2006) and Hawkes *et al*., (2004) have reviewed a tool to investigate the construct of intuitive eating; the so termed Intuitive Eating Scale (IES). Tylka (2006) suggests that the IES tool may be a useful clinical tool in a number of clinical arenas of intuitive eating including insight into how some women can follow their internal physiological hunger signals independent of environmental cues. Hawkes *et al.,* (2004) believes that the IES tool has value in measuring individuals' eating style. However, both studies advocate further research investigating the value and usefulness of the IES tool.

Mindfulness

There have been a number of research studies that have suggested there may be beneficial effects on individuals who have undertaken mindfulness training. The benefits included changing brain and immune functions in positive ways (Davidson *et al.,* 2003) and improving psoriasis (Kabat- Zinn *et al*., 1998). Grossman *et al.,* in their 2004 meta analysis study which investigated mindfulness based stress reduction in a structured group format concluded that mindfulness based stress reduction programmes could potentially help individuals to cope with a broad range of clinical and non-clinical problems. These conclusions were drawn from twenty studies out of sixty-four studies that were initially identified. Only twenty studies were deemed as having sufficient relevance or acceptable quality to be included in the meta analysis by Grossman et *al.,* (2004).

A prior study in 2003 by Brown & Ryan investigated the role of mindfulness in relation to its role in psychological well being. Brown & Ryan concluded that mindfulness is a characteristic that can be "reliably and validly measured" (2003:844) and that mindfulness has a definite role to play in the mental health arena. Brown & Ryan (2003) utilised the Mindfulness and Attention Awareness Scale (MAAS) to measure the construct of mindfulness in their study. Other measuring tools include the

Toronto Mindfulness Scale (Bishop *et al*., 2004); the Kentucky Inventory of Mindfulness Scale (KIMS) by Baer *et al.,* 2006 and the Freiburg Mindfulness Inventory (FMI) by Walach *et al.,* (2006). Although reportedly measuring the same construct, that of mindfulness, the different measuring tools have subtle differences. For instance, the MAAS tool, (Brown & Ryan, 2003) evaluates validity and sensitivity to change, however, the MAAS tool concentrates on attention and awareness and does not appear to concentrate equally on the other aspects of mindfulness such as being non judgemental and accepting. The TMS scale (Bishop *et al.,* 2004) measures mindfulness after meditation as a state like phenomenon. This scale is able to differentiate between the varying levels of meditation and individuals who have not meditated. The KIMS scale (Baer *et al.,* 2006) is largely applied to mindfulness in relation to Dialectical Behaviour Therapy (DBT) and was not tested on a broad population sample. This is unlike Walach *et al.,* (2006) (FMI), who deliberately tested their mindfulness (FMI) tool on a broader population including non-students. Although there are subtle nuances in these discussed mindfulness tools, such tools are useful in that they could potentially enable weight loss researchers to validate the efficacy of mindfulness for people trying to lose weight.

Despite the growth of mindfulness, as an approach to enhance awareness and reduce personal distress (Bishop *et al*., 2004) the mindfulness approach does have its detractors. For instance:

> Although there is some preliminary evidence that (MBSR) Mindfulness Based Stress Reduction may hold promise as an effective approach with applications in psychosomatic medicine and general psychiatry, there is a lot that we do not know about this treatment modality (Bishop, 2002:71).

Bishop's comments followed on from a review of the current literature available at that time, considering the construct of mindfulness and the effectiveness and action of mindfulness based stress reduction. Bishop (2002) acknowledges limitations in the approach of mindfulness and questions its operational definition and validation of the construct of mindfulness in the available literature. Although Bishop (2002) does acknowledge that further research is needed in this field. However, a number of studies have been identified that promote mindfulness in a number of settings, for

instance, in reducing stress, anxiety and dysphoria (Astin, 1997 and Shapiro *et al.*, 1998) and in psychological adaption when facing chronic pain (Kabat-Zinn, 1985). Furthermore, despite identifying potential weaknesses Bishop accepts that lack of evidence does not equate to lack of efficacy in the mindfulness approach.

Mindfulness and weight loss

When discussing mindfulness in relation to eating disorders there has been some limited research conducted in this arena, (Kristeller *et al.,* (2006) and Smith *et al.,* (2006). Kristeller & Hallett (1999) investigated the effectiveness of a six-week meditation based group attempting to reduce binge-eating episodes. The group consisted of eighteen obese women and during the group duration binge eating episodes and their severity reduced. Measures assessing depression and anxiety also showed reduction. Other studies such as Teasdale *et al.,* (2000); Teasdale *et al.,* (1995); Miller *et al.*, (1992) and Kabat-Zinn (1992) also reported similar findings. The women's sense of eating control, awareness of hunger and satiety cues all increased as did their sense of awareness.

Despite reporting changes in behaviour and perception, Kristeller & Hallett (1999) reported no overall weight loss for their participants. Agras *et al.*, (1995) also reported similar findings. However, both groups were of relatively short duration, six and twelve weeks' duration respectively. Experience and evidence suggests that weight loss often takes a considerable period of time, months rather than weeks. The findings are positive when considering the reduction of binge eating episodes, depression and anxiety and increasing awareness of hunger and satiety cues and a person's sense of mastery. Long-term aspects could enable women to achieve the weight loss they desire.

A later study by Smith *et al.*, (2006) investigated the effects of mindfulness training on binge eating. Similar findings as the previous study by Kristeller & Hallett (1999) were reproduced including increased self-acceptance and mindfulness. Anxiety states were reduced and a significant reduction in depressive symptoms were recorded and also a small to moderate decrease in binge eating episodes. The positive responses

that were obtained may potentially lead to the conclusion that mindfulness as a theory may be applied with validity in the field of weight loss.

Connectedness appears to reduce self-sabotage and internal conflict so therefore people wishing to lose weight could be taught a "mindfulness" technique similar to that proposed by Kristeller *et al.,* (2006) and Smith *et al*., (2006) which appears to enhance connectedness. Mindfulness based approaches encourage individuals to observe their emotions more clearly and encourage individuals to disengage from automatic thoughts and actions to situations and feelings. When applying this to the field of weight loss this may be very helpful for the individual. If an automatic response to stress or anger for instance, is to eat to escape from the emotion, termed eating in response to a negative stimuli (Nguyen-Rodrguez *et al.,* 2009), being able to observe the emotion in a clear and mindful way without responding automatically (eating) may enable weight loss to become less of an onerous experience for the individual attempting to lose weight:

> Mindfulness may be important in disengaging individuals from automatic thoughts, habits and unhealthy behaviour patterns and thus could play a keynote in fostering informed and self-endorsed behavioural regulation (Brown & Ryan, 2003:823).

There is little evidence that the theory of mindfulness has been directly applied in the field of weight loss. Hence whilst discussing the theory of mindfulness I have attempted to co-join the supporting literature in relation to eating disorders to weight loss. The applicability of such findings would appear to be limited in the traditional weight loss arena.

Consequently, if a mindfulness approach and the application of intuitive eating is to be incorporated into educational interventions then it may be presumed that practitioners advocating such an approach would need to be both trained in these new concepts and techniques and also practise intuitive eating and mindfulness themselves.

Currently, intuitive eating and mindfulness in relation to eating is not taught in any country to a significant extent. Therefore, such a change in health promotion

education strategy would need significant input of commitment and financial resources. It also has to be acknowledged that the training of intuitive eating and mindfulness may not be an overall panacea because even if individuals are taught intuitive eating and mindfulness techniques and strategies there is no guarantee that they will use them. For instance, individuals may choose to respond to environmental cues to eat. An example may be eating at a family meal when physiologically the individual has not received any hunger signals. Another instance may be automatically eating in response to emotion rather than being mindful. Both of these responses demonstrate individuals overriding intuitive eating and mindfulness despite potential training and practice. However, it is anticipated that if individuals are taught intuitive eating and mindfulness strategies that this would reduce these types of responses to environmental and emotional cues.

Another issue to consider is that in today's research arena large, randomised, controlled trials are valued above smaller qualitative studies particularly in the findings arena (see chapter two, page 19). The findings from small studies such as the one discussed in this thesis are less likely to be acted upon. Therefore, it is less likely that the national health service and primary care trusts will advocate such changes considering the financial and time resources it would involve. Therefore, further research in this arena may be required to validate the effectiveness of such interventions.

