BRINGING THE ADULT LEARNING EXPERIENCE OF SUCCESSFUL WEIGHT LOSS MAINTENANCE INTO FOCUS: A NARRATIVE ANALYSIS WITH IMPLICATIONS FOR EDUCATORS AND CLINICIANS

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by
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ABSTRACT

In light of the many social, medical, and political viewpoints on obesity, little is known of the weight loss maintenance experience and the impact on learning processes and outcomes among adults. The purpose of this study was two-fold: a) to explore the experience and meaning-making processes of individuals who have maintained a weight loss and b) to explore how this learning manifested in successful weight maintenance and improved self-identity despite cultural stressors. This study was grounded in three intersecting theoretical frameworks relating to adult education: Transtheoretical Model of Behavior Change Transformational Learning Theory and Critical Media Literacy as informed by Critical Public Pedagogy. Narrative inquiry was chosen to study the nine stories of adult participants who successfully maintained a weight loss that bring meaning to the weight loss maintenance experience.

The collective analysis resulted in two categories and five themes. The first category centered on adult learning. The first theme was related to triggers that were grounded by health and life events. Secondly, learning processes were evident in the narratives and were either self-directed, largely instrumental knowledge and occurred in a non-formal environment. Thirdly, weight loss was seen primarily as a physical transformation motivated by increased self-concept and helping relationships. The second category centered on hegemony and resistance. The fourth theme focused on cultural stressors including the fashion and entertainment industries. The fifth theme focused on changes in obesity discourse post weight loss. The study ends with a consideration of the findings in light of the theory for adult learning and practical implications for strengthening subsequent intervention design.
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CHAPTER 1

INTRODUCTION

This chapter provides an overview of a study which explores the lived experience of weight loss and weight loss maintenance in an adult learning context. Chapter one describes the background of the problem including a discussion on the obesity epidemic, the current status of weight loss approaches, an examination of health behavior theories, and a brief review of relevant studies regarding weight loss maintenance experience. The purpose, research questions, theoretical framework, and design follows. Lastly, I discuss the significance of the study, definition of terms, assumptions and limitations of the study.

Background of the Study

Leading health agencies such as the World Health Organization (WHO) (2010) and the Centers for Disease Control and Prevention (CDC) (2011), report that the prevalence of overweight and obese adults has steadily increased over the years across gender, age, race, ethnicity, and educational levels. Two-thirds of United States adults are overweight or obese (WHO, 2010). Obesity accounts for premature deaths (Ogden, Flegal, Carroll, & Johnson, 2002), increased risks of chronic diseases (National Institutes of Health, National Heart, Lung, and Blood Institute, 2003), and over 122 billion dollars annually in costs to care for obesity related conditions (National Institutes of Health, 2011). For adults, overweight and obesity ranges are determined by using weight and height to calculate a number called the "body mass index" (BMI) (CDC, 2011). An adult who has a BMI between 25 and 29.9 is considered overweight; a BMI of 30 or higher is considered obese (CDC, 2011).
Fortunately, research shows that even modest weight loss can reduce health risks (Pi-Sunyer et al., 2007). However, little is known of the weight loss maintenance experience and whether effects on learning outcomes and learning processes are ones that could lead to permanent change in individual learners. In fact, many studies have confirmed that weight loss maintenance is often not a permanent change (Jeffery et al., 2000). Because Americans live in an “obesogenic” environment, characterized by messages, products, schedules, and places that promote increased food intake, unhealthy foods, and physical inactivity, the obesity epidemic is a complex issue that involves government, healthcare, industry, media, family and individual efforts for collaboration and change (CDC, 2011). Many of the barriers to effective treatment of this disease are unlike any other medical problem.

**The War with Obesity**

Growing attention on obesity in the United States remains a highly controversial scientific and social debate. The war with obesity is not only concentrated on the individual, but on which systematic philosophical approach can best support, research, educate, or advocacy (Saguey & Riley, 2005). There are many forces behind an individual’s weight gain: economics, food marketing, socio-cultural disparities, changes in agriculture, sedentary lifestyles, influence of industry, and media. The fear of fat has created many ways to frame this situation, which is often associated with social problems (Hilgarten & Bosk, 1988, as cited in Saguey & Riley, 2005); obesity as a disease, the need for “self-management, the need for increased tolerance and diversity education, fat-acceptance theories, and anti-fat crusades” (Saguey & Riley, 2005, p. 869) are among the approaches. There are four primary groups of individuals: antiobesity researchers,
antibesity activists, fat acceptance researchers, and fat acceptance activists who are all at “the forefront of framing positions over the nature and consequences of excess body weight” (Saguey & Riley, 2005, p. 869). Given the multi-layered positions towards obesity, it is important to uncover the philosophical underpinnings upon which this research is based. Throughout this research I take the position of obesity as an illness or a disease. The research argues that obesity is a health problem in need of urgent attention. Members supporting the antiobesity agenda view higher weights as potentially harmful with health consequences such as increased risk of chronic diseases and psychological issues including diabetes, back pain, hypertension, arthritis depression and lower self-esteem (Medscape, 2009; Saguey & Riley, 2005; Wang, Brownell, & Wadden, 2004; Yach, Stuckler, & Brownell, 2006). It is also assumed that the behaviors surrounding weight gain, specifically sedentary behavior and unhealthy eating are culturally learned and therefore can be unlearned and replaced by healthier behavioral practices.

Too often, even for those who take an antiobesity position, obesity fits into the small category of a few other chronic diseases; HIV-AIDS and alcoholism for example, in the medical system often come with a “blaming the victim” mentality, or the belief that obesity is a result of voluntary bad habits, which can include laziness, gluttony, bad hygiene, and lack of education (Puhl, Moss-Racusin, Schwartz & Brownell, 2007; Puhl & Brownell, 2003; Puhl & Heuer, 2010). A socially constructed powerful fear of fat that is perpetuated by negative perceptions of persons who are obese is helping the discrimination against these persons to persist, which has implications for the individual weight loss battle. Popular culture, which includes mass media, works to reinforce these
dominant values of beauty and worth and is often seen as a public form of education for the American public (Sandlin, 2007). This type of popular, public mis-education guarantees continued controversy from a socio-cultural perspective on how to approach this disease. Approaches from the socio-cultural perspective usually have two positions; the first associates obesity with the lack of willpower, and the second views obesity as a systemic societal problem. These conflicting epistemological views on how to approach the problem of increasing obesity and its accompanying health costs create additional barriers for obese and overweight persons (Goldstein, 2005).

This conviction creates a substantial burden for health care professionals and their patients in managing this disease due to the philosophical underpinnings and beliefs on how to approach this subject (Goldstein, 2005). Practitioners have an important role in developing interventions and communicating effective medical care strategies that leads to better quality of life. Yet, patients who feel stigmatized about their weight are more likely to avoid routine preventive care, and when they do seek health services, their care may be compromised. When patients feel stigmatized, they are vulnerable to depression and low self-esteem, they are less likely to feel motivated to adopt lifestyle changes, and they are more likely to turn to unhealthy eating patterns for comfort (Carr & Friedman, 2005, MedScape, 2010, Myers & Rosen, 1999, Wang et al., 2004). Positioning obesity as a disease could potentially limit the individual blame and suggest that there is also a biological and genetic influence in the obesity epidemic and weight loss struggle.

Weight Loss Strategies

Although science has made strides about metabolic, environmental, and genetic influences that may impact weight, the question of why losing weight and keeping it off
on an individual level is difficult remains unsolved. With increased attention to the social and medical issues surrounding obesity, many weight loss programs were developed in an attempt to solve the weight loss hurdle including commercial weight-loss programs, weight-loss reality television series, pharmacological treatments, surgery, and in-patient medical supervised treatments. Many weight loss interventions report factors that influence weight loss including social class, gender, and intensity of the program, peer support, perceptions, and acculturated beliefs surrounding the nature of the problem (Elfag & Rossner, 2005; Finch et al., 2005; Wing & Phelan, 2005, as cited in Odgen, Stavrinski, & Stubbs, 2008). In addition, many individuals who engage in weight loss programs usually lose a modest amount of weight and often regain the weight over time (Wing & Hill, 2001; Wooley & Garner, 1991, as cited in Elfhan & Rossner, 2005).

Little evidence exists about the learning process, learning outcomes and meaning of successful weight loss. Because of this, it is important to understand the current environment of weight loss strategies for individuals that could impact and influence learning and behavior. The weight loss industry is estimated to be worth $586.3 billion by 2014, leveraged from foods and beverages, dietary services, drugs, television shows, and equipment (Cleland, Gross, Koss, Daynard, & Muoio, 2002; Markets & Markets, 2011). With the treatment of obesity hitting popular culture there has been a “rogue’s gallery of rascals and snake oil-salesmen, a library of junk science and nutritional gibberish, and a catalogue of nonsense cures and commercial hustle” (Goldstien, 2005, p. 385). Often, media acts as public pedagogy, which refers to “the education provided by popular culture; popular culture teaches audiences and participants through the ways it represents people and issues and the kinds of discourses it creates and disseminates”
(Sandlin, 2007, p. 76). This public pedagogy is a compelling example of the social acceptability of weight stigmatization (Heuer, McClure, & Puhl, 2011). The view of obesity through this medium is often seen in a multitude of forms, from the constant ridicule of persons with obesity in television and film, to the media’s portrayal of “blaming the victim” rhetoric in the majority of news coverage, magnifying the causes of weight gain at the individual level (Heuer et al., 2011). The weight loss treatment arena is saturated with medical exploitation and programs that lack a scientific foundation and increase discrimination. This cultural exploitation includes reality television shows that focus on weight loss that often have contestants taking full blame for their failure to reject the neoliberal politics and the responsibilities to regulate their bodies (Hoechsmann & Poyntz, 2012).

**Commercial weight loss programs.** Because of such cultural exploitation and misinformation, much of the public has come to be both skeptical and confused by such mixed messages, with discriminating messages against the target audience—those seeking a solution, aim to recruit (Cohen, Perales, & Steadman, 2005; Maclean et al., 2009). Yet, the public buys into popular commercial weight loss programs in the United States such as Weight Watchers, Jenny Craig, and LA Weight Loss. These programs are costly, averaging $107 for an initial membership fee with additional periodic fees associated with food purchases and meetings and key components to these programs are the approach to a restricted calorie diet, behavioral modification counseling and recommendations for exercise (Tsai & Wadden, 2005).

**Integrative health approaches.** Although the majority of weight loss programs focus on behavioral modification through traditional approaches, Overeaters Anonymous
(OA) offers an alternative treatment philosophy. Taking an integrative health approach by connecting the soul and spirit, OA believes they help individuals connect to new ways of thinking (Overeaters Anonymous, Inc., 2011). The program relies on a 12 format similar to that of other addictions, specifically, Alcoholics Anonymous. The steps “reflect practical experience and application of spiritual insights recorded by thinkers throughout the ages” and each step associates itself with a spiritual principle including hope, love, spiritual awareness and courage (Overeaters Anonymous, Inc., 2011).

However, there are no published evaluations of the efficacy of Overeaters Anonymous (Tsai & Wadden, 2005). Through the systematic review of such programs, Tsai and Wadden (2005) concluded that Weight Watchers was the only commercial weight loss program whose efficacy has been demonstrated in a randomized controlled trial.

**Medical treatments: surgery and pharmacotherapy.** In addition to those who voluntarily enroll in a weight loss treatment program bariatric surgical procedures are becoming more prevalent (Lopez, 1997). Bariatric surgery is a medical procedure used to aggressively induce weight loss, often recommended for individuals suffering from severe obesity (Sutton, Murphy, & Raines, 2009). There is a body of research focused on the physiological outcomes of these procedures, and bariatric surgery has become the most effective measure of sustainable weight loss (Sutton et al., 2009). This surgical weight loss intervention requires a rapid number of imposed individual physiological and behavior changes following surgery.

Dietary supplements and pharmacotherapy are also becoming more common for the reduction of body weight. The majority of dietary supplements are over the counter, but pharmacotherapy must be prescribed by a physician. Dietary supplements are largely
not regulated and individuals do not need prescriptions to obtain these supplements from local convenient stores.

**Successful Weight Loss Experience**

There is substantial literature and attention given to obesity prevention efforts and weight loss approaches; however, the literature fails to deeply explore the lived experiences of successful weight loss. Little is known about this experience, and it is likely that important findings from studying this phenomenon can lead to a deeper understanding of the experience that can assist in developing multidimensional approaches to obesity prevention education, weight loss treatments, and the communication of effective medical care strategies that lead towards a lifelong journey of recovery. Studying the lived experience and meaning-making processes of successful weight loss, within the specific issues of the complex cultural web surrounding obesity, is the next logical step in obesity research, given the failure of almost all existing prevention approaches that start with the assumption that adults will act rationally and in their best interest to change their behavior (Robinson, 2010). Dalton (1997) wrote:

> Compared to managing body weight, few contemporary human undertakings produce so little outcome for the effort put forth. This effort can be measured in several ways; individual emotional, physical, and social expenditures; collective time and expertise expenditures of health professionals; and amount of money spent by industry and consumers on weight-related products, services, and media. (p. xv)

There has been considerable attention to the concept of transformation in the both the healthcare literature and the adult learning literature that often refers to people being
transformed, or changed, by the experience living with a chronic disease, including diabetes, HIV, stroke, and grief (Baumgartner, 2002; Courtenay, Merriam, & Reeves, 1998; Dubouloz et al., 2010; Fielden, 2003; Kessler, Dubouloz, Urbanowski, & Egan, 2009; Paterson, Thorne, Crawford, & Tarko, 1999). Often this event or experience is described as a change in the way subjects understand themselves and their relationship to the world. With further exploration of these experiences we may be able to explain the learning processes that create permanent change for certain individuals, or what Mezirow (1978) refers to as perspective transformation. By focusing on a specific area of concern, in this case successful weight loss, we can narrow down the weight loss patient’s experiences that led to permanent success. These success measures can lead to the development of treatment programs that potentially can result in long-term outcomes and better communication between patient and clinician.