Implications for health promotion and health education strategies

The results from this study appear to show that being connected enhances weight loss and conversely that being disconnected and exhibiting instances of self-sabotage and internal conflict appears to lead to no weight being lost or even weight gain. Code Red, Louisa, Lucy, Kate, and Peggy demonstrated this clearly throughout the study. It would appear that these individuals did not learn from their weight loss endeavours or reflect constructively on their actions. Hence, health promotion and health educational strategies that enhance an individual's ability to evaluate and reflect on their experiences may be useful in an individual's pursuit of weight loss. In the educational arena, this has been termed experiential (Kolb, 1984) and reflective (Schon, 1987) learning.

Experiential learning has the premise first postulated by Vyotsky that "learning from experience is the process whereby human development occurs" (Kolb, 1984:xi). Experiential learning incorporates a number of facets including adaptation to the world and re-learning. Experiential learning offers individuals the opportunity to learn from experience, adapt accordingly and enhance their knowledge base.

Experiential learning is about individuals gaining knowledge from their prior experience. "Learning is a continuous process grounded in experience" (Kolb, 1984:27). The individuals who appear to learn from their experiences have been termed as self-connected in this study. They are connected and adapt in response to their experience. This would include some women in this study such as Beth and Molly who from experiences gained during their weight loss journey learned what their dietary intake needs to be in order to lose weight (see chapter four, pages 151, 152 and 171). Therefore, experiential learning could potentially be applied to the field of weight loss, both to help individuals to lose weight and also the practitioners assisting individuals to lose weight.

However, it would appear that some respondents did not appear to learn from their weight loss experience, the respondents' non-learning in this study has been termed as being disconnected. Such non-learning in these individuals is in contrast to what the theory of experiential learning espouses, that individuals can learn and relearn. "We are the learning species, and our survival depends on our ability to adapt" (Kolb, 1984:1). Yet, this connection does not appear to happen in some of the respondents in this study such as Code Red, Louisa, Lucy, Kate and Peggy.

Kolb defines learning as:

> The creation of knowledge and meaning, occurs through the active extension and grounding of ideas and experiences in the external world and though internal reflection about the attributes of these experiences and ideas (1984:52).

However, this could not be applied to some of the women in the study such as Code Red and Louisa as they did not appear to learn from their past experience. The non-learners were therefore not connected and did not act in a mindful way. Consequently,

this appears to lead to disconnection and non-weight loss. For instance, the actions of Code Red and Louisa that defeated their intended aims of weight loss were often repeated (see chapter four, pages 127 to 130). The theory of experiential learning proposes that learning is a process of human interaction with others and their surrounding cultural environment and that such interaction shapes experience and personal knowledge (Kolb, 1984). The respondents who did not lose weight appeared not to learn from their past experiences although it is difficult to ascertain why certain individuals did not learn from their prior experiences. However, their key to non-learning may be their disconnection. Consequently, if these individuals could be reconnected they may be able to re-learn and achieve their weight loss goals. For instance, in order to lose weight individuals may need to learn more about themselves and how their social and physical environment affects their eating decisions. This could be termed connected or being mindful in the language of this thesis. The theory of experiential learning discussed integrated knowing (knowing one's self) and centering (dwelling within one's self). This concept of learning also considers:

> Only by personal commitment to the here and now of one's life situation, fully accepting one's past and taking choiceful responsibility for one's future, is…learning experienced (Kolb, 1984: 230).

In relation to weight loss, this may involve the individual considering their weight history, reviewing what strategies or cues helped or hindered them in their weight loss previously and deciding what their present goal is and how they will achieve that.

In relation to health education, it would appear that part of the role of the health educator whether delivering the weight loss programme or when formulating the programme may be to build into the programme the opportunity for the weight loss participants to become more connected through a process of experiential learning. For instance, this may include incorporating opportunities whether in one to one or group situations for individuals to reason through or discuss their previous weight history and what their present aims are. This involves an aspect of self-learning for the individual and being responsible for themselves. This opportunity may be taught or facilitated by the health educator but such an arena allows the individuals to grow and

learn from their previous experiences and gain from their surrounding culture such as a weight loss support group.

The second learning theory to consider is reflective learning theory (Schon, 1987). In essence, this theory considers that learners are not passive and that they are insightful and thus make sense of their experience. Dewey discussed reflection in relation to teaching but it can equally be applied to weight loss intentions. Reflective thinking is important as "it enables us to know what we are about when we act. It converts action that is merely appetitive, blind and impulsive into intelligent action" (Dewey, 1964:211). In the context of weight loss if individuals were able to reflect about their life experiences, it is proposed that they could learn and act with purpose instead of acting mindlessly and in a state of blindness. It would for instance, reduce repetitive actions termed "automatic" by Brown & Ryan (2003, see chapter four, page 213). Therefore, reflection may enhance an individual to be more self-aware and act in a mindful way. For instance, an automatic response for some of the respondents discussed in this thesis was to eat in response to loneliness (see chapter four, page 151, Molly's first transcript and chapter five, pages 189 and 193, Louisa's first transcript).

Therefore, the ability to be reflective may be very useful to individuals wishing to lose weight and to practitioners working with individuals wishing to lose weight. However, the concept of reflection has two aspects, which need to be debated in relation to weight loss. Reflection is about questioning and practising investigation (Symth, 1992) and through framing and reframing (Dewey, 1933 and Schon, 1983, 1987) reflection may influence future action. This concept of distancing oneself from reality whilst still engaged in action may at first seem at variance to the concept of being connected and being mindful. However, Schon suggests we can not only "think about doing something but that we can think about something while doing it" (Schon, 1983:54). Such phrases as "thinking on your feet" and "keeping your wits about you" (van Manen, 1995) would support this proposition. However, van Manen (1991, 1992) also discusses how difficult reflection in action may be to achieve. For instance, how reflective could an individual be whilst trying to decide what to eat?

van Manen discusses another aspect of reflection, anticipatory reflection:

Anticipatory reflection allows us to deliberate possible alternatives, decide on courses of action, plan the kind of things we need to do, and anticipate the experiences, we and others may have as a result of expected events or our planned actions (1991:101)

It appears that some of the individuals discussed in this thesis may already be participating in a form of anticipatory reflection although it has been termed connection in this thesis. For instance, Pat plans to eat differently than before to lose weight and Karen decides to avoid social occasions to lose weight. Both of these individuals are utilising reflection pre their weight loss attempts and knowledge of their past experiences to guide their weight loss efforts.

When considered in relation to mindfulness it may be difficult for individuals to initially achieve reflection as a tool. However, repeatedly practising reflection may make it a more useful and easier tool for the practitioner and individual to utilise. "Effective, reflective practice…is a powerful way of informing practice as it makes the tacit explicit, meaningful and useful" (Loughran, 2002:38). Reflection may also be useful for the educator, health promoter or clinician to use when creating, or delivering weight loss programmes. Self-questioning of practice (Ulrich, 2000) may be useful to utilise in order to assess the value of what is currently being offered. For instance, a practitioner may reflect on what it is specifically about the programme or their actions, which help individuals to lose the weight they desire. In addition, reflection may be a useful tool for the individuals in relation to their decisions about for instance, their dietary intake, eating decisions and lifestyle changes such as increasing activity levels.

Reflection would appear to be a skill that has been practiced by some of the individuals discussed in this thesis. It would appear that the individuals who practised reflection, lost weight and appeared to be connected. However, other individuals who did not lose weight, did not appear to be connected or to practice reflection. Hence, reflection would appear to be a skill that may be useful in assisting individuals to lose weight although it does not appear to be a universal skill.

Therefore, some individuals undergoing weight loss attempts and health educators may be better skilled than others but discussing reflection and opportunities to reflect both individually and in-group settings may assist in the skill generation of reflection. Supporting an individual's reflection progress may be a challenge (Daloz, 1986) but beneficial to the individual trying to learn more about themselves and to the health educator trying to improve their practice. The theories of experiential learning and reflection it appears may therefore potentially be usefully applied by health educators when formulating and delivering programmes to individuals and by the individuals who are attempting to lose weight.

In the light of these considerations one strategy that may enhance weight loss interventions considering the results from this study, may include the use of inter-disciplinary working as no one discipline is going to solve the issue of weight gain and assist individuals to lose weight as after all, obesity by its very nature is multifaceted (see chapter one, pages 6 to 9). Although inter-professional working and education has been advocated by prime movers such as the World Health Organisation (1978) "Health for all by the year 2000", such partnerships in the United Kingdom are potentially being threatened by government directives for proven and sustainable cost efficiency and effectiveness (Oandasan & Reeves, 2005).