Equal to the need to understand how to prevent weight gain, there is also a need to understand individuals who have successfully reversed this trend. There is a wealth of literature surrounding addictive behaviors such as drug and alcohol addiction, and obesity rehabilitation can be seen through a similar perspective of addiction. However, little exists in the area of successful weight-loss experience through this lens. For example, the lived experience of weight loss was investigated in several studies, which includes bariatric patients (Liberman, Robbins, & Terras, 2009; Lopez, 1997; Riggs, 2005; Sutton et al., 2009). All studies used a qualitative methodology and determined that the weight loss experience is “transformative” in nature and often included a critical event, meaning an experience that may lead an individual to make a choice. In a bariatric setting, dissonance was determined to be a motivating factor in the decision to undergo the
surgery and, through the surgical process, participants stated that their dissonance was resolved and was a crucial aspect of their meaning-making process (Riggs, 2005). Sutton et al. (2009) found that for some women, the post-operative experience was one of rebirth and a transformational experience. Although these studies focused on the ‘transformative’ experience of weight loss, the authors did not approach the research using an adult learning perspective as a theoretical foundation. Nor did the transformative experiences discussed in the literature center on reflected beliefs, attitudes or perceptions. Bradshaw’s (2008) dissertation was the only study found that examined long-term, permanent weight loss using Mezriow’s (1991) adult learning framework. However, Bradshaw (2008) focuses on the post-perspective transformative experience and body weight as an outcome.

However, the transformative learning theory lens has been applied to areas outside of weight loss, including a number of chronic diseases; diabetes, stroke, and HIV (Baumgartner, 2002; Courtenay et al., 1998; Epiphaniou & Ogden, 2010; Kessler et al., 2009; Paterson et al., 1999). A number of articles that focus on behavior change because of a chronic disease report an identity shift and argue that redefining themselves as “non-smokers” or “non-alcoholics” changes their identity (Epiphaniou & Ogden, 2010). The research among chronic disease and transformative learning has indicated that a common feature in patients who experienced an identity shift after being diagnosed with a chronic disease is a “critical trigger,” or an event that disrupts an individual’s “world view”. In Mezirow’s (1978) transformative learning theory, this is called a “disorienting dilemma”, the tipping point that leads to a process of self-examination and eventually a new meaning scheme that can lead to behavior change.
Similarly, critical events were often stated as a motivating factor for weight loss. These events ranged from childhood sexual abuse, power struggles with family member, pregnancy, to the deterioration of health and experience of not being able to take care of oneself (Engrsrom, Wiklund, Olsen, Lonroth, & Forsberg, 2011; Liberman et al., 2009; Lopez, 1997). Primarily, these results focused on a physical transformation neglecting the social and emotional experiences of the patients (Engstrom et al., 2011). Only one study concluded that the weight loss process made adolescents see themselves differently in relation to weight, diet, and often activity, indicating an identity shift through this experience (Liberman et al., 2009). However, this was not focused on adult participants.

Weight loss can be a life changing catalyst resulting in identity development (Epiphaniou & Ogden, 2010) yet little is known of about how this learning process occurs. This presents several unanswered questions: a) How do individuals make meaning of their successful weight loss? b.) What are the key learning constructs that individuals engage in that lead to successful weight loss? c.) Can successful weight loss lead to a perspective transformation? d.) What are the learning processes and outcomes from the socio-cultural context and perspectives of change? Transformative learning theory has not been used in the study of significant successful weight loss or obesity literature in an adult population. The research to date provides a foundation to study the experience of successful weight loss through a critical transformational learning lens and to better inform the treatment of obesity. This study aims to add to the concept on critical transformative learning and the reflection on one’s beliefs that can emancipate, largely focusing on the sense of agency among adult learners (Mezirow, 2000).
Therefore, this study was grounded in three intersecting theoretical frameworks relating to adult education: Transtheoretical Model of Behavior Change (TTM) (Prochaska & Velicer, 1997), Transformational Learning Theory (TLT) (Mezirow, 1991), and Critical Media Literacy as informed by Critical Public Pedagogy (Giroux, 2001, 2004; Heuer et al., 2011; Hoeschsmann & Poyntz, 2012). Health behavior change theories, like the TTM are useful conceptual models that can help to inform the processes of health behavior change. TLT can add depth to the processes of health behavior and focus on how individuals learn to change their pre-disposed assumptions and culturally constructed perceptions over time.

**Problem Statement**

Jeffery, Kelly, Rothman, Sherwood, and Boutelle (2004) found that “the single most important challenge in the clinical management of obesity is improving long-term maintenance of weight loss” (p. 100). Knowledge does not equal behavior (Value Based Management, 2011) and the numerous weight loss interventions, which are often oriented through a behaviorist perspective and centered around “doing it for your own good,” (Kahneman, 2003) are contrary to the science that has indicated that “human decision making and behavior are far from rational, but influenced by contextual factors and cognitive biases and limitations” (Wansink, 2006 as cited in Robinson, 2010, p. 20). Regardless of how many bike paths created, healthy choices in a cafeteria, or industry promotions, an individual must balance her or his own energy intake (food) and energy expenditures (activity) to maintain a healthy weight.

Current approaches to weight loss have had marginal success in sustaining obesity-related behaviors (Robinson, 2010). Most individuals, who initially lose weight,
do not continue with healthy lifestyle choices and regain weight over time. It may be that to capture all the ingredients needed to create a recipe for long-term, permanent success, a new perspective or conceptual framework applied to a weight loss context is needed. Literature has agreed that it may be a trigger, or a critical event that sparks an individual to change their physical activity pattern, or to eat healthier food items (Engrstrom et al., 2011; Liberman et al., 2009; Lopez, 1997). But what is not well studied is the lived experience of that successful weight loss journey in light of the multi-dimensional viewpoints of obesity through a critical transformative learning lens and whether that trigger is reflected upon, or if a person changes their assumptions that can lead to a perspective transformation.

**Purpose of Research**

Therefore, the purpose of this study is two-fold: a) to explore the experience and meaning-making processes of individuals in a medically supervised weight management program who have lost weight and maintained a healthy lifestyle, and b) to explore how this learning manifested in successful weight maintenance and improved self-identity despite cultural stressors.

**Research Questions**

Based on the purpose of this study, this research is guided by the following questions:

1. What are the dynamics of the successful weight loss experience, including behaviors, cognition, perceptions, and self-image?
2. How do individuals make meaning of their successful weight loss experience and does that meaning-making lead to a perspective transformation?
3. What are the key learning outcomes and learning processes of the successful weight loss experience that impacts transformational learning?

**Theoretical Frameworks**

There is both a physiological and emotional component to losing weight and keeping it off. Yet, this experience can be catalyst for lifelong changes. Although science has made strides about metabolic and genetic influences that may impact weight, the question of why sustaining losing weight on an individual level remains unsolved.

Excess weight is a result of many factors; regardless, an individual’s behavior impacts weight gain or weight loss. In order to create weight loss treatment programs, one must understand the experience of individuals who have been successful at weight loss. To better understand the weight loss experience and meaning-making process through its relationship with adult learning, it is important to discuss the theoretical framework for which this study is situated.

A theoretical framework is a construct that allows the investigator to gain insight and better understand aspects of the phenomenon being studied (Anfara & Mertz, 2006). To make sense of the experience of successful weight loss, it is helpful to draw on two related theoretical perspectives of the Transtheoretical Model of Behavior Change (TTM) (Prochaska, Norcross, & Diclemente, 1994) and Transformational Learning Theory (TLT) (Mezirow, 1978, Tisdell, 2003). Both of these theories provide great insight into the behavior change process. The TTM is a health behavior change theory that is a useful conceptual model and can help to inform the processes of health behavior change. TLT can add depth to inform these processes of health behavior and focus on how change occurs and how it is sustained over time.
Transtheoretical Model

The Transtheoretical Model of Behavior Change (TTM) (Prochaska et al., 1994) provides a structure to study an individual’s intentional behavior change. This theory integrates key constructs from other theories, primarily those in psychotherapy, which creates a detailed model that describes behavior change, and more importantly, sustained behavior. TTM helps describe a person’s intentional motivational readiness to progress towards modifying a health behavior (Velicer, Prochaska, Fava, Norman, & Redding, 1998). This model has been used in many health contexts, including smoking cessation, exercise and diet (Velicer et al., 2008; Velicer, Prochaska, Rossi, & Snow, 1992). This model consists of four core constructs: a) stages of change, b) processes of change, c) decisional balance, and d) self-efficacy.

Stages of change. The core of the model is the stages of change, or the temporal dimension (Velicer et al., 1998). This core is comprised of six stages: pre-contemplation, contemplation, preparation, action, maintenance, and termination.

Briefly, the pre-contemplation stage is described as when an individual is not intending to take action in the foreseeable future, measured in the next six months. Contemplation is when an individual is intending to change in the next six months. Preparation is the stage when an individual intends to take action in the immediate future, or within 30 days. Action is the fourth stage where an individual makes a modification to their life-style, measured within the past six months. Behavior change is the key to this stage, and to count as such it is noted that science must conclude that the change is measurable enough to impact disease (Prochaska & Velicer, 1997). And the final stage is maintenance, which is when an individual is working to prevent relapse and has
continued to demonstrate the health behavior for at least 6 months. Maintenance is the hardest to achieve in the context of weight loss. Lastly, termination is the final stage and when an individual has achieved enough self-confidence to overcome any attempt to regress to the negative behavior.

**Processes of change.** In addition to the stages, there are also ten major processes of change, the independent measures. The processes of change are the covert and overt activities that people use to progress through the stages (Prochaska & Velicer, 1997) which focus on attempting to “modify affect, behavior, cognitions, or relationships” (Moore, 2005, p. 397). The processes of change help to explain how the changes in the stages of change occur.

**Decisional balance and self-efficacy.** These constructs form multivariate outcomes that include measures to progress through the five stages. These include immediate and dependent measures of Decisional Balance, self-efficacy, and temptation (Prochaska & Velicer, 1997; Velicer et al., 1998). In the TTM, as a person travels through the stages, decisional balance shifts and self-efficacy strengthen, giving the individual increased confidence and competence (Moore, 2005). Decisional Balance reflects the individual’s weight of the pros and cons of changing a certain behavior(s). Janis and Mann (1977) developed this model of decision-making.

Self-efficacy represents the confidence that an individual has in a specific situation (Bandura, 1977). Temptation reflects the urges to engage in a specific habit in the midst of a stressful situation (Prochaska & Velicer, 1997). As self-efficacy increases, it is notes that temptation decreases (Prochaska & Velicer, 1997).
Transformative Learning Theory

Transformative Learning Theory (TLT), which is grounded in humanistic philosophy, has similarities to TTM. The TLT offers an insight into how learning is understood as a process of using one’s prior interpretations and assumptions to construct new meaning that may guide change in behavior (Mezirow, 1997). Ultimately, TLT can provide a framework to look at how individuals make meaning of their experiences, how they question their points of view, reflect, create new and meaningful ways of knowing that differentiate from previous habits of mind that can lead to change.

The rational and cognitive process of Mezirow’s TLT occurs when individuals change their frames of reference by critically reflecting on their assumptions and beliefs and consciously making and implementing plans that bring about new ways of defining their worlds (Mezirow, 1991). Critically examining previous assumptions and beliefs that result in new meaning can occur through a process of personal perspective transformative, illustrated in ten phases. Perspective transformation is defined as “the process of becoming critically aware of how and why our assumptions have come to constrain the way we perceive, understand, and feel about our world; this process makes possible a more inclusive, discriminating, and integrative perspective and potential choices or action” (Mezirow, 1991, p. 167).

Mezirow’s theory of transformative learning is that of personal, individual transformation, and is often criticized for neglecting the role of context and social change. The dramatic journey of successful weight loss is contextual and often involves aspects of culture, gender, and race. For that reason, it is important to include aspects of Tisdell’s (2003) cultural-spiritual orientation of transformative learning. This orientation
places a greater degree on positionality that may relate to the integration of some aspect of one’s identity, around culture, gender, sexuality or life role status. Tisdell (2005) stated that this view is concerned with the “connections between individuals and social structures…and the notions of intersecting positionalities” (p. 256). Key components of the cultural-spiritual view of transformative learning include cross-cultural relationships and a culturally relevant learning environment that supports the need to explore cultural, symbolic, and affective levels (Tisdell, 2003).