Consequently, such combined working may involve a fusion of new models for health education and promotion to enhance weight loss. It would also include utilising the theories of experiential and reflective learning theory in combination with potentially the concepts of connectedness and the related concepts of self-sabotage, internal conflict, control and choice.

Therefore, a new model or type of models has the potential to be used in the field of weight loss. This would include a synergistic fusion of educators and clinicians combining together in an inter-disciplinary approach utilising the most appropriate educational models some of which have already been discussed (see chapter two, pages 54 to 63). By combining the learning theories of experiential learning and reflective practice and the approaches of mindfulness and intuitive eating hopefully, this would enhance connection and reduce self-sabotaging actions and internal conflict. As it appears from the results of this study that increased connection and

decreased self-sabotage and internal conflict leads to weight loss, which was the aim of all the respondents in this study.

Implications for future research

This research study has suggested possible areas of future research. These broadly include investigating the arena of self-connectedness, investigating the techniques to enhance such connection and investigating the effectiveness of these techniques:

- Investigating the concept of connection further in relation to weight loss. For instance, investigating what factors increase individuals' levels of being connected as being connected appears to enhance weight loss.
- Investigating the concept of connection further with individuals who have successfully lost weight as successful weight loss would appear to support the concept that weight loss individuals were connected.
- Investigating tools to enhance individuals' insight into themselves and their decisions around food and weight as this additional insight or connectedness appears to lead to weight loss.
- The usefulness of the Intuitive Eating Scale merits further investigation in relation to women's insight of physiological hunger signals and environmental cues (Tylka, 2006 and Hawkes *et al.,* 2004).
- Further investigating the usefulness of such tools as the Mindfulness and Attention Awareness Scale (MAAS), Toronto Mindfulness Scale (TMS), the Kentucky Inventory of Mindfulness Scale (KIMS) and the Freiburg Mindfulness Inventory (FMI) to validate the theory of mindfulness in relation to weight loss.
- Further investigation of obstacles that reduce the likelihood of individuals achieving their desired weight loss. For instance, self-sabotage and internal conflicts were clearly identified in this study as inhibitors to individuals achieving the weight loss they desired.
- Investigating or formulating a research model that accommodates the newly identified themes of self-sabotage and internal conflict that would appear to inhibit an individual's ability to lose weight.

- Further studies may be needed into the efficacy of mindfulness and intuitive eating as strategies to promote weight loss.
- Creating or investigating future health promotion models, which may be usefully utilised, to assist with health behavioural change such as desired weight loss.

Deciding the priority of this future research may well depend upon a number of factors including ethical considerations. However, possibly the greatest challenge to clinicians, researchers, legislators and health care trusts may be firstly, how to fund such research as the present political environment favours large, randomised controlled trials. Secondly, how to fund the interventions needed to combat the increasing incidence of weight gain. However, bearing in mind the potentially damaging social, physical and psychological consequences that the individuals' weight status implies for the individual, their family and the community, such research and interventions are vital to reduce the sustained increase in weight gain in the United Kingdom and the majority of other countries worldwide.

Contribution of research

This qualitative study has contributed to the field of research in a number of ways including methodological and theoretical contributions. Following an exhaustive literature review, a number of deficits of knowledge were evident about the individuals' experience of trying to lose weight. This included the fact that very few studies were British or based in the community setting. A qualitative and longitudinal approach to investigate the experience of weight and intentional weight loss was also infrequently used.

It was anticipated that utilising a qualitative and longitudinal approach would serve to provide valuable and informative data about individuals' weight loss experience and improve on the methodological limitations that had been previously identified in the weight loss arena. It had also been previously identified that there were a substantial number of studies about the causes and present statistics of obesity so therefore I did not seek to repeat these types of studies and consequently add more data in the areas

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with a high level of knowledge already. Therefore, I designed this study to attempt to fill some of these identified deficits in this arena.

All the qualitative and longitudinal data collected in this study was analysed by the Hycner (1985) data analysis framework. This framework has been discussed previously in this thesis (see chapter three, pages 79 to 85). Although this framework has been used in a number of potentially emotive studies before such as Gallagher & Jasper (2003) and Whitman *et al.,* (2000) the framework does not appear to have been utilised in any weight related studies previously. In using the Hycner (1985) data analysis framework, albeit in an adapted form to analyse the longitudinal data in this study, a greater exploration of women's weight loss experience was facilitated. This exploration has offered insights in relation to "connectedness".

The previous studies such as Bidgood & Buckroyd (2005); Goodspeed Grant & Boersma (2005); Hurd Clarke (2002); Barker & Cooke (1992) and Johnson (1990) had identified a number of themes in the arena of weight and intentional weight loss. I therefore also designed this study to enable this area of an individual's life to be further explored with a view to possibly producing themes that are more pertinent or consolidating the existing established themes. The established themes included feelings around food, self-beliefs, self-blame and the dichotomy of self-control and lack of control. In this study, all of the themes previously identified in the other studies were also identified but the theoretical contribution this study brings to the research arena is the new concept of connectedness. Connectedness does link to some of the previous identified themes but also to the two new themes of self-sabotage and internal conflict, which were identified. A deeper level of understanding was also gained about the themes of control and choice.

This combination of a novel methodological approach in exploring individuals' weight loss experiences, the new conceptual knowledge gained about connectedness, and the themes of self-sabotage and internal conflict establish the value of this study within the research setting as a valuable addition to the knowledge base about individuals' weight loss. Also by investigating a number of models and theories in order to further explore and expand on the concept of connectedness and the four identified themes of self-sabotage, internal conflict, control and choice identified in

this study, the boundaries of knowledge about women's intentional weight loss has been further explored and enhanced. Consequently, this small, women only, qualitative study has produced increased data about women's longer-term experience of trying to lose weight in a British community setting where previously such information was limited.

Reflection on methods utilised

When reflecting on the methods utilised in this study a number of strategies proved very useful and appropriate for a research study of this nature. These strategies included piloting the interviews prior to their use with the respondents. This ensured that any teething difficulties could be amended prior to their use with the respondents. The benefits of piloting these interviews has also been discussed in chapter three, page 95.

The use of semi-structured interviews ensured that a significant amount of data about the phenomenon being investigated, the individual's experience of weight loss, was obtained from the respondents during the course of the study. The strengths of semi-structured interviews have been discussed in chapter three, pages 72 to 74.

Utilising the Hycner (1985) data analysis framework ensured that the significant amount of qualitative and often emotive data collected from the respondents over the year long duration of the study was effectively handled and analysed. This ensured that from the data, the commonalities and uniqueness of the themes were correctly identified. Although the Hycner (1985) data analysis framework has been little used in the weight loss arena, its use proved very effective in this study. The strengths of the Hycner (1985) framework has also been discussed in chapter three, pages 79 to 85.

Part of the reason for obtaining the data over the duration of a year and utilising a longitudinal approach was to ensure that a research relationship could be established and built upon. This hopefully permitted the respondents to reveal a significant amount of the phenomenon being investigated, the individuals' experience of weight

loss and also feel supported whilst revealing their feelings. Interviewing the respondents over a year also ensured that the respondents had the opportunity to add or amend what they had previously said in other interviews and add content and layers to their previous comments. This has been previously discussed in chapter three, pages 76 to 79.

Although the strategies I employed minimise potential limitations to some extent, some limitations inevitably existed within the study: small sample size, female only sample, sole researcher issues, collecting socio-demographic data in the interview, overly stretched recruitment campaign, missing self-reported data for height, lack of a follow up at the end of the study and also a potential Hawthorne effect. I will discuss each of these limitations in turn.

Although a sample size of ten respondents is not unrespectable in qualitative research, including more people in the sample could strengthen this study. In future research I would attempt to increase the sample size by for instance, approaching individuals who may have access to individuals trying to lose weight such as health professionals and advertising in commercial weight loss journals.

Despite non-gender specific advertising, I obtained only female respondents. It has been identified before that more women than men participate in community studies (Cioffi, 2002, see chapter three, page 88). Therefore, I proceeded with only female respondents. If I was to repeat the study again, I would for instance, consider advertising in arenas where men are likely to be such as in working environments which tend to be more male dominated and advertise in commercial literature aimed at the male market in order to increase the chances of recruiting more men into the research study.

Another potential limitation in this study was that I was the only researcher. Hence, there were potential issues including researcher and subject bias. I endeavoured to ensure that this was not an issue by ensuring that I wrote up my methodology clearly and used a valid data analysis tool. These issues have also been discussed in chapter three, pages 94 and 95.