**Summary.** Grounded in a behaviorist philosophical orientation, and developed around “cognitive-behavioral indicators” the TTM does not offer much value in understanding how individual’s change over time (Moore, 2005, p. 296). The TTM helps to predict if an individual is ready to change, whether to include in an intervention, and to assist in guiding a change. The TTM is primarily cognitive based, rooted in psychology and does not draw attention to how the individual’s experience impacts meaning, or how environmental or social factors may impact change processes.

By adding an adult learning perspective, specifically the Transformative Learning Theory (TLT) to the TTM, the ability to interpret meaning-making behind life experiences can be deeply examined (Moore, 2005). There is an organic need to converge these two theories. As Moore stated, “both theories offer schemes of learning, changing, and growing for people seeking to make meaningful, life-transforming changes” (p. 394). It may be that adding the TLT lens to TTM provides a more holistic approach to represent “what the individual experiences and how to cope as she or he proceeds through the journey of transformational change” (Moore, 2005, p. 409).
Critical Media Literacy & Critical Public Pedagogy

Critical media literacy as informed by critical public pedagogy also informs Transtheoretical Model of Behavior Change and Transformative Learning Theory. Critical media literacy, or a “set of competencies that enables us to interpret media texts and institutions, to make our own media, and to recognize and engage with social and political influence of media in everyday life” is an important skill for individuals who struggle with weight (Hoeschsmann & Poyntz, 2012, p. 1). The mass media is a compelling example of the social acceptability of weight stigma (Heuer et al., 2011). Stigma through this medium is often seen in a multitude of forms, from the constant ridicule of persons who are obese in television and film (consider the example of Honey Boo Boo), to the media’s portrayal of blaming the victim in the majority of news coverage, magnifying the individual level causes of weight gain (Heuer et al., 2011). Critical public pedagogy “should ascertain how certain meanings under particular historical conditions become more legitimate as representations of reality and take on the force of commonsense assumptions shaping a broader set of discourses and social configurations at work in the dominant social order” (Giroux, 2001, p. 170 as cited in Rich, 2011). Reality media is a part of the environment that creates obesity discourse where individuals come to learn about their bodies and health (Rich, 2011). This study examines how individual learning took place in relation to their weight loss through means such as media and other social spectrums.

Overview of Methodology

A qualitative methodology is most appropriate for this study since understanding the research participant’s experiences of successful weight loss and their interpretations
of meaning are central to the study’s purpose. The research methodology must match the particular phenomenon of interest, which in this study is experience, meaning-making, and worldview change/identity shift. Therefore, narrative inquiry was chosen to study the personal accounts, or stories that bring meaning to the successful weight loss experience.

Qualitative research explores the meaning-making experiences of individuals through the lens of a social problem, by adding depth and detail to the analysis. Offering an inside perspective of the research subjects adds power to qualitative reporting (Patton, 2002). Contrary to the rigid format of quantitative research, which does not account for the social reality of the human existence, qualitative methods are more flexible, allowing for greater spontaneity and adaption of the interaction between the researcher and research subject. Qualitative research has the flexibility to capture rich data that is meaningful and culturally relevant to the participant. These data help to create meaning of how people make sense of the world and how they experience certain events (Polkinghorne, 1988), which is a key assumption situated in a constructivist orientation, and aligns with the qualitative research paradigm.

Narrative studies, a research type embedded in the qualitative research paradigm, aims to understand the lived experience and perceptions of experience, and was chosen as the research type for this study. Specifically, narrative inquiry argues that people understand and explain their lives through stories (Hones, 1998). The personal narratives can be analyzed to provide a window into the connections between psychological, sociological, cultural, and the political dimensions of human life (Patton, 2002). Narrative inquiry is the study of epiphanies, rituals, routines, metaphors, and everyday
experiences (Clandinin & Connelly, 2000). The experience of successful weight loss discovered through inquiry can reveal larger meanings. Exploring the meaning-making process of individuals who have lost weight and kept it off can be a crucial step to understanding this disease.

In order to capture the lived experiences of weight loss maintainers, a purposeful sample, comprised of individuals who were once enrolled in a medical weight management program who have successfully lost weight were used in the research. A purposeful sample, a sample that was selected because they can inform an understanding of the research problem and can provide rich information, was chosen as the recruitment strategy for this study (Patton, 2002). Criterion sampling, a type of purposeful sampling, was used to recruit participants that all met specific weight loss criteria and who are enrolled in a specific weight management treatment program. The sample for this study was recruited from an integrated health system’s weight management clinic via electronic health record data pull and a follow-up opt-out recruitment strategy.

Loosely structured, face-to-face interviews were the main data collection method used in this study. The stories that arise from the interviews are central to the qualitative approach and can reveal deep meaning (Barton, 2004). Narrative inquiry reduces the stories into understandings by addressing the three-dimensional model comprised of the past, present, future, and place (Clandinin & Connelly, 2000). An interview guide was created to ensure that all participants received the basic set of study guidelines that covered participant consent, confidentiality, and guiding questions (Appendix B). The interview guide also provides the researcher with areas in the interview that may need probing, or sub-questions (Patton, 2002).
Significance of Study

The National Heart, Lung, and Blood Institute in collaboration with the North American Association for the Study of Obesity developed a guide to treat obesity (National Institutes of Health, National Heart, Lung, and Blood Institute, 2000). This report stated that the best practice treatment plan was comprised of exercise, diet, and behavioral therapy. If the treatment of obesity should be addressed in the medical community, the primary care and specialty care physicians should be prepared to provide appropriate lifestyle modification counseling in a time of request (Frank, 1993).

However, current research has indicated that many medical professionals hold bias and discriminatory attitudes and beliefs about obese individuals (Medscape, 2009) and are relatively unprepared to counsel on lifestyle changes. Brendel (2009) noted that “A picture of meaningful medical care must not only focus on improving diagnostic and technological capabilities but should also aim to invite a patient’s narrative into dialogue, in line with a medical practitioner’s objective expertise, not beneath it, to empower the patient to embrace a more robust understanding of illness” (p. 28).

Because of the lack of appropriate attention to the obesity epidemic in a medical context, industry has leveraged this opportunity and created a plethora of commercial weight loss programs in the United States (Cleland et al., 2001). Millions of Americans each year enroll in a commercial or self-help weight loss programs (Tsai & Wadden, 2005). There is little research that has been established on these types of commercialized programs that leave the medical profession less satisfied with their ability to feel comfortable giving a patient the appropriate advice when asked about these types of programs or messages. A disconnect between the weight loss industry and the healthcare
profession leaves patients skeptical and confused on the accuracy of messages about weight loss that they hear from the media or their physician.

Due to the aforementioned factors, it is important for caregivers of this population to evaluate and create relative changes in practice that offer the individual not only a physiological perspective, but also a well-being perspective. This study adds significance needed to expand current weight loss treatment approaches due to the empirical evidence that many of the approaches do not have lasting effects; individuals lose weight and then gain weight back over time. Health behavior changes in the area of chronic disease prevention and obesity prevention has been widely studied for years, using mostly quantitative methods. Sutton (2009) argues, “There is a need to increase research attention to qualitative methods that will approach the research as a journey, rather than an outcome” (p. 300). Moreover, there are only a few studies that focus on the impact of learning, and only two studies using an adult learning lens to examine the transformative process of weight loss; however, in one case the research participants were adolescents (Bradshaw, 2008; Liberman et al., 2009).

The need to understand the meaning-making processes of those who successfully lost weight and kept it off is a crucial step toward understanding this disease. This study would add significance to the literature and knowledge advancing weight loss, weight loss maintenance, and also the field of adult education. Mezirow (1991) believes meaning-making is the process of making sense of experiences, or to construct an interpretation of that experience. Educators, physicians, and other individuals on a weight loss multi-disciplinary team “who understand the centrality of meaning-making in transformational learning and who understand the nature of the process can maximize
their role as facilitators of change in people’s lives” (Courteney et al., 1998, p. 15). Further, learning how successful weight loss impacts overall meaning perspectives can add significance and insight into the development of weight loss programs, and educational curriculum interrelated with the processes associated with TLT and TTM. It is my hope that exploring the meaning-making experiences of successful weight loss can “accelerate the pace at which a medical culture in the United States shifts its expectation to create critically reflective patients” (Brendel, 2009, p. 29). The processes associated with the TLT can lead to the development of treatment programs that will lead to long term outcomes and better communication between patient and clinician.

In addition, this study aims to add knowledge to the research in transformative learning and chronic disease in adults. Currently the research applicable to transformation in chronic illness is inconsistent with a definition of transformation and a critical analysis (Paterson et al., 1999). Developing a new dimension of TLT in an obesity context can help identify barriers to the change process and help clinicians and educators become facilitators of change in a medical setting (Dubouloz et al., 2010). Both the TLT and TTM address behavior change as a gradual process, with TLT adding more insight into the cognitive and socio-cultural pressures that impact weight. The TTM is commonly used in weight loss activities, such as physical activity and nutrition as a part to examine the outcomes according to medical criteria, but lacks a learning lens (Boyle, O'Connor, Pronk, & Tan, 1998; Vallis et al., 2003). Studying the weight loss experience through the lenses of TLT and TTM can provide critique into current successful weight loss strategies and encourage alternative approaches to this type of treatment.
Researchers believe that how people respond to weight loss varies differently which can be explained through their unique experiences (Jeffery et al., 2004). Exploring these experiences of the meaning-making journey is of interest to health researchers, health educators, nurses, physicians, and other professional members commonly seen on a weight management team. The medical community can find purpose in helping patients engage in meaningful, healthy behavior change. Paterson et al. (1999) noted, "The idea of transformation is fundamentally pleasing to health care professionals who struggle to find purpose and reason for the suffering and loss that they witness in those who experience chronic illness" (p.799).

Personally, as a health researcher working in an integrated health system, I believe there is a desperate need to address the disease of obesity in an alternative way, one that empowers and activates the patient, by learning the successful and perhaps transformational moments in a triumphant journey of weight loss. By understanding a patient’s story, this research can advocate from the patient’s perspective, which can be used to spark change in the workflow of the modern medical paradigm.

Assumptions

The following assumptions are embedded in the research study:

1. This research study assumes that maintaining a healthy weight is beneficial to an individual’s overall well-being. Obesity is still a controversial topic in our society, and there are four primary groups that aim to frame their position over the nature and consequences of excess body weight. As a health researcher, this study is taking an anti-obesity research approach.
2. Individuals are capable of changing health behaviors that impact weight. This is an important distinction in the research due to the topic of discussion. Again, there are several arguments in the obesity literature, one of an environmental and industry interaction that suggests an individual is a victim of their environment; or one of obesity as a chronic disease that can be manageable through healthy lifestyle factors. It is assumed that the behaviors surrounding weight gain, specifically sedentary behavior and unhealthy eating are learned, and therefore can be unlearned and replaced by healthier behavioral practices.

3. There are many medical conditions and psychological conditions (cancer, depression, eating disorders) that can impact weight unintentionally. This study assumes that the research participants lost weight intentionally and naturally, without a surgical procedure or as an end product of disease.

4. Research participants attach meaning to their weight loss experience, and this experience is a resource for learning.

5. Research participants can articulate their experience associated with the successful weight loss journey. This assumption relies on the fact that all research participants are developmentally mature, self aware, and able to be reflective. The research participants are not members of a vulnerable or at-risk population.

**Limitations**

Limitations of this study include:

1. Research participants in this study were limited to one medical management program in rural Pennsylvania. Due to the location, there is a lack of diversity in the research participants, and the results may be that of the dominant culture.
2. The definition of weight loss is indefinable in the context of experience. The medical definition of weight loss is the reduction of body mass. However, experience can be attributed to a loss of ten pounds, or one hundred and twenty pounds. The research methodology is qualitative; therefore, the results should not be generalized on a population level.

3. Qualitative research quality is dependent on the skill level of the researcher, who could hold biases.

**Definition of Terms**

To clearly understand the terms presented in the study, the following definitions are offered below.

**Bariatric Surgery:** A surgical operation that restricts food intake, makes an individual feel fuller quickly, decreases calories consumed which aids in the weight loss process (National Institutes of Health, National Institute of Diabetes, Digestive and Kidney Diseases, 2009).

**Body Mass Index (BMI):** A number calculated from a person's weight and height. BMI provides a reliable indicator of body fatness for most people and is used to screen for weight categories that may lead to health problems (CDC, 2011).

**Critical Media Literacy:** “A set of competencies that enables us to interpret media texts and institutions, to make our own media, and to recognize and engage with social and political influence of media in everyday life” (Hoeschsmann & Poyntz, 2012, p. 1).

**Critical Public Pedagogy:** “Ascertains how certain meanings under particular historical conditions become more legitimate as representations of reality and take on the force of
commonsense assumptions shaping a broader set of discourses and social configurations at work in the dominant social order” (Giroux, 2001, p. 170).


**Disease**: A medical condition associated with specific symptoms and signs that can impair normal functioning.

**Energy Balance**: The balance of calories consumed through eating and drinking compared to calories burned through physical activity. What you eat and drink is energy in. What you burn through physical activity is energy out (National Institutes of Health, National Heart Lung and Blood Institute, 2011).