In a future research project I would conduct the socio-demographic data collection separately from the qualitative interview. This is because it is possible that the socio-demographic data collection affected the respondents' initial responses in the first interview as some of the respondents were a little hesitant to discuss how they felt at this stage. This did not appear to be the case in the later stages of the first interview and subsequent interviews. However, it has to be acknowledged that it may simply and understandly be that the respondents were a little nervous as it was their first interview and that their discomfort reduced later in the first interview and in the subsequent interviews as the research relationship grew.

In order to recruit my participants I initially contacted two well-known commercial organisations and asked if I could recruit participants on their premises. Although I contacted each organisation twice, they declined to take part. No reason for declining was given. On reflection, this is not a strategy I would employ again unless I was specifically contacted by these organisations. I also used a poster campaign, which was in place for over three months and only obtained two respondents. As there was so little response, I advertised in the local newspaper, which covered the defined geographical region. I advertised in this newspaper for a fortnight and obtained seven respondents and one further respondent from snowballing. Recruitment has also been discussed in chapter three, pages 105 and 106. Consequently, it took over four months to obtain these respondents. In future if I was undertaking such community based research again I would implement a joint advertising strategy such as the use of posters and newspaper advertisements to ensure all spheres of society were aware of the research study but also with the anticipation that respondent recruitment would not take so long.

In order to enhance the visual picture of the respondents for the readers I would ask the respondents at the beginning of the study for their self-reported height. I would then calculate their body mass index (see appendix 1) at each interview. I would also give the respondents this information about themselves, if they desired it. Having such information could be useful for a number of readers and the respondents.

Upon reflection I would have contacted (if able) the respondents one year from the final interview. This would have been in the form of a telephone contact asking how the respondents were, obtaining a history of their weight loss journey over the last

year, thanking them for their support and also giving them an update on the present stage of the research study.

Finally, on reflection it is possible that participating in the research study may have affected the weight loss outcomes or experience of the respondents. However, it is difficult to quantify as none of the respondents directly said to me that being part of the study affected their weight loss outcomes or experience although, some of the respondents said they looked forward to seeing me. However, it may be anticipated that the presence of a researcher (Hawthorne effect) may alter the situation. This may be due to the participant wishing to avoid, impress, direct, deny, influence or be influenced by the researcher (Cornell, 1984, public and private accounts). Exactly how my presence influenced the participants' behaviour or weight loss experience is difficult to assess with any confidence. However, it must be noted that participants in the study both lost and gained weight, suggesting an influence in one direction was unlikely or remote.

Personal reflections on the PhD/research journey

On a professional basis I feel undertaking the PhD journey has opened doors for me, none of which I originally anticipated. My original reason for undertaking this PhD was to find out about individuals' experiences' about weight loss. I anticipated that this new knowledge would assist me in my work with individuals who were trying to change their weight status. I learned a great deal from the process of conducting this research and the results gained I believe will inform my future practice working with individuals who are trying to lose weight. By being more aware of the concept of connectedness and how it influences individuals, I will endeavour to address this concept with the individuals I am working with.

There is a different emphasis I believe in being a researcher working with individuals and being a health clinician working with patients. As a health visitor, I have certain expectations about my patients, but my patients I believe have expectations about me. For instance that I will be professional and competent in my role. Therefore, there are similarities between being a health practitioner and a researcher. In some ways, I tried

to separate my role between health visitor and researcher in a mental and a physical way. For instance, I set aside holiday time to interview respondents so that I was in a research mode, rather than mixing research interviews with health visiting patient contacts. This was also ethical as I was conducting my research in my own time and not being supported by the trust. This action allowed a physical and mental separation between the two roles. I feel this was useful as the roles of researcher and health visitor are different, although every encounter with an individual is going to be multi-faceted. One example of the roles being different is that every encounter as a health visitor usually has a purpose because the patient expects a solution or resolution to be completed by the health visitor. Whereas in the research encounters the time together appeared to be less driven and as a researcher you are empowered to be more open (as is the respondent) with no finite solution being demanded from the researcher by the respondent.

For this type of research, I feel there were a number of advantages of the research being conducted by a health visitor. This included the fact that health visitors are used to working with individual women in their own homes and empowering them to speak and hearing their voice, which is important in a qualitative, longitudinal study of this nature. This may also be a disadvantage because by being so used to working with women in their own homes as a health visitor it could be potentially easy to slip into the health visiting role when conducting research. However, by being open to such potential, I was able to remain research focused and although all the women knew I worked for a local primary care trust, I did not elaborate on my health visiting role. Also, none of the respondents asked about my occupation. Above all, I hoped that I showed to all the respondents that I was interested in them and in hearing about their own unique experiences of trying to lose weight regardless of what my background was.

At the beginning of this PhD journey, I will admit to being naïve about the PhD process and the potential ramifications such an undertaking would produce. I feel that professional doors have been opened to me that previously were closed or did not exist including potentially undertaking further research in this field or related areas and also the clinical application of the knowledge gained and potential input into

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future programmes being developed in the weight loss field and the health promotion arena.

Conclusion

This community based British qualitative study exploring women's experiences of weight loss intended to fill the identified existing research gaps. In this endeavour, this study has succeeded in significantly increasing our qualitative knowledge base about women in Britain undertaking a weight loss process based in the community using a qualitative and longitudinal methodology.

From the qualitative data a new concept of connection in relation to women undergoing weight loss has been identified and explored in relation to what it means and how the concept of connection affects women trying to lose weight.

Four further themes were identified, self-sabotage, internal conflict, control and choice. Although the themes of control and choice have been previously identified in other weight studies, it would appear that enhanced knowledge about them has been gained. It would also appear that in relation to the women's experiences of weight loss, self-sabotage and internal conflict are new themes that have been identified in this study.

The new and enhanced information gained from this study about the experience of weight loss would appear to necessitate a new approach or way of working to take into account this new information gained. Therefore, it is suggested that a potential fusion of educational theories such as experiential learning and reflective practice with a range of theories including those of intuitive eating and mindfulness may enhance the effectiveness of weight loss programmes. It is anticipated that this approach would acknowledge that insight appears to be a factor in weight loss.

However, it is acknowledged that incorporating other health education models such as the health action model into weight loss initiatives may also be beneficial. In addition, in the future weight loss programmes need to be more tailored to fit the individual to maximise each individual's opportunity to lose the weight they desire.

The negative impact of obesity and the difficulties encountered by individuals trying to lose weight has been clearly expressed by the respondents in this study. It is anticipated that the enhanced knowledge gained from this study will help to inform clinical practitioners, health educators, health promotion interventions and the individuals themselves in future weight loss endeavours.

APPENDIX 1: BODY MASS INDEX

Body Mass Index

Body mass index is measured by dividing a person's weight by the square of their height. The calculation produces a figure that can be compared to various thresholds that define whether a person is overweight or obese. For adults these thresholds are:

BMI below 18.5   Underweight

BMI between 18.5 and 25   Healthy weight

BMI between 25 and 30   Overweight

BMI between 30 and 40   Obese

BMI over 40   Morbidly obese

(Healthy Weight, Healthy Lives, 2008)

APPENDIX 2: HYCNER (1985) DATA ANALYSIS FRAMEWORK

Hycner's method of data analysis has fifteen stages. These include:

1. Verbatim description
2. Bracketing and phenomenological reduction
3. Listening to the interview, for a sense of the whole
4. Delineating units of general meaning
5. Delineating units of meaning relevant to the research question
6. Training independent judges to verify the units of general meaning
7. Eliminating redundancies
8. Clustering units of relevant meaning
9. Determining themes from clusters of meaning
10. Writing a summary from each individual interview
11. Return to the participant with the summary and themes
12. Modifying themes and summary
13. Identifying general and unique themes for each interview
14. Contextualisation of themes
15. Composite summary

(Hycner, (1985) Data Analysis Framework)

APPENDIX 3: SEMI-STRUCTURED BASELINE INTERVIEW

Thank you for agreeing to this interview today. As you are aware I am looking into the issue of weight and weight loss and I am very interested to know what you feel, believe and think about this issue.

I would like to reassure you that this interview is confidential and that your anonymity will be ensured.

Discuss consent form and sign if not previously completed.

Socio-Demographic Data.

Full Name:

Date of Birth:

Address:

Home Telephone or Contact Number:

Occupation:

Family details such as structure:

How did you find out about this research study?

Aim of taking part in this research study?

May I ask what is your present weight and height?

What is your life history in relation to your weight?

I understand that you have decided to lose some weight. Could you explain to me what factors have led to your decision to try to lose some weight?

What is your present weight loss goal?

How will you measure your progress?

What do you feel about the process of losing weight?

How do you feel about your weight at the moment?

What do you feel about your previous or past experiences of trying to lose weight? If there were any?

What aids/strategy have you chosen to help you lose weight?

How do you believe or perceive the strategy you have chosen to lose weight will affect your life?

What or whom do you feel or believe will help you in your weight loss process and why do you think that?

What or whom do you feel or believe may hamper or hinder you in your weight loss process and why do you think that?

Thank you very much. I look forward to seeing you in about twelve weeks time when it is convenient with you. I will show you the transcript of this interview at that time and discuss what has happened in the three-month period.

APPENDIX 4: SECOND SEMI-STRUCTURED INTERVIEW

Thank you for agreeing to this interview today. It is very nice to see you again.

As you are aware, I am looking into the issue of weight and weight loss and I am very interested to know what you feel, believe and think about this issue.

I would like to reassure you that this interview is confidential and that your anonymity will be ensured.

As you have had the opportunity to look at the transcript of your previous interview, are there any areas you would like to address or discuss?

Are there any areas you would like to clarify?

How do you feel about the last twelve weeks, about yourself and in relation to your weight?

May I ask what is your present weight?

How do you feel about yourself and/or your weight at the moment?

How has the experience of trying to/achieving/not achieving weight loss affected you?

How do you feel about this whole process of trying to lose weight?

What strategies, tools or measurements have you used to elicit your weight change and to measure your weight change?

Has your chosen style of trying to lose weight affected your life?

What or whom has helped you in the last twelve weeks?

What or whom has hindered you in the last twelve weeks?

Is there anything else you would like to share with me about your weight change process over the last twelve weeks?

Is there anything else you would like to share or discuss with me?

Thank you very much. I look forward to seeing you in about twelve weeks time when it is convenient with you. I will show you the transcript of this interview at that time and discuss what has happened in the three month period.

APPENDIX 5: THIRD SEMI-STRUCTURED INTERVIEW

Thank you for agreeing to this interview today. It is very nice to see you again.

As you are aware I am looking into the issue of weight and weight loss and I am very interested to know what you feel, believe and think about this issue.

I would like to reassure you that this interview is confidential and that your anonymity will be ensured.

As you have had the opportunity to look at the transcript of your previous interview are there any areas you would like to address or discuss?

Could you clarify…?

How do you feel about the last twelve weeks, about yourself and in relation to your weight?

May I ask what is your present weight?

How do you feel about yourself and/or your weight at the moment?

How has the experience of trying to/achieving/not achieving weight loss affected you?

How do you feel about this whole process of trying to lose weight?

What strategies, tools or measurements have you used to elicit your weight change and to measure your weight change?

Has your chosen style of trying to lose weight affected your life?

What or whom has hindered you in the last twelve weeks?

What or whom has helped you in the last twelve weeks?

Is there anything else you would like to share with me about your weight change process over the last twelve weeks?

Is there anything else you would like to share or discuss with me?

Thank you very much. I look forward to seeing you again in six months time when it is convenient with you. I will show you the transcript of this interview at that time and discuss what has happened in the last six months.

APPENDIX 6: FOURTH SEMI-STRUCTURED INTERVIEW

Thank you for agreeing to this interview today, our last interview of the year. It is very nice to see you again.

As you are aware, I am looking into the issue of weight and weight loss and I am very interested to know what you feel, believe and think about this issue.

I would like to reassure you that this interview is confidential and that your anonymity will be ensured.

As you have had the opportunity to look at the transcript of your previous interview, are there any areas you would like to address or discuss?

Could you clarify…?

How do feel about the last six months, about yourself and in relation to your weight?

How do you feel about the last year, about yourself and in relation to your weight?

May I ask what is your present weight?

How do you feel about yourself and/or your weight at the moment?

How has the experience of trying to/achieving/not achieving weight loss affected you?

How do you feel about this whole process of trying to lose weight?

What strategies, tools or measurements have you used to elicit your weight change and to measure your weight change?

Has your chosen style of trying to lose weight affected your life?

What or whom has hindered you in the last six months?

What or whom has hindered you in the last year?

What or whom has helped you in the last six months?

What or whom has helped you in the last year?

What were the main reasons or beliefs as to why you started trying to lose weight?

Over the last year, what feelings or beliefs have motivated you to continue trying to lose weight?

Is there anything else you would like to share with me about your weight change process over the last six months?

On reflection, is there anything else you would like to share with me about your weight change process over the last year?

Is there anything else you would like to share or discuss with me?

Thank you very much indeed for your support and time over the last year. I will send you a copy of the transcript and you can feedback to me any points you wish to clarify. I will ensure you receive a written copy of the thesis in the future.

APPENDIX 7: COVERING LETTER

Dear Sir or Madam,

      I am approaching all managers of libraries, post offices and supermarkets across the region to ask if they will display this enclosed poster for approximately eight to twelve weeks. If there is a small charge for this please inform me and I will respond appropriately.

It is an advertisement for a community-based piece of research. The focus of this research is to investigate how individuals experience the process of trying to lose weight.

I would like to interview a number of individuals about; their experience of trying to lose weight and what they think, feel and believe about the weight loss process.

My name is Teresa Burdett and I am currently undertaking research for a PhD in Education at the University of Southampton. I am also a nurse and health visitor working in Dorset.

My supervisor at Southampton University is Dr Jane Seale, who can be contacted at any time with queries relating to this dissertation. Dr Seale's contact details are:
The School of Education
Southampton University
Highfield
Southampton SO17 1BJ
Email: J.K.Seale@soton.ac.uk

Please feel free to make as many photocopies to display, as you require. I would also like to say that your staff members are welcome to be involved in the research.

I would be grateful if you would display this poster in your premises, as it will ensure that the individuals in your area have the opportunity to see the poster and take part in the research if they wish to.

Yours faithfully,

ARE YOU CURRENTLY TRYING OR ABOUT TO ATTEMPT TO LOSE WEIGHT?

If you are over 18 and willing to talk to a researcher about how you feel and your experiences about trying to lose weight.

Please contact:

Teresa Burdett

PO BOX 6179
POOLE
BH14 0AS

Or Telephone Teresa on: 07910886745

APPENDIX 9: ECHO ADVERTISEMENT

ARE YOU CURRENTLY TRYING OR ABOUT TO ATTEMPT TO LOSE WEIGHT?

If you are over 18 and willing to talk to a researcher about how you feel and your experiences about trying to lose weight, please contact

Teresa Burdett, Po Box 6179, Poole BH14 OAS

Or telephone 07910 886 745

APPENDIX 10: INFORMATION LETTER

Individual's experiences of trying to lose weight

My name is Teresa Burdett. I am currently undertaking research for a PhD in Education at the University of Southampton. I am also a nurse and health visitor working in Dorset.

The focus of this research is to investigate how individuals experience the process of trying to lose weight.

I would like to interview a number of individuals about:
- Their experience of trying to lose weight.
- What they think, feel and believe about the process of weight loss.

The interview will take about an hour and will take place in the individual's home or in a mutually convenient place.

The interview will be tape-recorded (with permission from each participant). The interviews will commence approximately this month and it is anticipated the participants will be re-interviewed in three and six months time and finally in a year from now.

To be eligible to take part you need to be:
- Over 18.
- Have recently started (in the last month) or are about to start trying to lose weight.
- Consider yourself to be overweight, i.e. at least three stone over your ideal weight.
- A resident in the Dorset and West Hampshire area and planning to stay here for approximately the next year.

However, you are not eligible to take part in this study if you are
- Under 18.
- If you are actively undergoing medical treatment for weight loss such as surgery.

- If you have been diagnosed or are receiving treatment for an eating disorder.
- If you have been diagnosed or are receiving treatment for depression or other mental health conditions.

Participants are free to withdraw from this study at any time and do not need to answer all the questions asked. Although this is a student research project I hope it will provide valuable information about the unique experiences individuals' experience when trying to lose weight. This project will be available for inspection following its completion.

Participant's names or those people they refer to; will not be identified in the research. Transcripts for the interview will be passed on to the participants for discussion and validation.

My supervisor at Southampton University is Dr. Jane Seale, who can be contacted at any time with queries relating to this dissertation. Dr. Seale's contact details are:

The School of Education
Southampton University
Highfield
Southampton
SO17 1BJ
Email: J.K.Seale@soton.ac.uk

If you are interested please return this including your contact details using the enclosed self-addressed envelope.