**Health**: A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (WHO, 2010).

**Meaning-making**: 1) Establishing, shaping, and maintaining intersubjectivity; 2) relating events, utterances, and behavior to the action taken, 3) constructing of particulars in a normative context – deals with meaning relative to obligations, standards, conformities, and deviations; 4) making propositions – application of rules of the symbolic, syntactic, and conceptual systems used to achieve decontextualizes meanings, including rules of inference and logic and such distinctions as whole-part, object-attribute, and identity-otherness; 5) becoming critical aware of one’s own tacit assumptions and expectations and those of others and assessing their relevance for making an interpretation (Bruner, 1996 as cited in Mezirow, 2001, p. 4).
Medical Weight Management Program: A non-surgical program which involves a thorough medical and lifestyle consultation with specific plans for weight loss, including long term planning and follow ups.

Obesity: A medical condition in which excess body fat has accumulated to the extent that it may have adverse effects on health. An adult who has a BMI of 30 or higher is considered obese (CDC, 2011).

Overweight: An individual having more body fat than is optimally healthy. An adult who has a BMI between 25 and 29.9 is considered overweight (CDC, 2011).

Transtheoretical Model of Behavior Change (TTM): A behavior theory that assesses an individual's readiness to act on a new health behavior, and provides strategies, or processes of change to guide the individual through the stages of change to action and maintenance (Prochaska & Velicer, 1997).

Transformative Learning Theory (TLT): A process where previously uncritically assimilated assumptions, beliefs, values, and perspectives are questioned and thereby become more open, permeable, and better validated which leads to new or revised interpretation of experiences that leads to action or behavior change (Mezirow, 2000).

Weight bias: Negative attitudes and stereotypes towards individuals who are overweight and obese, and often lead to unfair treatment and discrimination (Brownell, Puhl, Schwartz, & Rudd, 2005).

Weight cycling: The repeated loss and regain of body weight. When weight cycling is the result of dieting, it is often called “yo-yo” dieting.
CHAPTER 2

LITERATURE REVIEW

The purpose of this study is to explore the experience and meaning-making process of individuals who were once enrolled in a medical weight management program who have lost weight and who have kept it off long term. The literature review informs this investigation by providing a better understanding of the knowledge pertaining to the theoretical perspectives used to frame this study including: current strategies used in obesity prevention and weight loss within the medical paradigm, weight discrimination literature with an emphasis on popular media, and the experience of weight loss and weight loss maintenance from an adult perspective. The following main sections are presented: theoretical frameworks, including Transtheoretical Model and transformational learning informed by critical public pedagogy and critical media literacy; impact of obesity; weight discrimination and media; weight loss strategies; and weight loss and weight loss maintenance experience. These main sections are included to provide insights into the multiple bodies of research that connect the theories, current programs and strategies used to lose weight and maintain the weight loss, the effects of weight bias and the role of media, and the practical implementation of developing a transformative weight loss program for a medical paradigm.

Database searches located the articles used in this review included: ERIC, ProQuest, PubMed, Google Scholar, Sciencedirect Elsevier, and Wilson. The key search terms used were: weight, weight loss, weight maintenance, learning, meaning-making, fatism, stigma, discrimination, nutrition, exercise, transformative learning, transformation, learning outcomes, learning processes, experience, public pedagogy,
obesity, media literacy and qualitative research. In addition, reference lists located in articles were reviewed for pertinent citations. Lastly, TV documentaries, reality media, sitcoms, comedians, advertisements, newspaper and magazine articles were also examined in the research. The majority of the research was focused on adult populations. However, there were two studies whose subjects were children, adolescents and young adults that were included in the review due to the scope and significance of the findings, specifically the theoretical frameworks.

**Problem Statement**

Knowledge does not equal behavior (Value Based Management, 2011) and the numerous weight loss interventions, which are often oriented through a behaviorist educational perspective and centered around “doing it for your own good,” are contrary to the science that has indicated that “human decision making and behavior are far from rational, but influenced by contextual factors and cognitive biases and limitations” (Ariley, 2008; Kahneman, 2003; Wansink, 2006, as cited in Robinson, 2010, p. 20).

Regardless of the environmental, systematic approach to creating healthier environments, individuals must balance their own energy intake (food) and energy expenditures (activity) to obtain and maintain a healthy weight. Understanding that there is a socially constructed, powerful fear of fat that is perpetuated by negative perceptions of persons who are obese is helping to continue the discrimination faced by overweight persons. This fear of fat is coupled with a cultural saturation of fast, greasy, nutrition-absent foods and sedentary jobs and technology-driven life-styles that results in an epidemic of obesity often delineated along class lines, with working-class and poor people caught in the catch-22. This stigma has negative implications for winning the individual weight loss
battle. And there is a multi-billion dollar weight loss and dieting industry that markets directly to individuals who are the victims of such discrimination.

Current approaches to weight loss have shown marginal success in sustaining obesity prevention related behaviors (Robinson, 2010). As Jeffery et al. (2004) stated, “The single most important challenge in the clinical management of obesity is improving long-term maintenance of weight loss” (p. 100). Most individuals who initially lose weight do not continue with healthy lifestyle choices and tend to regain weight over time, also called weight cycling, or yo-yo the weight loss/weight regain. It may be that to capture the ingredients needed to create a recipe for long-term, permanent success, a new perspective or conceptual framework for weight loss is needed. The literature indicates that a trigger or a life critical event often sparks a desire to change an individual’s physical activity pattern, or to eat healthier food items (Engstrom et al., 2011; Liberman et al., 2009; Lopez, 1997). But what is not well studied is the experience of that weight loss journey through an adult learning lens. If the critical event or medical trigger is reflected upon, it could lead to a change in an individual’s assumptions that may develop a perspective transformation, which has potential for lasting behavioral change (Mezirow, 2000).

**Purpose of the Study**

Therefore, the purpose of this study is two-fold: a) to explore the experience and meaning-making processes of individuals in a medically supervised weight management program who have lost weight and maintained a healthy lifestyle, and b) to explore how this learning manifested in successful weight maintenance and improved self-identity despite cultural stressors.
Research Questions

Based on the purpose of this study, this research is guided by the following questions:

1. What are the dynamics of the weight loss experience, including behaviors, cognition, perceptions, and self-image?
2. How do individuals make meaning of their successful weight loss experience and does that meaning-making lead to a perspective transformation?
3. What are the key learning outcomes and learning processes of the successful weight loss experience that impacts transformational learning?

Approach to Literature Review

The purpose of this literature review is to integrate obesity prevention efforts and the processes of weight loss and weight maintenance from an adult learning and critical public pedagogical perspective. This review begins by discussing the theoretical frameworks upon which the research is based, Transtheoretical Model of Behavior Change (TTM) (Prochaska & Verlicic, 1997) and Transformational Learning Theory (TLT) (Mezirow, 1991, 2001) and how TLT is informed by Critical Media Literacy and Critical Public Pedagogy (Giroux, 2001, 2004; Heuer et al., 2011; Hoeschsmann & Poyntz, 2012; Rich, 2011). Constructs from all frameworks are discussed and applied to the research context. Next, I explored empirical and conceptual literature surrounding the experience of weight loss. This segment is intended to provide insight into what is known of the meaning-making experience and learning of individuals who have lost weight, and maintained a healthier weight. I also included a wider chronic disease perspective, while acknowledging limitations in current transformative learning research,
in order to position the need to apply an adult learning lens to this context. Lastly, I examined the complexity of issues surrounding obesity in American consumer culture. Sections include empirical research on the human impact of obesity situated in the media, industry, and for-profit medical weight loss management.

**Theoretical Frameworks**

There is both a physiological and emotional component to losing weight and keeping it off. Yet, the weight loss experience can be catalyst for lifelong changes. Although science has made strides concerning metabolic and genetic influences that may impact weight, the question of why losing weight on an individual level is difficult remains unsolved. There are two philosophical perspectives that can provide insight on how individuals differ in adopting and maintaining healthy lifestyle practices that lead to successful weight loss; transformative learning theory and the transtheoretical model of behavior change. Mezirow (1991, 2001) and Prochaska et al. (1994, 1997) have produced a volume of research that focuses on how people change behaviors through these theories. Both of these theories offer lens through which to view the behavior change process.

**The Transtheoretical Model of Behavior Change**

The Transtheoretical Model of Behavior Change (TTM) has been popular in designing interventions for the promotion of different health behaviors. Developed by Prochaska and colleagues in 1977, during a comparative analysis of theories in psychotherapy, TTM integrates processes and principles of change from different theories of interventions (Prochaska & Velicer, 1997). The TTM framework consists
four core constructs; stages of change, processes of change (Prochaska & Velicer, 1997), decisional balance (Janis & Mann, 1977), and self-efficacy (Bandura, 1977).

**Stages of change.** There are five main stages of change: pre-contemplation, contemplation, preparation, action and maintenance. The five stages are organized to create change over time, unlike many theories that imply that change is an event. The pre-contemplation stage is described as when an individual is not intending to take action in the foreseeable future, measured in the next six months (Prochaska & Velicer, 1997). Contemplation is when an individual is intending to change in the next six months (Prochaska & Velicer, 1997). Individuals often get stuck in this stage due to the analysis of the pros and cons of changing. For example, a person contemplating a plan to lose weight might be ambivalent about giving up certain foods, or make a habit of saying that they “will start their diet tomorrow.” Preparation is defined as the stage an individual undertakes when he or she intends to take action in the immediate future, or within 30 days (Prochaska & Velicer, 1997). Typically, this stage is when a plan of action is developed. A weight loss action plan could include buying a dieting book, or talking to their physician about their weight gain. Prochaska and Velicer (1997) believe that people in this stage should be recruited for an intervention and enrolled in a weight management program.

Action, the fourth stage is marked by a modification to an individual’s life-style, measured within the past six months (Prochaska & Velicer, 1997). Behavior change is the key to this stage and, to count as such, Prochaska and Velicer (1997) stated that the change should impact disease. In a weight loss context, pounds lost could measure this, or improved vitals and lab measurements at a routine encounter like lipid panel or blood
pressure. And the final stage is maintenance, which is when an individual is working to prevent relapse, or keeping the weight off.

**Processes of change.** Another core construct of the TTM are the processes of change. There are ten major processes of change divided into two experiential and behavioral processes. Experiential processes include: consciousness raising, dramatic relief, self-reevaluation, environmental reevaluation, self-reevaluation, and social liberation. The behavioral processes include: helping relationships, counter-conditioning, contingency management, stimulus control and self-liberation (Prochaska & Velicer, 1997). The first five are classified as experiential processes and are used primarily for the early stage transitions, pre-contemplation, contemplation, and preparation. The last five are labeled behavioral processes and are used primarily for later stage transitions, which are action and maintenance. Combining these components within the Stages of Change creates a theoretical foundation and application for facilitating behavior changes in individuals by moving through a sequence of stages, propelled by several psychological processes.

Processes of change are the hidden and explicit activities that people use to progress through the stages (Prochaska & Velicer, 1997) that focus on attempting to “modify affect, behavior, cognitions, or relationships” (Moore, 2005, p. 397). Prochaska and Velicer (1997) compare the processes to independent variables, which provide a framework for the development of interventions and programs. Moore (2005) believes that these processes are the fundamental basic change principles that are the foundation of any attempts that focus on coping activities, educational techniques, and psychotherapy interventions.
**Decisional balance and self-efficacy.** In addition to the five stages of change and the ten processes of change, TTM offers a third and fourth construct that forms complex variables that includes measures to progress through the five stages. These include decisional balance, self-efficacy, and temptation (Prochaska & Velicer, 1997). Decisional balance reflects the individual’s subjective pros and cons of changing. This measurement of the importance of the pros and cons in deciding to change has been related to the stages of change progression (Velicer et al., 1998).

For example, across the first three stages, the benefits of exercising outweigh the cons. However, as an individual progress through the stages of change, the cons sharply increase. In the remaining two stages, the cons outweigh the pros. This example reflects the cognitive choices that are needed to progress through behavior change that is a continual lifestyle decision (Velicer et al., 2008). With this example demonstrated by Velicer and company, the model indicates that exercise behaviors require a constant series of decisions, which are often difficult to adhere to (Velicer et al., 2008). However, in theory, as a person travels through the Stages of Change, decisional balance shifts and self-efficacy strengthens (Moore, 2005).

Self-efficacy refers to a situation-specific confidence that enables individuals to cope with high-risk situations without relapsing to their unhealthy habits (Prochaska & Velicer, 1997). For example, Joan has been losing weight and is looking forward to a family reunion to show off her new figure. But Joan has realized through therapy that her family has always put her down and has exacerbated her eating issues by their behavior towards her. Her self-efficacy has suffered at their hands and she has yo-yo dieted for the past fifteen years. Now, she finds herself weighing her desire to see her family with her
efforts to build her own self-efficacy and eat healthily. Self-efficacy research conducted by Bandura (1977) showed that the perception a person has about his or her own ability to act out a specific behavior is important in determining behavior change. Self-efficacy is an important concept in weight loss as research as demonstrated that weight gain has psychological and social implications that can lead to lowered self-concept (Puhl & Latner, 2007). For example, can a person attending a family picnic that contains high caloric foods resist a poor food choice? Temptation reflects the urges to engage in a specific habit in the midst of a stressful situation (Prochaska & Velicer, 1997). Both self-efficacy and temptation have the same structure and can be tracked through the stages of change. There are typically three types of temptations: negative affect or emotional distress, positive social situations, and craving (Prochaska & Velicer, 1997). As a person travels through the stages, decisional balance shifts and self-efficacy strengthens, giving the individual increased self-efficacy and competence (Moore, 2005). The balance between decisional balance and self-efficacy decreases temptation to relapse and increases the likelihood for the maintenance stage.