Please delete as appropriate:
I am/am not willing to take part in this study about the experiences of trying to lose weight.
Send to Teresa Burdett.

Name:

Address:

Contact telephone number:

APPENDIX 11: PARTICIPANTS CONSENT FORM

RESEARCH CONSENT FORM

Name of researcher: Miss Teresa M. Burdett.

Purpose of study: To discuss the global process surrounding weight loss.

I, the undersigned understand that my participation is voluntary and I agree to take part in this study.

I have been given a full explanation by Miss Teresa Burdett about the nature, purpose and likely duration of the study, and what I have been asked to do. I confirm that I have the opportunity to discuss this study with the researcher and that I have the opportunity to ask questions and that I have understood the advice and information given as a result.

I understand that all personal data relating to volunteers will be anonymous and will be processed in the strictest confidence, and in accordance with the Data Protection Act (1984). I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity will be preserved.

I understand that my interviews will be audio taped.

I understand that my participation is voluntary and that I am free to withdraw from this study at any time without needing to justify my decision, without prejudice and without any of my rights being affected.

I understand that this study is part of a PhD programme and may also be published although my anonymity will be maintained.

I therefore confirm that I have been given sufficient time to consider the above and that I freely consent to taking part in this study.

Name of participant:

Signature:

Date:

Name of researcher:

Signature:

Date:

APPENDIX 12: EXAMPLES OF HOW THE INTERVIEW DATA WAS EXPLORED UTILISING THE HYCNER (1985) DATA ANALYSIS FRAMEWORK

1. Transcription

   I personally transcribed the qualitative data verbatim obtained from all the respondents over the year long period of the study.

2. Bracketing and the phenomenological reduction

   In this stage, I attempted to be as open as possible to the phenomenon being investigated. I also attempted to suspend or bracket my own meanings and interpretations. For instance, I used a list system to record my meanings including being a health professional, being large and being a woman. This was to allow me to lay aside my personal meanings. This was to enable me to more fully enter into the unique life world of each respondent being interviewed.

3. Listening to the interview for a sense of the whole

   After bracketing as much as possible of my own interpretations, I listened to the each interview at least three times but usually more. This enabled me to hear the voice of the respondents. I also read the transcripts through a number of times. This enabled me to obtain a sense of the whole interview "a gestalt" (Giorgi, 1975:87).

4. Delineating units of general meaning

   At this stage of the data analysis process, I rigorously reviewed every word and phrase in each transcript in an attempt to stay close and open to the literal data. The result is called a unit of general meaning.

   1) You see when I have a bad day 2) I think that's it then 3) I am doomed so 4) I might as well carry on. But 5) I can't understand 6) where that attitude comes from because 7) it is a rebel, 8) it is almost like mm mm mm. 9) All right then I will have three donuts no I won't I'll have four. Then 10) afterwards I'll just feel what did I that for? 11) Who am I rebelling against? (Code Red, first interview).

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At this stage, all the respondents' experiences and meanings are compiled into units of general meaning regardless at to whether eventually they are composites of the phenomenon being investigated, the experience of weight loss.

1. Was having a bad day
2. Code Red thinks
3. She is doomed!
4. So I might as well carry on
5. She cannot understand
6. Where did that attitude comes from?
7. She is a rebel
8. It is almost like mm mm mm
9. All right she will have three donuts no she won't she'll have four
10. Afterwards she feels what did she do that for
11. She asks who is she rebelling against?

5. Delineating units of meaning relevant to the research question
   At this stage I highlighted which units of general meaning were relevant to the individuals weight loss experience. For reader comprehension and to understand the process I have continued with the sample example utilised in stage 4.

1. Was having a bad day
2. She thinks and 3. She is doomed
4. So I might as well carry on
5. She cannot understand and 6. Where that attitude comes from?
7. It is a rebel
9. All right I will have three donuts, no I won't I'll have four
10. Afterwards she feels what did she do that for
11. She asks who is she rebelling against

Some units not relevant to the experience have been eliminated at this stage (original numbering has been retained for reader comprehension).

6. Training independent judges to verify the units of relevant meaning

   By utilising independent judges, I aimed to enhance the validity of the study. I endeavoured to achieve this by dialogue with my supervisor and asking a senior dietetic with an extensive knowledge and interest in obesity and weight loss and fellow PhD research peers to verify the units of relevant meaning I had previously identified.

7. Eliminating redundancies

   In this study I eliminated previously identified units of relevant meaning which were in fact redundant to the phenomenon in question to further clarify the experience being investigated. Although I was careful to consider aspects which may have changed the literal meaning of the words being utilised.

8. Clustering units of relevant meaning

   In order to explicitly demonstrate to the reader the stages that led to the emergence of the four themes, self-sabotage; internal conflict; control and choice, stages 8 and 9 have been repeated.

   Self-sabotage

   i.   Awareness of self-sabotage

        It is very interesting because you realise that you are self-destructing, that what you are doing is not doing you any good, as I said (Louisa, fourth interview).

   ii. Non-understanding of self-sabotage

        I am actually buying bars of chocolate. I don't really want them but there is something about because I am not allowed it, it's like, I don't know, its like I am actually fighting myself. It's a very, very odd and I do go through these little phases where you know I am on the way to…I'll stop and I'll buy croissants and I will do really stupid things and I will eat food I don't really want and I will have naughty things just to show that I can to myself. It's a very, very odd thing and I will and so I went through a couple of weeks like that. Like I say I went through that slightly self-destruct couple of weeks when I was eating whatever (Beth, second interview)

iii.   Self-sabotaging actions

There hasn't been a lot of change only going down and going back up again and every day I am going to start the next day and do it right. But I do, do it all right and when, when dinnertime comes I don't do it right. That's what happens every day (Kate, second interview).

iv.   Self-sabotaging journey

It's like when you reach a crossroads and you think I'll go left, you go left and it's the wrong road you know, so what do you do? (Louisa, first interview).

 v.   Spoiling things

Well, the three tins of chocolates that get brought at Christmas, that didn't help at all, just looking at them I gave in one night (Margaret, third interview).

vi.   Self-sabotaging thoughts

It's just like being two people. When I wake up positive I am the most positive person you will ever meet and nothing gets in my way. But it's something stupid like a piece of cheesecake that will knock me right off my perch. But seven pounds in two weeks was pretty good going and I know a lot of it will be fluid but I was really pleased with it, like 'cos they've got this graph and you can see it go down and I get this little star and I thought yes and that was on Friday and on the Saturday I had just completely well bollixed it all up for the want of a better word. Not had the cheesecake, it just makes you think well you shouldn't have had any, but if I hadn't have had any, I wouldn't have needed to go out and buy another one and it was the mandarin one, you know, ahh. I just love the taste of it and the crunch and I ate the whole bloody thing and afterwards I didn't feel guilty, I just felt a complete bloody failure and then I think ahh well stuff it! I might as well have another one and it's that silly attitude that's stopping me from doing what I want to do (Code Red, second interview).

Internal conflict

i. Contradictory actions

(Although wanting to eat healthily to lose weight). It doesn't interest me at all; all that interests me is the fat food, food what's tasty (Lucy, first interview).

ii. Contradictory aims and goals

Over all the years of wanting to lose weight since I was, well since I was an adult, I wanted to lose weight. I have never been happy. I wasn't happy at ten stone but I would die to be ten stone now (Beth, second interview).

iii. Contradictory beliefs

I am always trying in to lose weight, always trying to find, I am always looking for that way I can lose weight. Some sort of appetite suppressant that would be the only way with me, you know, so that I don't want to eat but that sent you up the wall because you thought you were meeting yourself coming back. I couldn't keep them going for very long, from what I can remember (Peggy, first interview).

iv. Contradictory self-dialogue

But I diet, I eat, I diet, I eat…well you know everything you want to eat or if you do eat it, nice dinners and that, I like you are thinking all the time I shouldn't be eating this…I don't really like dieting but I know I've got to do it now (Kate, first interview).

v. Contradictory thinking

It's very frustrating. It is very frustrating. I think it is very frustrating because I am not; I am not making the effort. Well, I have got these scales next door that I occasionally get on, and there's scales at work that I occasionally get on but when they don't tell me what I want to know, I've not done anything much (Beth, second interview).

vi. Self-awareness of contradiction

No, the only thing you can do that is funny, it is ever so funny to read it back, it is ever so funny what you say and I am so contradictory when I look back at certain things. I said that, did I really? So it is a good read back, it is a good reference because you can look back and think I did say I tried that (Code Red, third interview).

Control

i. All or nothing

I am going to be as good as possible, no cheating, no snacks, no breaking off the diet. It is very difficult because I am very much an all or nothing person either I am so good people will say "my god aren't you good" or I will just eat everything and dieting or life control or weight control isn't like that. What you need to do if you go off it, is what you need to do is get right back on again (Karen, first interview).

ii. Being out of control

Scared, scared of failing you know. That's the whole thing. I am sort of frightened of starting something and failing again…I just can't stick at anything. I've tried going to 'Slimming World' and you know where they lie to you and say you can eat as much as you like of certain foods. It's a lie, because I can't stop eating and I just don't lose weight even if I stick to the right format that they give you. What they mean is you are supposed to eat one plate of food, I can sit and eat three or four plates of food and still be hungry after you know, ten minutes later (Louisa, first interview).

iii. Beliefs about genetics

My mum was big, my sons are big now. I've got uncles, aunts and cousins they're big so there is more to it than what you just put in your mouth. My Nan during the war was a big lady (rationing). My eldest grandchild he is tending to be but his mum she's big as well as my son but even if (Peggy's grandson) is not big as a child when he gets bigger, older, he will put on weight (Peggy, first interview).

iv. Controlling and addictive aspect of food

Just the thought of stacks of fresh toast (laughing) with butter and marmite, you know I am drowning (laughing). See the temptations. It is like an addiction, in fact some people it is really is as though I mean some people is as though. I mean it is the same sort of level as a heroin addiction and they just cannot get away from the desire to have high carbohydrate food, pizza and pasta and potatoes and…(Margaret, fourth interview).

v. The concept of control

Control is a big word in weight, it really is. You know it has become more and more clear over the years, you know yourself, how much control you

really have and when you are doing something like 'Sole Source' you are in control, completely (Molly, fourth interview).

Choice

i. Choice of foodstuffs

(Dieting). Well it is just so boring and awful. I just find it boring and awful and I mean all the things they do not want you to eat I like. I am not a salad person. I like sweets, chocolate, cream, cakes, biscuits, crisps. I like everything, not eating the sweets, not eating the crisps, not eating the biscuits, not eating the cakes and not having the cream, not a lot left is there, boring diet (Peggy, first interview).

ii. Magical or quick fix remedies

I am always trying to lose weight. I am always looking for that way that I can lose weight and I know that the only way I can lose weight is by having some sort of appetite suppressant and that would be the only way for me, so that I don't want to eat. I'd take tablets if they (GP) would give them to me. I have asked but you have to show you can lose weight to start with, which is daft but never mind. I would like to be ten stone tomorrow, that's what I'd like. Not unless they put me on a bacon slicer. I don't want a difficult way. I want an easy way (Peggy, first interview).

After eliminating any redundancies (stage 7), whilst trying to stay true to the phenomenon and essence of the meaning I tried to determine if any of the units of relevant meaning clustered together.

I repeated this stage a number of times to ensure the units of relevant meaning clustered together in a manner that felt appropriate. This was termed "creative insight" by Colaizzi (1978:59).

9. Determining themes from clusters of meaning

In order to explicitly demonstrate to the reader the stages that led to the emergence of the four themes, self-sabotage; internal conflict; control and choice stages 8 and 9 for each theme have been included in this appendix.

In this stage, I reviewed the clusters of relevant meaning and determined the central theme.

Clusters of meaning
  i.   Awareness of self-sabotage
 ii.   Non-understanding of self-sabotage
iii.   Self-sabotaging actions
 iv.   Spoiling things
  v.   Self-sabotaging thoughts
 vi.   Self-sabotaging journey

I determined the central theme of this clustering of meaning was self-sabotage.

Clusters of meaning
  i.   Contradictory actions
 ii.   Contradictory aims and goals
iii.   Contradictory beliefs
 iv.   Contradictory self-dialogue
  v.   Contradictory thinking
 vi.   Self-awareness of contradiction

I determined the central theme from this clustering of meaning was internal conflict.

Clusters of meaning
  i.   All or nothing
 ii.   Being out of control
iii.   Beliefs about genetics
 iv.   Controlling and addictive aspect of food
  v.   The concept of control

I determined the central theme from this clustering of meaning was control.

Clusters of meaning
  i.   Choice of foodstuffs
 ii.   Magical or quick fix remedies

I determined the central theme from this clustering of meaning was choice.

10. Writing a summary of each individual interview

At this stage, I re-reviewed each interview transcript and wrote a summary attempting to reflect the themes that had been evident in the data.

11. Returning to the participant with the summary and themes: Conducting a second (third and fourth) interview

At this stage, I returned to each participant to share the summary and transcript with them to ensure that the respondent agreed with their data and my interpretation of their transcript in the form of the summary. All of the respondents felt their transcript and summary accurately reflected what they had said but obviously if this had not been the case, I would have amended what had been written.

12. Modifying themes and summaries

In this stage, Hycner (1985) discusses a second interview. However, in this study each respondent was interviewed up to four times so I repeated all the stages at each data collection.

13. Identifying general and unique themes for all of the interviews

Once all the stages one to twelve had been repeated for each individual interview I began to look for commonalities and also for individual variations. I was careful to ensure that similar thematic data was clustered together and individual differences were recorded.

14. Contextualization of themes

After reviewing the general and unique themes I identified in the qualitative interview data I endeavoured to place these themes back into the context from which they were produced.

15. Composite summary

In the final stage of the Hycner (1985) data analysis framework, after reviewing all the qualitative interview data, I composed a composite summary in an attempt to gather the essence of the phenomenon being investigated, the individual's experience of weight loss.

APPENDIX 13: REYNOLD'S (1979) ETHICAL CODE UTILISED

i. It is important for the researcher to reveal fully his or her identity and background.

ii. The purpose and procedures of the research should be fully explained to the subjects at the outset.

iii. The research and its ethical consequences should be seen from the subjects' and institution's point of view.

iv. Ascertain whether the research benefits the subjects in any way (beneficence).

v. Where necessary, ensure the research does not the harm the subjects in any way (non-maleficence).

vi. Possible controversial findings need to be anticipated and when they ensue, handled with great sensitivity.

vii. The research should be as objective as possible. This will require careful thought being given to the design, conduct and reporting of the research.

viii. Informed consent should be sought from all participants. All agreements reached at this stage should be honoured.

ix. Sometimes it is desirable to obtain informed consent in writing.

x. Subjects should have the option to refuse to take part and know this; and the right to terminate their involvement at any time and know this also.

xi. Arrangements should be made during initial contacts to provide feedback for those requesting it. It may take the form of a written resume of findings.

xii. The dignity, privacy and interests of the participants should be respected. Subsequent privacy of the subjects after the research is completed should be guaranteed (non-traceability).

xiii. Deceit should only be used when absolutely necessary. (No deceit was employed at any time throughout the duration of this research study).

xiv. When ethical dilemmas arise, the researcher may need to consult other researchers or teachers.

(Adapted from Reynolds, (1979)

4th Interview with Code Red 10th July 2006

How do you feel about the last six months and last year, about yourself and in relation to your weight?

It has been totally, utterly upside down, I have probably tried more things this year than I have tried all together, it has been one, two, oh five or six different things I have tried, and none of those worked, ha ha but I have now got another one, which is I sat and looked at the internet the other night, and I thought what shall I do now, I have just cancelled my weight watchers, before that it had been slimming world so I cancelled that, then I tried fit bug, have your heard of fit bug, that's where they give you so many steps to do every day and they sort of text and email you and you wear this pedometer thing, I just got fed up with them telling me I hadn't walked enough so it annoyed me (laughs) so I switched it off, that was that one so I sat there and I thought there must be something that I can take that's like the slimming tablets, because the slimming tablets, I really do get hungry, that's the best of it, especially in the evening I pick and I'm really like what shall I have now and that's when I do my damage, so I looked on the internet and I did find these tablets called houdia, pure houdia and I thought well its only 30 quid, I have tried everything else, I have spent thousands haven't I, anyway they came and I thought try one in the morning, I think it was three o'clock before I realised I hadn't eaten any lunch, so I took another one and then I had lunch well I had something to eat, I didn't touch a thing in the evening, I just didn't want to know, same the next day, same the next day, and then went on for, I think it was, I lost 8 and a half pounds within two weeks, and they were doing exactly the same thing as the slimming tablets but they weren't giving me any side effects, no headaches, no dry mouth, no sort of they didn't make me feel very agitated but you could tell the difference when you took them, tenuate dospan, you know a bit, I can't quite explain the feeling but they you and I thought I will carry on taking these and they really did work until the dog had an accident and then I sort of it all went haywire and I didn't take them properly, but I am going to start again today because I feel ready to do it, but I really have put quite a lot of hope in them because they are not affecting anything else and they just make, its hard to explain, I noticed it because my ex husband came back from Belgium, and he had a big bar of chocolate in his hand and he broke a piece of and said do you want some and I said no thanks and that's just unheard of of me, its just like cardboard, like looking at cardboard, I was like no I don't want it and nothing else apart from the slimming tablets and made me feel like that. I think I do need something to help me, I can't go and do slimming world or weight watchers, I am not at that stage where I want it bad enough, so these it took that hunger away and it really did help, so I am going to carry on taking that, so it is houdia now girls.