**Transformative Learning Theory**

Transformative Learning Theory (TLT) is abstract, idealized, and grounded in human communication and sprung from the discipline of adult education (Taylor, 1998). TLT fills the gaps in TTM by offering a framework and theory for understanding how individual life experiences impact the creation and transformation of meaning. TLT offers a theoretical lens through which to view the role of individual development through personal experiences in the weight loss and maintenance process.
TLT helps researchers understand how people make meaning of their experiences, their relationships, and perhaps even society. Most importantly, TLT constructs a new or revised interpretation of those experiences, which often involves deep, powerful emotions or beliefs, and is evident in action or behavioral change. When an individual experiences something that does not fit into their pre-conceived expectations that are based on past experiences, or when something out of the blue occurs that contradicts previously held values and beliefs, they can accept, reject, or question that experience. When they critically examine their expectations, revise them, and establish actions based on those revisions, transformative learning can occur. In order to clearly understand our experiences we must know under what circumstances an idea is true. Mezirow (2000), the dominant developer of the theory of transformative learning insists “that in the absence of fixed truths and confronted with often rapid change in circumstances; adults cannot trust what we know or believe” (p.3). Beliefs must be reevaluated. TLT helps people make meaning through assisting with “becoming aware of one’s assumptions and expectations and those of others and assessing their relevance for making an interpretation” (Mezirow, 2000, p.4). This type of learning can lead to the development of perspectives that are more inclusive and integrative of wider experiences (Mezirow, 2000).

Experience is essential to a perspective transformation taking place. In essence, individuals who experience transformative learning develop more reliable beliefs, validate their fidelity, and can make more informed decisions; attributes which are fundamental to an adult learning process that results in lasting change (Mezirow, 2000). Mezirow (1994) describes transformational learning theory as being “constructivist, an
orientation which holds that the way learners interpret and reinterpret their sense experience is central to making meaning and, hence, learning” (p. 222).

Mezirow (2000) has identified ten phases of perspective transformation that include:

1. A disorienting dilemma
2. A self-examination with feelings of guilt or shame
3. A critical assessment of epistemic, sociocultural, or psychic assumptions
4. Recognition that one’s discontent and the process of transformation are shared and that others have negotiated a similar change
5. Exploration of options for new roles, relationships, and actions
6. Planning a course of action
7. Acquisition of knowledge and skills for implementing one’s plan
8. Provision trying of new roles
9. Building of competence and self-confidence in new roles and relationships
10. A reintegration into one’s life on the basis of conditions dictated by one’s perspective. (p.11)

The majority of these phases align with contemplation and the implementation of an individual’s revised perspective in the TTM.

Mezirow (1978) defines a perspective transformation as “a structural reorganization in the way that a person looks at himself and his relationships” (p. 162). These ten phases of perspective transformation encapsulates three dimensions: psychological (changes in understanding of the self), convictional (revision of belief systems), and behavioral (changes in lifestyle) (Clark, 1991). Within the ten steps of
transformative learning, there are four main phases that include emphasis on how individuals encounter an experience: disorienting dilemma, critical reflection, reflective discourse, or rational dialogue and action. Central to all phases of the process of transformative learning is experience.

Mezirow believes that transformative learning usually results from a “disorienting dilemma” (Taylor & Cranton, 2012, p. 212), which is triggered by a life crisis or major life transition, although it may also have a wider meaning and can result from an accumulation of transformations in meaning schemes over a period of time. These meaning schemes over time are also called ‘other triggers, or “integrating circumstances”, all of which may promote transformative learning experiences (Clark, 1993, p. 54). Clark (1993, May) argues that these “integrating circumstances” can invite an individual into greater personal exploration. These “integrating circumstances” are described as missing contextual factors that allow for a person’s life issue to be resolved (Clark, 1993). These circumstances do not appear suddenly, instead “they are more subtle and less profound, providing an opportunity for exploration and clarification of past experiences” (Taylor, 2000, p. 299).

For example, weight gain occurs over an extended period of time, as can dramatic weight loss. The transition to weight loss can arguably be a result of a disorienting dilemma that triggered the remaining nine steps leading to a perspective transformation of behavior, or taking those steps could have resulted from an accumulation of small behavior changes and meaning schemes over a period of time, yet little is known about this occurrence in this context.
It is important to recognize the rational and analytical processes of transformative learning. These processes involve individual’s changing their frames of reference by critically reflecting on assumptions, beliefs and consciously implementing plans that bring about new ways of defining their worlds (Mezirow, 1991). A frame of reference has two dimensions; a habit of mind and resulting points of view (Mezirow, 1991). Every adult has developed a habit of mind, meaning the broad predispositions that an individual uses to interpret an experience (Cranton, 2006). Mezirow (1997) describes habits of mind as:

- broad, abstract, orienting, habitual ways of thinking, feeling, and acting
- influenced by assumptions that constitute a set of codes. These codes may be cultural, social, educational, economic, political, or psychological. Habits of mind become articulated in a specific point of view - the constellation of belief, value judgment, attitude, and feeling that shapes a particular interpretation. (p. 5)

However, a point of view is described by Cranton (2006) as a cluster of meaning schemes that are habitual and implicit for interpreting experiences.

A key component to TLT is critical reflection. Critical reflection is the questioning of the integrity and validity of assumptions and beliefs based on experience (Mezirow, 1991). Critical reflection often occurs after a disorienting dilemma, or a group of experiences that contradict our previous thoughts, assumptions, and beliefs. Critical reflection takes the form of self-examination, or a critical assessment of our sociocultural or epistemic assumptions. Mezirow (2003) suggests that adults must establish or development a capacity to be critically self-reflective and to exercise reflective judgment. The ability to critically reflect isn’t innate, it must be learned.
This type of reflection can lead to the need to create dialogue with others. Mezirow (1991) calls this process rational discourse. Rational discourse is the essential medium through which transformation is promoted and developed. During this process, an individual will explore his or her newly discovered dilemma with others, either in a one-on-one or a group environment. It often involves those that have had similar situations of discontent and questioning, and where an environment is created to share how others have encountered the process of transformation (Mezirow, 1991). Rational discourse can help individuals explore new roles, alternative perspectives and meanings, and to establish a plan of action. Ultimately, this type of discourse needs ideal conditions. Habermas believes that having “complete information, being free from self-deception, being able to evaluate arguments objectively, having empathy, and having an equal opportunity to participate in the discourse is critical” to rational discourse (Merriam, Caffarella & Baumgartner, 2007, p. 134).

Developing an action plan is the last phase of transformative leaning. This occurs after an individual involves emotions and changes their frames of reference by critically reflecting on previous assumptions. Ultimately, change can occur immediately or over time, but an individual must be able to select appropriate actions in different environments. Having gone through these steps, Mezirow (2000) believes that individuals may consciously implement plans that create change and new ways of dealing with and defining their assumptions, values and belief systems – the way they make meaning from life experiences. Bruner (1996 as cited in Mezirow 2000) defined meaning making as:
Establishing, shaping, and maintaining intersubjectivity, relaxing events, utterances, and behavior to the action taken, constructing of particulars in a normative context – deals with meaning relative to obligations, standards, conformities, and deviations, and making propositions – application of rules of the symbolic, syntactic, and conceptual systems used to achieve decontextualized meanings, including rules of inference and logic and such distinctions as whole-part, object-attribute, and identity-otherness. (p.4)

Derived from the works of Mezirow and the rational, cognitive transformation, adult education literature on transformative learning has grown to emphasize additional perspectives that include cultural-spiritual (Tisdell, 2005), social change (Freire, 1994) and psychology (Boyd, 1991), among others. This theory continues to develop and the body of literature grows to capture these theoretical developments. According to Mezirow (2000), research in transformative learning stems from “… our desire to understand the meaning of experiences, integrate it into what we do, and avoid chaos” (p. 3). Transformative learning adds depth to the meaning making process by helping adults become critically aware of their assumptions and beliefs and making meaning in everyday experiences. Tisdell’s (2005) cultural-spiritual transformative learning orientation pays a close attention to the role of context and positionality to the literature on TLT that informs the use of TLT in the weight loss context.

Cultural-spiritual orientation. Mezirow’s theory of transformative learning is a theory of personal, individual transformation, and is often criticized for neglecting the role of context and social change (Taylor, 1997). The dramatic journey of weight loss is contextual and often involves aspects of popular culture, socio-cultural contexts, social
structures, gender and race. For that reason, it is important to include aspects of Tisdell’s (2003) cultural-spiritual orientation of transformative learning. This orientation places a greater degree on the positionality of the learner that may relate to the integration of some aspect of one’s identity, around culture, gender, sexuality or life role status. Tisdell (2005) stated that this view is concerned with the “connections between individuals and social structures….and the notions of intersecting positionalities” (p. 256). Key components of the cultural-spiritual view of transformative learning include cross-cultural relationships and a culturally relevant learning environment that supports the need to explore cultural, symbolic, and affective levels (Tisdell, 2003).

**Critical Media Literacy and Critical Public Pedagogy**

Critical media literacy and critical public pedagogy also inform the theoretical grounding of transformative learning. Media has a conscious and unconscious effect on what we think and how we think about both social and personal issues (Tisdell, 2008). From the perspective of adult education, media has the power to educate and “miseducate” the public. Critical media literacy, or a “set of competencies that enables us to interpret media texts and institutions, to make our own media, and to recognize and engage with social and political influence of media in everyday life” is an important skill for individuals who struggle with weight (Hoeschsmann & Poyntz, 2012, p. 1). A related topic, public pedagogy, refers to “the education provided by popular culture” and how “popular culture teaches audiences and participants through the ways it represents people and issues and the kinds of discourses it creates and disseminates” (Sandlin, 2007, p. 76).
Within this topic of obesity prevention and weight loss, the media often reinforces a dominant ideology of beauty and thinness (and beauty as thinness). Learning how to critically analyze how body shapes and sizes are positioned in film, TV, and advertising, individuals may better understand how this position presents an argument of obesity as a personal responsibility which hinders public policy and the treatment of obesity from a medical perspective, while creating a market for industry to develop and sell weight loss products based on junk science and/or lies and hype. There is an overwhelming corporate dominance of media with the single purpose of making money, as opposed to the humanist approach of selling products that promote health and wellness. The ideals of a capitalist society, including personal autonomy and individual responsibility, help to mask the powerful social and industrial productions that continue to create ‘obsogenic’ environments.

In addition, the mass media is a compelling example of the social acceptability of weight stigma (Heuer et al., 2011; Puhl, 2011). Stigma through this medium is often seen in a multitude of forms, from the constant ridicule of overweight persons in television and film, to the media’s blaming the individual for weight problems while ignoring structural and economic causes in the majority of news coverage (Heuer et al., 2011; Puhl, 2011). Critical public pedagogy “should ascertain how certain meanings under particular historical conditions become more legitimate as representations of reality and take on the force of commonsense assumptions shaping a broader set of discourse and social configurations at work in the dominant social order” (Giroux, 2001 as cited in Rich, 2011, p. 170). Reality media is a part of popular culture that creates obesity discourse where individuals come to learn about their bodies and health. For example,
TLC’s television series *Obese & Expecting* follows obese women who are pregnant. This documentary type series aims to illustrate the medical complications that could arise with obese pregnancies, an important health topic. The intent of the show, one could assume, would be to better understand the dangers behind obesity related medical conditions that could impact mother and baby during delivery. However, a common phrase like “eating for two” takes on new meaning when watching this show. In fact, bloggers have gone as far as calling the participants selfish and needing “to hit the gym hard and stop hoping that the latest fad diet will do the trick. They need to think about their kids and how devastating it will be to their children if Mommy dies young at the hands of her enormous weight” (Horton, 2012). From these comments, it is evident that obesity is positioned as self-regulation, which often assists negative connotations towards weight.

Additionally, Rich’s (2011) article reveals the connection between public pedagogy and the obesity crisis, positioning reality media as an avenue that creates obesity discourse. Her work critically examines how individuals learn about their bodies and obesity through these social contexts. She situates obesity media specifically that of reality television shows, as cultural texts and shows how they function as public pedagogy (Rich, 2011). She states that it is crucial to recognize that when “considering these media as forms of public pedagogy, they can be understood in terms of their political and educational character and how they align with broader social, racial, economic, class and institutional configurations” (Giroux, 2008, as cited in Rich, 2011, p 5). This includes issues of lookism and fatism as they are structured for public consumption.
However, not until recent years has reality media on weight loss been studied from the angle of changing individual’s worldviews or actions. Glidden’s (1976, 1984, 1990) noted, “Questions about social, economic, and technical structures should not be approached separately from questions about human agency” (as cited in Hoechsmann & Poyntz, 2012, p. 40). Media can impact human experience and the ability to act and make changes in the world. Giroux notes that “learning extends well beyond the boundaries of formalized education sites, and instead operate[s] within a wide variety of social institutions and formats including sports and entertainment media, cable television networks, churches” (Giroux, 2004, as cited in Rich, 2011). Research supports a connection between adult learning and popular culture, noting “popular culture influences individual worldviews” (Tisdell, 2008; Tisdell & Thompson, 2007; Wright, 2007a, 2007b as cited in Wright & Sandlin, 2009, p. 119). Reality media in the United States such as *We’re Killing the Kids,* *Supersize and Superskinny,* *The Biggest Loser,* and *Celebrity Fit Club* at times carry health messages with undertones of ethics, values, and how individuals should behave, which in most cases are in accordance with the dominant ideology (Evans, 2006, as cited in Rich 2011). From a theoretical perspective the media may send a pervasive message about obesity that can influence worldviews on individual responsibility, and result in blaming the victim (Rich & Evans, 2005). Media may also send messages on ways of thinking about large body sizes, what constitutes beauty and overall health education. In this study I examine how media and other social spectrums impact individual learning processes in relation to weight loss.

It is important to note that “Fattertainment” (Heuer, 2013) in film and weight loss interventions on television are a form of what Giroux calls “teaching machines” (Giroux,
1995, as cited in Hoechsmann & Poyntz, 2012, p. 50). Although Giroux (1995) (as cited in Hoechsmann & Poyntz, 2012) the example of Al Gore’s documentary *An Inconvenient Truth*, many television programs surrounding weight also use fancy propaganda, ad placements, and celebrity figures to draw people into current events. Just as Handley (2007) pointed out that the hip-hop culture can shift ideological paradigms that challenge the viewpoints of earlier generations, the same can hold true by critically examining and making room for dialogue regarding the implicit associations that the majority of individuals have on obesity.

Hoechsmann and Poyntz (2012) stated that the hardest part of evaluating media is determining the impact on everyday life. If a message is dominant in the media and consumers are constantly exposed to the same message, what are the effects? One outcome is the “effects without guarantees” which means, “some people, some of the time, can be impacted by media experience to the point of it directly affecting their behaviors or actions” (Hoechsmann & Poyntz, 2012, p. 93). Some television series are an ideal example of fatism. Many thin characters that star in television shows are usually involved in romantic relationships and are active. This is compared to heavier characters that are rarely seen in romantic relationships, although if they are, the relationship is most likely with someone of the same size. In addition, heavier characters are usually the “funny” character and often the victim of ridicule (Greenberg, Eastin, Hofschire, Lachlan & Brownell, 2003).

**Theoretical Assumptions**

I have presented the basic constructs of TTM with accompanying empirical literature, as well as TLT, a theory of adult learning. Because no single theory is likely to
explain all of the complexities of behavior change, or weight loss, the similarities and differences between TLT and TTM provide an interesting context to explore how these different bodies of literature might inform the practice of adult learning and program implications for weight loss in a medical paradigm.

Prochaska and Velicer (1997) acknowledge that behavior change is dynamic, and always changing. The TTM is an ever-changing theory and there are always new developments. Prochaska and Velicer (1997) outline several critical assumptions to the TTM. One assumption is no one theory that can predict behavior change in all humans, which is why the TTM is comprised of a multitude of psychotherapy models. The second assumption is that without planned interventions individuals will stay in the early stages of change and never advance. Prochaska and Velicer (1997) believe that this is true because there is no intrinsic motivation to move through the stages. In addition, the third assumption is that not all individuals are able to move through the stages of change. This is true for vulnerable and at-risk populations, which corresponds with many assumptions of TLT and Maslow’s Hierarchy of Needs (Huitt, 2007). The fourth assumption is that the TTM does not acknowledge power structures or hegemony. Prochaska and Velicer (1997) believe that chronic behavior patterns are created by influence from biological, social, and willpower or self-control, which is the fifth assumption.

**Adult education orientation.** Additional philosophical assumptions of TTL and TTM stem from the theoretical orientations. TTM is situated in a behaviorist orientation and TL is situated in a humanist orientation, while critical media literacy and critical public pedagogy takes a critical orientation. There are numerous health behavior change theories, specifically geared towards healthy eating and physical activity that are oriented
in a behaviorist education perspective and centered around “doing it for your own good.”

Strobe (2008) noted that:

These theories assume that behavior is a function of a deliberate intention formed by individuals on the basis of the evaluation of the expected consequences of that behavior, their subjective norms with regard to performing the behavior, their assessment of the ease of difficulty of performing that behavior. (p. 142)

TTM, grounded in a behaviorist philosophical orientation, does not offer much value for understanding how individuals change over time. This model helps to predict if an individual is ready to change, it may help to predict success in an intervention, and to assist in guiding a change. The TTM is primarily cognitive based, rooted in psychology and does not draw attention to how the individual’s experience impacts meaning, or how environmental or social factors may impact change processes (Strobe, 2008).

Moreover, TTM and TTL both focus on the individual and are learner-centered. A perspective transformation involves individual development, which is both inherent, and an outcome of the process (Merriam et al., 2007). In both theories the process of learning is individually based on the current stage of change that is more important than the content of an intervention (Merriam et al., 2007). In many weight-loss interventions the content is the primary driver, which often indirectly places blame on the individuals and increases discrimination, specifically in a weight context. A good example is the Georgia Children’s Health Alliance obesity prevention campaign; Strong4Life (2012) is geared towards children and is the latest prevention campaign that has been criticized for bullying and non-constructive messaging. Judgment was also passed on this campaign in a Washington Post article by D’Arcy (2012) for going too far in its messaging, which
features children who appear lazy and inactive and does not analyze or educate about the “larger forces that lobby for and market sedentary, nutritionally void lifestyles.”

**Humanism.** Humanism assumes that people control their destiny, are inherently good, and will strive for a better world (Merriam et al., 2007). Similarly, TLT focuses not on what happened to people, but how he or she interpret and explain their experiences and how that interpretation determines their actions and emotional well-being. However, a researcher’s perspective on obesity can impact their philosophical assumptions. Weight gain and weight loss are multi-dimensional and involves socio-cultural, physiological, psychological, and educational perspectives. Many of which are controversial and, depending on the epistemological viewpoint of the researcher or educator, this could have implications for choosing the approach to investigate this phenomena. The causality of the weight gain should be explicitly stated in order to agree with the above assumptions. On one hand the assumption that “people are free to act, and behavior is the consequence of human choice” (Merriam et al., 2007, p. 282) does not solely support the facts that food can be an addiction or obesity as a disease or behavior is heavily influenced by culture. In fact, this assumption brings back the debate that living with a chronic weight condition increases social discrimination due to connected beliefs that they are lazy and unintelligent (Puhl & Heuer, 2010). As Puhl (2010) stated, “Throughout history, stigma has imposed suffering on groups vulnerable to disease and impaired efforts to thwart the progression of those diseases” (p. 1019).

**Constructivism.** Mezirow’s (2000) work and the subsequent orientations of TLT are based on a constructivism worldview. A constructivist educational paradigm has similarities to a humanist philosophy. Constructivism posits that learning is an active,
constructive process (Merriam et al., 2007). Assumptions that underpin this paradigm are that individuals participate in their own construction of reality and the context of those experiences influences that reality (Cranton, 2006). Constructivists also differ as to the nature of reality, the role of experience, and the process of meaning-making (Merriam et al., 2007). Learning is an internal cognitive task and teaching from this perspective must create cognitive conflicts that encourage learners to develop new knowledge schemes. Critical reflection and rational discourse can be fostered in this way through supportive group settings or individual mentoring, which are an active process that helps the learner understand that others have been through similar situations. Supportive groups or helping relationships can also build a bridge new relationships and new actions that build self-efficacy and competence. These steps of the transformative process can lead to a perspective transformation in which meaning schemes or habits of mind undergo a modification. Again, similar to the humanistic approach, experience is central to learning in the constructivist worldviews.

**Critical orientation.** For the purposes of this research a critical orientation in the area of weight focuses on recognizing how capitalism shapes social relations, our belief systems, and assumptions that justify economic and political inequality. From a theoretical perspective, individuals should learn to critique and question the current status of our obesity epidemic. Critical theory assumes that social reality is historically constituted and that it is produced and reproduced by people. Critical theory focuses on how power structures and how the influences of propaganda create certain ideologies in our society.
There are three assumptions deep-seated in a critical orientation: challenging ideology, exposing hegemony, and unmasking power (Brookfield, 2005). Ideology “signifies ideas and beliefs which help to legitimate the interests of a ruling group or class specifically by distortion and dissimulation” (Eagleton, 1991, p. 30). Ideology becomes hegemony, the second assumption of critical theory when everyday decisions and actions are influenced by aggressively persuasive entities like the media. In chapter four of Brookfield’s The Power of Critical Theory, hegemony is defined as “the process by which we learn to embrace enthusiastically a system of beliefs and practices that end up harming us and working to support the interests of other who have power over us” (Brookfield, 2005, p 93). A hegemonic culture is “a culture successful in persuading people to ‘consent’ to their oppression and exploitation” (Brookfield, 2005, p 93). Instead of being a system of dominance, hegemony is the behaviors and actions the people of a community engage in on a daily basis. In essence, this term can describe the process of an elite group convincing another group that being obedient is the right thing to do. The third assumption of critical theory is uncovering power structures. Power is involved in all human interactions and relationships (Brookfield, 2005). Foucault states that unmasking power is difficult due to “the configuration and exercise is justified by and embedded in prevailing ways of thinking and speaking” (Brookfield, 2005, p 47). Foucault called this the “regimes of truth” (Brookfield, 2005, p 47). A goal of critical theory is to become critically reflective, questioning and challenging status-quo and the unjust circumstances that many adults face on any given day until alienation and domination is eliminated (Brookfield, 2005). A critical orientation looks at systems and forces that shape adults’ lives and oppose attempts to challenge ideology, recognize
hegemony, and unmake power. This orientation connects adults to a democratic state across barriers of race, gender, class, and weight.

**Theoretical Intersection**

To this point, I have presented the basic constructs of TTM and TLT, as well as the tenants of critical public pedagogy and critical media literacy and theoretical assumptions. Because there is not one theory that can explain the complexities of behavior change in relationship to weight loss or weight gain, the differences and similarities of these theories can provide a framework to explore how adults learn through weight loss and weight loss maintenance. This section begins by discussing the intersection of TLT, TTM and critical public pedagogy.

Mezirow (1992, as cited in Moore, 2005) stated that it is important to understand that “there is no simple one-to-one relationship between deciding to change a behavior and doing so, or everyone would have quit smoking long ago” (p. 404). Researchers using both theoretical lenses believe in change occurring over time, and not as a singular event. When working in the fields of behavior change and adult education it is important to examine how the TLT and TTM compliment and inform each other. Although TLT is not a stage theory per se, there are many similarities to TTM. However, with a more complex issue like weight loss, there are degrees that may impact the individual’s experience that may not fit exactly into any one model, or any specific change process. The schema adopted from Moore (2004, p. 413), clearly organizes how the TTM and TLT models are correlated (Table 1). The TLT phases of perspective transformation clearly align well with the TTM.
Table 1

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<th>Phases of Perspective Transformation and the Process of Change in Relation to the Stages and Levels of Change</th>
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Both theories explain change as transformational and a process. TTM concurs that change occurs in stages, although not necessarily in a specific order. However, TLT recognizes that critical reflection and validation of experiences does not usually happen in a singular event (Moore, 2005). Mezirow (1991) posits that once an individual
“transforms” and fully understands an issue and is committed to action, change is irreversible. However, before an individual achieves this irreversible change, backsliding is possible. This is in alignment with TTM that often suggests the possibility of relapse. These theoretical tenants are often nonlinear, as individuals enter at different levels of readiness and learning approaches which impact the change processes citing the change to be recycling, or a spiraling movement (Mezirow, 1991; Prochaska & Velicer, 1997).

The theories also have differences. TTM has been criticized for the fact that human functioning is too versatile and multidimensional to be categorized into discrete stages (Bandura, 1977). Using weight loss as an example, the TTM model seems to be too constricting. A number of studies attempting to change a single behavior use TTM (Spencer, Wharton, Moyle, & Adams, 2007; Wilson & Schlam, 2004). Weight loss, however, is a multifaceted and complex set of behavioral modifications and in need of higher level learning constructs that could lead to multiple behavior changes at once. In this case, the addition of TLT as a tool of analysis adds the necessary schema to understand a change in an individual’s worldview leading to weight maintenance.

Lastly, TLT differs dramatically from TTM and other theories because of its implications for adult learning. TTM describes the stages of changes through a given health behavior. This is valuable because it offers a framework to assess an individual’s readiness to participate in change. However, it does not offer much in the way of how an individual changes through learning processes. TLT offers a way to analyze the cognitive, emotional, and social learning processes that assist an individual to create change. TLT can provide a lens through which to explore the experiences associated with a given context over time. The intersection of these two theories adds value to this
study of adult health education and behavior change. By adding an adult learning perspective, specifically the TLT to the TTM, the ability to interpret meaning-making behind life experiences can be deeply examined (Moore, 2005). There is an organic need to converge these two theories. It may be that adding the TLT lens to TTM provides a more holistic approach to represent “what the individual experiences and how to cope as she or he proceeds through the journey of transformational change” (Moore, 2005, p. 409).