May I ask what is your present weight?

12 stone 8lbs.

How do you feel about yourself and/or your weight at the moment?

I am not too bothered actually to be honest I mean it doesn't stop me doing anything, I mean I went out last week and I lay in the pool, the health club I go to in a bikini but then I am like that I don't care about anyone else do I couldn't give a stuff if I feel alright then stuff them, but, I would like to lose some definitely, I would like to lose a good couple of stone, but I have said that for years and it is not quite happening yet but I am waiting to wake up you know when you wake up and think today is the day I am going to get positive but its not I just think I have too many distractions, and I probably don't want it enough, I probably look quite comfortable I this stone and I am staying in it, but I told you I tried the zenical as well don't bother, dreadful, it gave me really nasty stomach pains as well, it didn't work, no I definitely need something that comes in and blocks the evenings, it's the evenings from 6 o'clock to 10 o'clock I can demolish the kitchen and not even be hungry and I know I am not hungry, but what shall I have, the funniest thing I have done this year is joined weight watchers and found these crisps that they do, chocolate bars, I spent 28 quid on them, and I think I demolished them in three days because they were so low in points I thought I could eat all of them, you can't do that really, it tells me I've got something, some eating problem there along the lines, it is not, I don't know? And I do go into this cocky mood when I think I'm having it, don't care, I'm eating it, I'll have what I want thank you, and I do it, so I do myself the damage really, but so.

How do you feel about this whole process of trying to lose weight?

It gets on my nerves, I get fed up with it, like I said to you I would still if you came in today and said to me you are never going to guess what? Take this and you'll lose a stone by the end of the month I would ask how much is it? A grand here right here you are I'll do it, that's the mind set I am still in I am afraid, looking out for that wonder fix isn't it, they have found something else now but it isn't out until next year, its I keep seeing it advertised its like a slimming table but it just stops you wanting the cravings, so I am waiting for that one now, but that houdia is really good, I put my sister on it, and it is not working for her although she has said it is just started she said last week, she can feel the difference, with me it was instant, and it was instant, it is no good saying to me its in the mind well I am sorry it isn't, because I know what I am like come 6 o'clock I am like mmm, (searching for food) and I was doing, where I was eating my meals, I was thinking about what we are going to have next, what I could eat later, oh what shall I have next, and I was actually eating food when I was thinking that, I wasn't thinking I am enjoying what I am eating now, I what shall I have later? And it is always the sweet things that I crave, the chocolate and that, the rubbish.

What strategies, tools or measurements have you used to elicit your weight change and to measure your weight change?

Scales, oh no that isn't true, I have got a pair of trousers they are a very small size 14 and I have got a friend who is a size 12 and they are tight on her and if I can get them done up I am buzzing, If I can't I am just like eeeerr, I use them and I have had them for about four years but they just stay in the wardrobe because I know I wouldn't be able to go out in them, but I can get them up, that to me is better than the scales, you

just go all over the place with scales, you do need scales 'cos otherwise you just, it just creeps up and up and up, yea these trousers are really good (giggles).

Has your chosen style of trying to lose weight affected your life?

No, not really, it doesn't stop me going out and eating, it costs me a fortune, I have spent a hell of a lot of money on it, in the thousands I would say, definitely in the thousands, yes, it has got to be easily in the thousands.

What or whom has hindered you in the last six months?

Me, and only me to be honest, I mean I do have a lot of distractions which is the family but if I am really wanted to lose weight I would lose it, its simple, its black and white, I want to lose it, I would lose it, so it is only me I have all the answers.

What or whom has hindered you in the last year?

(As above).

What or whom has helped you in the last six months?

(Long pause) well, considering I am sort of still the same weight I can't really answer that one, I have had quite a lot of people saying why don't you try this and that and my friend when I joined weight watchers because she lost three stone on it she was fabulous, but she was the one that introduced me to the crisps and the chocolate, and I just ate them all didn't I.

What or whom has helped you in the last year?

(As above).

What were the main reasons or beliefs as to why you started trying to lose weight?

I just got totally fed up with the weight that I was, and about five years ago I tried slimming world and I was 10 stone 2 and absolutely horrified about being 10 stone 2 and I got down to nine stone 1 quite quickly, and so I think I have been shocked that I have not been able to do that again, I actually put on weight this time with slimming world because I was eating all the pastas and the rice's that I cannot stand. I do have a real problem with bread, if I eat bread I really know about it. I feel quite ill on bread, but sometimes I am that hungry that any bread or anything like that will you know sort of fill me up.

Over the last year what feelings or beliefs have motivated you to continue trying to lose weight?

I am not that motivated really, I have still got that really good friend who is in the marines, who he is always saying to me come and get to the gym, always telling me to get to the gym. The only other good thing, my partner is doing this course and he is staying at the Hilton hotel so he is using the gym every night and he is I can really see

the difference because he went up to 14 stone which I thought was brilliant for me because I thought it was hilarious because he was only about 12 ten when I met him because he was in the army and he was fit as a flea and he came out of the army two years ago, and he has piled on a bit of weight since then, but he has actually got off his bum and started going to the gym and there is this big difference in him now so that might make me suddenly think oh hang on, you know, that might help, it might.

Is there anything else you would like to share with me about your weight change process over the last year?

Not particularly, I mean its just two, no three weeks ago I went up to 13 stone 2 and that's the heaviest I have never been that heavy, even in labour, childbirth so that was really heavy for me so I am back down to 12 8 just taking those tablets and I did get down to 12 6 so they were, that was good, that was 8 and a half pounds, that was good, in two weeks, having said that I wouldn't want to maintain that as I know that would go back on, it would make me think they weren't working, a good two pounds every week would do me, so I am going to try again, and see if they'll do it, because it is no good all these things that say oh yes you lose 8 pounds and you'll lose this, great until you put it all back on isn't it, and I have done that before, I have done it on the slim fast and lost weight and put on double what I have lost, I really don't know what the answer is other than, doing it the right way, eating healthy and taking more exercise, I understand all that and I have read every book, you know, I read all the time about things, I know that is really, there is no secret, you've got to do it properly, just that, doing that properly that I'm hindering at the moment.

Is there anything else you would like to share or discuss with me?

No, I don't think there is, I mean I still think underneath all this sort of fat problem is still me and to be honest it is not really made much difference to my life, its not, I don't think that I have lost any friends, or have not been chatted up became of it in fact it doesn't matter, so maybe if I felt that maybe I was being ignored I thought oh god! But then I never have and then I'll turn it round and say if that's the way I am, that's the way I am, so that's me, so no, not really, I just would like, I would like to, it would be very nice to sort of be a good size 10 or a 12 but obviously not enough, yea, well I really believe that, if I wanted it that bad I would have it so I get everything else I want in my life if I wanted it bad enough so obviously something is stopping me maybe it is I don't know, I can't answer that one, I will just carry on and try again, you want pure hoodia, I can vouch for that, it seriously did it for me, it really did work, it was just not, it was not too healthy because I wasn't eating, but then I would eat and in the evenings I could not entertain anything, it must have been because I lost 8 and a half pounds in two weeks, and that my nibbling in the evening and I completely stopped that, completely stopped it, bizarre, but they said its, its from south Africa and the tribesmen used to live on this houdia which is cactus when they were going out for days hunting, they knew they would be starving, so they used to eat it and it curbed their appetite, that's what they say, but it did work and I know for a fact that it is not psychological because it stopped working now, because ever since the dog and everything went haywire I have not been taking them properly and I have put two pounds on again, I have not been doing it properly, taking one and then not taking one, you don't help do you do you want a penguin (addressed to one of the dogs), you don't help do you.   `

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