By adding the third theoretical intersection of critical public pedagogy and media literacy, this work in weight maintenance will add depth to the current literature on how to approach the obesity epidemic. It is stated that adult educators should focus on public pedagogies because it is “at least partially in and through these spaces of learning that our identifies are formed” (Sandlin, Redmon-Wright, & Clark, 2011, p. 5). Messages that are received through media are how individuals read the world and create assumptions and beliefs on gender, race, beauty, and culture. Learning how to critically analyze and deconstruct the positionality of obesity in film, TV, and advertising, paying specific attention to power relations and representation of images, from a theoretical perspective, may assist individuals to better understand how media presents an argument of obesity as a personal responsibility. Adults are not independent, autonomous agents of change. We live within “cultural institutions with which they interact” with media and popular cultures (Sandlin et al., 2011, p. 5).

Media can impact human experience and the ability to act and make changes in the world. Hoechsmann and Poyntz (2012) pointed out that the hardest part of evaluating media is determining its impact on everyday life. If a message (e.g. food advertising,
extremely thin celebrities, heavy people as objects of ridicule, public service announcements that discriminate against obese persons, etc.) is dominant in the media and consumers are constantly exposed to the same messages, what are the effects? One outcome is that “some people, some of the time, can be impacted by media experience to the point of it directly affecting their behaviors or actions” (Hoechsmann & Poyntz, 2012, p. 93). In fact, Giddens (1976, 1984, 1990) stated “Questions about social, economic, and technical structures should not be approached separately from questions about human agency” (as cited in Hoechsmann & Poyntz, 2012, p. 40). The last theoretical tenant of this study aims to uncover how individuals who have successfully lost weight developed critical awareness about the negative messages in popular culture in spite of the toxic environment. Therefore the question still remains unanswered; what learning happens through the experience of weight loss and weight loss maintenance? The next section reviews the literature of these experiences paying specific attention to qualitative methodology and adult learning.

**Weight Loss and Weight Loss Maintenance Experience**

Some scholars have discussed the concept of transformation in the healthcare setting. In this framework, transformation often refers to people being changed by the experience living with a chronic disease and moving beyond the negative aspects associated with that disease and realizing the positive aspects of the life-altering affliction (Dubouloz et al., 2010). Transformative experiences have also been described in other medical literature regarding living with diabetes or stroke (Paterson et al., 1999 & Kessler et al., 2009), the process of grieving (Fielden, 2003), meaning-making of an HIV diagnosis (Baumgartner, 2002; Courtenay et al., 1998), and organ transplantation (Sharp,
1995). Often this event or experience is described as a change in the way he or she understands themselves and his or her relationship to the world. Further exploration of these experiences may explain the process that creates permanent change or perspective transformation for certain individuals. By focusing on a specific area of concern, in this case weight loss maintenance, we can narrow down these experiences that led to success. These success measures can lead to the development of treatment programs that will lead to long term outcomes and better communication between patient and clinician.

**Experience of Chronic Disease**

Dubouloz et al. (2010) literature review found that there was an abundance of articles that studied personal change in chronic diseases. However, only five studies were found with a focus on transformation in a primary care setting (Dubouloz, et al., 2010). Of these, three of the five focused on Mezirow’s transformative process and the others had little conceptualization around a theory that explained the transformation process. Studies including diseases with a medical diagnosis were HIV/AIDS, arthritis, and Type II diabetes (Baumgartner, 2002; Dubouloz, Laporte, Hall, Ashe, & Smith, 2004; Paterson et al., 1999). In addition, these studies did not discuss a particular theory explaining the transformative process and, therefore, few practical implications have resulted from such research (Dubouloz et al., 2010). There was only one study found that focused on the complex issue of body weight and perspective transformation (Bradshaw, 2008).

It is important to recognize the significance of investigating individual experience with chronic disease. This body of literature can inform and recommend the support and facilitation of transformation from the healthcare team (Dubouloz et al.,
In addition, Dubouloz et al. (2010) recognized the importance of creating a conceptual framework that could help guide practitioners. However, the obesity and weight loss context is much different from those diseases that have been studied to date. Dubouloz’s (2010) transformation process is characterized by three phases: “initial reaction, embracing the challenge, integration of new ways of being” (p. 288). This concept is surrounding the initial reaction period and subsequent period of making adjustments to adjust to living with the disease. Obesity is not diagnosed in the same way as other chronic diseases and, in many ways, is more preventable. Moreover, in physical and physiological dimensions, obesity is nearly 100% reversible, with exceptions. Transformation in the obesity context is more aligned with permanent behavior changes.

Of the five studies focusing on transformation in the primary care setting all were situated in the constructivism paradigm (Dubouloz et al., 2010). With the equal need to understand how to prevent weight gain, there is also a need to understand those who accomplished this successfully on an individual level. There is a wealth of literature surrounding the addictive behaviors such as drug and alcohol addiction, and obesity rehabilitation can benefit from what works for those health issues. However, little research exists in the area of weight-loss and weight loss maintenance experience through this lens, except for Bradshaw (2008).

Bradshaw’s (2008) dissertation was one of the only studies to offer a conceptual framework for sustaining long-term behavior change as it relates to body weight and transformative learning. This study used a qualitative phenomenological research method, interviewing 10 women who have ‘sustained’ a behavior change that led to the
management of their weight. This foundational study found that behavior change resulting from transformative learning could exist through what she coined ‘mini-episodes’ of transformation that helps individuals navigate through evolving environments. There still are gaps in the evidence that could aid in weight management interventions, and furthermore the transformative learning theory. First, this study focused on women only. Secondly, evidence suggests that media has substantial impact on how we make sense of the world. There was no mention of media in the study. Furthermore, weight loss seemed secondary to the intent of the research, with the background of the overall problem being lack of research in sustaining intended behaviors. We know that obesity is a complex, multifaceted disease that has specific consequences and influenced by a variety of factors.

Although there were few articles focusing on transformative learning theory and weight loss, there is a small body of literature in other disciplines that addresses this type of experience in other health related contexts. Individuals with cancer seeking integrative care were researched using a four phase transformative process in which patients learned about how they relate to the world (Mulkins & Verhoef, 2004). Alternative care approaches, often not seen in a traditional medical system were found to be important to the transformative process; these included aspects of services that supported journal writing, a focus on well-being, healing relationships, and overall cancer management (Mulkins & Verhoef, 2004). Implications for practice suggest that practitioners can create environments that support a transformative experience. The remaining sections focus on the literature that focuses on the weight loss and weight maintenance experience, which is not informed by an analysis of transformative experience.
In addition, Kessler et al. (2009) studied the meaning perspective transformation following stroke. Results indicated that four main factors contributed to the process of transformation that helped patients re-interpret areas of their lives; triggers, support, knowledge, and choice of action (Kessler et al., 2009). Specifically, a supportive environment enabled patients to seek knowledge and make action changes. Similarly, in a study exploring the meaning-making experience of patients diagnosed with HIV indicated that support systems created the opportunity for dialogue (Courtenay et al., 1998). Meizrow (1991) supports the notion of dialogue through “rational discourse with others”. However, there are critiques with his lack of attention to supportive relationships in the transformational process (Taylor, 1997).

**Experience of Weight Loss**

Losing weight and maintaining weight loss are two different processes (Wadden, Butryn, & Byrne, 2004). Losing weight is a process situated in time, and weight maintenance is forever (Reyes et al., 2012). The startling numbers estimate that 100% of Americans will be overweight by the year 2030 (Dalton, 1997). Research indicates that in 2000, 38.5% of US adults were trying to lose weight, 35.9% were trying to maintain weight, and only 25.6% were doing neither (Serdula et al., 1999). In that same year, 72.9% of US adults reported that they had changed their diet and 59.5% reported that they had increased their physical activity as ways to achieve their individual weight loss goals (Serdula et al., 1999).

Clinicians in a medical environment often believe that the desire to lose weight is inherently healthy and the number of pounds lost on a scale is the outcome through which to judge the effectiveness of a program (Brownell & Wadden, 1991). There is a
consequence created by this assumption, one that creates a complex interaction between a person, their environment and the way he or she will go about their treatment plan (Lopez, 1997). There were seven studies reviewed regarding weight loss experience. Lopez’s (1997) study, grounded in feminist theory, examined the lived experience of women in treatment for weight loss. The basic assumptions of this framework were that the impact of prevailing social conditions is imbedded in the daily experiences of the members of a culture, and the personal voices of women give important clues about where social change is needed to improve a women’s quality of life (Lopez, 1997). Data was collected through a series of semi-structured interviews with women enrolled in a variety of weight loss programs: physician-supervised, commercial programs, and a self-help model. Of the six women participating in this study, all spoke about past experiences that established their unhealthy relationship with food. These critical events ranged from childhood sexual abuse, power struggles with family members, to pregnancy (Lopez, 1997). The critical events that occurred in adulthood could be closely related to a disorienting dilemma or catalytic experience, which Mezirow (1991) describes as a life crisis or major life transition. Narratives from the study participants echoed the need for autonomy and a desire to make personal choices (Lopez, 1997). The treatment protocols were often difficult to adhere to without comprising quality of life. The women suggested that satisfaction with the program might be related to how well the programs support autonomy and personal growth (Lopez, 1997). The voices of the women illustrated the need for individualized programs due to how each woman interacted with perceived cultural issues or body size, relationship management, and weight management tactics (Lopez, 1997).
The findings of this study can assist health professionals to better understand women’s needs in a treatment model. A practical implication could be for program staff to involve clients in designing their own individual program. The added pressure on women to adhere to a certain physical look and weight norms will have lasting effect on how women approach treatment. Critical reflection, consciousness-raising, and supportive relationships are helpful in addressing needed social change (Smith, 1984; Watson, 2005). Individuals need the right to self-define themselves with encouragement by family and health care professionals in order to respect their bodies and lifestyles (Lopez, 1997).

Jeffery et al. (2004) also explored the weight loss experience using TTM. One of the components of the TTM model is decision balance. Decisional balance reflects the individual’s subjective pros and cons of changing. This scale of importance of the pros and cons in deciding to change has been related to the stages of change progression (Velicer et al., 1998). Jeffery and colleagues (2004) used this component as a theoretical framework to engage in research that explored how participants’ individual perceptions reverted, leading to weight regain. Individuals who have lost weight engage in behaviors that bring benefits (weight loss). However, individuals who regain weight have abandoned those behaviors. Data collection suggested that a lack of sustained reward for weight loss was the primary cause of the failure to maintain weight loss efforts (Jeffery et al., 2004). Because weight loss momentum over time can fade, it is suggested that the behaviors associated with weight loss become habitual, and the psychological significance is diminished over time (Jeffery et al., 2004). Statistical methods were used to calculate experience in the women research participants. Lack of overall statistical
power, or small sample size, limited the author’s ability to examine temporal co-variation of weight change and process measures (Jeffery et al., 2004).

Individuals, who lose weight, are likely to regain it over time (Jeffery et al., 2000; Sciamanna et al., 2011; Wadden et al., 2007). In an attempt to more clearly understand the complex issue and relationships between sociocultural factors and weight regain or obesity relapse, in-depth interviews (N=90) were conducted with individuals seeking assistance for obesity-related problems (Sarlio-Lahyeenkorva, 1998). This study was one of the few studies grounded in a theoretical framework. Using social constructivism and grounded theory, Sarlio-Lahyeenkorva (1998) found that three different factors explained weight gain; deprivation of supervision, anti-dieting values, and isolation and unfulfilled dreams (Sarlio-Lahyeenkorva, 1998). These factors can explain failures in social contexts and represent a subjective reality of the individuals (Sarlio-Lahyeenkorva, 1998). Sociocultural factors as well as internal and external cues were also associated with obesity and weight regain (Sarlio-Lahyeenkorva, 1998). Consistent findings revealed that after successful weight loss, individuals look forward to a better quality of life but, unfortunately, this does not always occur (Sarlio-Lahyeenkorva, 1998). Further research should focus on the negative effects of weight loss through a socio-cultural lens.

A recent study focused on understanding the experiences of overweight adolescents who have lost weight. A transformative experience was described by six of the twenty-eight participants (Liberman et al., 2009). Most of the experiences mentioned were related to athletics or to medical conversations. These events made the adolescents see themselves differently in relation to weight, diet, and often activity. There were identity shifts through these experiences (Liberman et al., 2009). Implications to practice
suggest that medical care professionals can apply the findings of this study to help patients create their own form of narrative around important events and make meaning of their experiences (Liberman et al., 2009).

**Experience of weight loss surgery.** In addition to those who voluntarily enroll in a weight loss treatment program bariatric surgical procedures are becoming more prevalent (Lopez, 1997). Bariatric surgery is a medical procedure used to aggressively induce weight loss. Bariatric surgery is often recommended for those individuals who suffer from severe obesity (Sutton, et al., 2009). Bariatric surgery is the most well-known effective measure of sustainable weight loss (Sutton et al., 2009). Bariatric surgery is well documented from a medical and physiological perspective, but there is little research on the lived experience of awaiting bariatric surgery. There is a body of knowledge that is dedicated to studying this procedure, with the majority focusing on the physiological outcomes. This surgical weight loss intervention requires a rapid number of forced physiological and behaviors changes following surgery.

A recent study explored the lived experience and meaning-making in women who underwent this surgery (Riggs, 2005). Using a constant comparative method, the primary finding indicated that participants felt a strong sense of dissonance as a result of their self-concepts (Riggs, 2005). This dissonance was a motivating factor in their decision to undergo the surgery. Through the surgery their dissonance was resolved and was determined to be a crucial aspect of their meaning-making process (Riggs, 2005). The results have implications for health care workers. One suggestion is the implementation or a series of counseling and educational sessions, pre and post-surgery, to help patients overcome the dissonance that the participants felt. Sutton et al., (2009) also studied the
bariatric surgery experience of women, finding a consistent theme of bariatric surgery being a “life-changing” event. Two studies recognize the post-operative experience, as one of a perception of rebirth and a transformational experience (Sutton et al., 2004). Yet, this result is centered on a physical transformation (weight that was lost) and the analysis is not related to the feelings and experiences of the patients (Engstrom et al., 2011).

Lastly, a 2011 study investigated the meaning-making process of patients awaiting bariatric surgery (Engstrom et al., 2011). All the patients reported deterioration in their health and a general experience of not being able to take care of themselves as major reasons for requesting bariatric surgery, which may have been a disorienting dilemma (Engstrom et al., 2011). Loss of control, stigmatization by health professionals, and a complex relationship with food were other reasons mentioned (Engstrom et al., 2011).

Even though obesity is often related to genetic make-up and is considered a disease, many individuals view their condition in terms of the consequences from choices in daily life and interpret its meanings in a different way. It is important to identify the patient’s perspective between these relationships and obesity at the pre-operative stage in order to provide proper long-term care and achieve a successful long-term outcome. However, patients do not want guidance from their health care providers that is in a superficial form about diet, exercise or medication. Engstrom et al. (2011) believe that guidance could makes things worse, leading to increased food intake and a more negative self-perception. Therefore, there is a need for the profession to examine this problem in depth and at every step of the weight-loss journey. Although there is evidence of the
physical changes and improvements that result from this surgery, there is little known of the psychosocial processes. Coping with the loss of past behaviors, specifically, the changing relationship with food was evident. One patient explained that “Food, was my best friend, and now [I was] losing it …you lose your coping mechanism” (Sutton et al., 2009, p. 303). However, these types of culturally imposed eating rules are often a complication in the treatment programs. I found no articles that studied the impact that cultural food customs and rituals have in a bariatric setting. Fortunately, participants reported that the dramatic weight loss was a source of pleasure, which reinforced the need to stick with diet and exercise regimens (Sutton et al., 2009).

**Experience of Weight Loss Maintenance**

Studies have concluded that for individuals who lost weight, 33% to 50% of the weight is regained within the first year with more weight regain over an extended period of time (Jeffery et al., 2000; Sciamanna et al., 2011; Wadden et al., 2007). Approximately only 20% of Americans are able to maintain a weight loss of 10% for longer than one year (McGuire, Wing, & Hill, 1999, as cited in Sciamanna et. al., 2011). Elfhag and Rossner (2004) outlined several definitions used when evaluating weight loss maintenance, including:

Achieving an intentional weight loss of at least 10% of initial body weight and maintaining this body weight for at least one year, or losing at least 5% of baseline body weight between baseline and follow up maintaining that weight or less for a further two years…[and] moderators and mediators, which are characteristics that can identify pre-treatment success and mechanisms why a treatment effect is achieved, have been identified. These moderators include
“internal motivation, binge eating and weight cycling” and mediators included “increasing cognitive restraint and reducing the intake of dietary fat” (pp. 68, 75). Although successful components of weight loss intervention are better understood, the success of weight maintenance intervention programs remains unsolved (Sciamanna et al., 2011).

With little known about the process of successful weight maintenance, it is important to understand the current environment of weight loss strategies for individuals that have been linked to successful weight maintenance. The National Weight Control Registry (NWCR) is the largest prospective investigation study of individuals successful at long-term maintenance of weight loss (NWCR, 2012). Given the prevailing belief that few individuals succeed at long-term weight loss, the NWCR was developed to identify and investigate the characteristics of individuals who have succeeded at long-term weight loss. Now tracking over 5,000 individuals who have lost significant amounts of weight and kept it off for long periods of time through survey follow-up, the study examines behavioral and psychological characteristics of weight maintainers, as well as the strategies they use to maintaining their weight loss (NWCR, 2012).

The majority of the individuals sampled indicated they used a formal weight loss program with professional assistance, while the remaining 45% reported losing on their own (Klem, Wing, McGuire, Seagle, & Hill, 1997). Exercise and food restriction were the most popular stated methods for weight reduction; counting calories, limiting quantities, or limiting intake of certain food groups. Exercise habits were most often reported in their homes (92%) or with a group (31.3%). Only 4.3% reported using medication or surgery as reduction strategies (Klem et al., 1997).
Contrary to the literature indicating that weight maintenance is difficult, Klem et al. (1997) found that individuals reported that losing the weight, not maintaining the weight loss was the most difficult. A large portion of National Weight Control Registry (NWCR) members indicated preceding the weight loss was a triggering event or critical incident (Klem et al., 1997). Triggers that were medical in nature are associated with long-term weight loss outcomes (Gorin, Phelan, Hill, & Wing, 2004). Men more commonly reported this type of event and these events lead to less weight gain over two years (Gorin et al., 2004). Although the cause and effect relationship between triggering events and sustainable behavior change remains unclear, there is an opportunity to investigate this phenomenon using the transformative learning theory and an individual’s readiness for change, concentrating on aspects of critical reflection and rational discourse. The registry is based on self-report, which is a limitation because of the tendency for individuals to overestimate the amount of physical activity that was achieved and underestimate calories consumed per a given day (Lichtman et al., 1992).

Among sustained weight loss subjects there was an increase in the amount of time spent on thinking about food intake (Lichtman et al., 1992). This type of psychological stressor can create an unnecessary burden on individuals, creating unneeded thoughts of the scale. Although this study indicates that it is possible to lose substantial weight, future studies can focus on the triggering events that create a disorienting dilemma that can lead to lasting behavior change and the learning outcomes and processes of these individuals.

Although overweight and obese individuals wanting to lose weight must increase physical activity and decrease calorie consumption, many other groups of individuals,
businesses, and cultural aspects must work together to support these attempts to lose weight. Understanding the full spectrum of circumstances and barriers is needed to move forward “toward a resolution of these impediments to successful treatments” (Goldstein, 2005, p. 393). Regardless of the continuous knowledge that is built upon in the genetic, individual, environmental landscape, one question still remains unsolved, “Why does losing weight permanently remain difficult on an individual level?” From a medical perspective this is an important question, as echoed with “The single most important challenge in the clinical management of obesity is improving long-term maintenance of weight loss” (Jeffery et al., 2004, p. 100).

Programs that support increased physical activity, self-monitoring, stimulus control, regular weighing, and support from the medical community have been associated with successful weight loss maintenance (Reye, et al., 2012). However, the majority of commercialized programs and medical treatments contain these common program components. This raises the question of what separates the weight loss regainers and weight loss maintainers? Reyes and colleagues (2012) studied this exact question in a pivotal study, out of the Center for Obesity Research and Education at Temple University, published in 2012. In the study’s literature review Reyes et al. (2012) noted that only four qualitative studies exist focusing on weight maintenance, which all revealed similar findings. However, my review on weight maintenance found an additional four qualitative studies that focused on weight maintenance, yielding eight studies in total (Barnes et al., 2007; Bradshaw, 2008; Brynes, Cooper, & Fairburn, 2003; Epiphaniou & Ogden, 2010; Hindle & Carpenter, 2011; Kayman, Bruvold, & Stern, 1990; Reyes, et al., 2012; Sarlio-Lahteenkorva, 2000).
Reyes’ study reported that both the regainers and maintainers faced challenges that were typically described as changes in work or personal relationships (Reyes et al., 2012). Encouragement from personal relationships was also valued from both groups. Interestingly, both groups also reported that the way their clothing fit was a primary marker of weight status (Reyes et al., 2012). Maintainers reported having greater positive self-talk, self-efficacy, and problem-solving ability. This is consistent with the findings that concluded that regainers exhibited an all or nothing thinking style (Brynes et al., 2003).

Maintainers of weight loss engaged in healthy eating and physical activity patterns. Problem-solving abilities and social support were also indicated as successful behaviors associated with weight maintenance. Reyes et al. (2012) concluded “productive problem-solving skills, which suggest that cognitive differences and styles can provide a partial explanation of how maintainers are able to effectively swim upstream in an obesogenic environment” (p. 504). This assumption implies that with the correct tools there is hope for obese persons to reverse the cycle of weight gain/loss/regain (yo-yo effect).

Similarly, Barnes et al. (2010) also concluded that social support was a key component of successful maintainers. This study, which was situated in the Theory of Planned Behavior, concentrated on the attitudes, norms, and motivations that influence behavior. However, the framework focused on the why and not the how. Although this study resulted in important information that is specific to the African American population, these findings cannot be generalized to other groups due to the cultural constraints.
Hindle and Carpenter (2011) also used qualitative methods to explore the experiences of those who have been successful at weight maintenance. Results revealed similarity between the themes and that of the National Weight Control Registry data. The study determined that the motivation to lose weight was health related. This is similar to the Wing and Phelan (2005) study that determined that medical triggers were associated with greater weight loss and less weight regain. Hindle and Carpenter (2011) also found that the participants expressed having struggled with their weight loss for many years. This implies that successful weight loss is a gradual episodic approach. Three reasons were identified for lack of success: lack of long-term, personal reason to lose weight; short-term, strict approach, and overly ambitious goal (Hindle and Carpenter, 2011). Key contributors of success were self-monitoring, long-term view of weight control, social support and increased physical activity. Although the intent of the study was to recruit both male and female research participants, the study resulted in successfully recruiting only Caucasian females. This serves as a limitation to the research due to the lack of transferability to other groups.

One of the closest to the concept of transformative learning and successful weight loss is Epiphaniou and Ogden’s (2010) study that explored the process of transitioning the sense of self that occurs through weight loss. Results indicated that participant’s experiences that occurred through successful weight loss maintenance revealed a shift in identity towards a liberated self (Epiphaniou & Ogden, 2010). Interestingly, this study found that prior to weight loss, participants felt a weight-centered identity. Participants avoided social interactions due to negative stigma that they experienced in through social interactions (Epiphaniou & Ogden, 2010). Post weight loss participants experienced a
liberated sense of self that included increased self-esteem, social interaction and acceptance (Epiphaniou & Ogden, 2010). Again, the participants of this study were all women who were receiving counseling from consultants and were members of support groups. The authors concluded that the research participants’ weight loss experience was a learning process, a process that is not temporary, indicating that behavior changes become lifelong when “their behavior suits their self-representation and future plans” (Finagled, 1998, as cited in Epiphaniou & Ogden, 2010, p. 895). This finding also supports the idea that obesity fits into the category of a chronic disease and behavior modifications should not be viewed as short-term. Although this study yielded important information on the self-identity shift, additional research is needed to inform the adult learning perspective including the processes of how this learning took place.

All studies that focused on the weight loss maintenance experience had small sample sizes and two out of eight conducted focus groups, which can lead to group consensus, the remaining used a semi-structured interview format (Barnes et al., 2007; Byrnes et al., 2003; Epiphaniou & Ogden, 2010; Reyes et al., 2012). There is a need for further research to explore the learning processes and learning outcomes that investigate the “how’s” and “why’s” of weight loss maintenance. Whether weight maintainers have undergone a transformative learning experience and if that experience can translate into more effective treatment programs also needs further investigation.

Weight Experience Summary

Obesity is a chronic condition and individuals have had little success with weight maintenance. It is important to continue to explore the meaning-making process of this disease, specifically the weight loss maintenance journey. Socio-cultural, health,
economic, and psychological processes contribute to the success or failure of adults struggling to lose weight and keep it off. The ability to further understand if and how a perspective transformation occurs during successful, long-term weight loss is crucial to reverse this epidemic. It can also add a previously unexplored dimension to the transformational learning research.

Given that successful weight maintenance after significant weight loss is rare without surgery, successful weight loss maintainers are a unique group of individuals who should be studied. Understanding the learning processes and learning outcomes from this group from the perspective of adult learning and development can add important information to the burgeoning research on weight management. Yet, despite self-reported behavioral changes, predictors of long-term weight-loss maintenance have not been clearly identified because, in large part, there is a lack of longitudinal data to test hypotheses (Anderson, Konz, Frederich, & Wood, 2001).

With a plethora of quantitative studies addressing weight loss and weight maintenance, there is a lack of studies using qualitative methods. Even fewer that are designed specifically from an educational learning perspective and that explore weight loss maintenance from this perspective. Additional research is needed to understand what learning is necessary to enable individuals to sustain lifestyle changes that are needed for weight maintenance. Reyes’ (2012) article revealed a qualitative perspective of different factors that promoted or prevented weight maintenance efforts among a diverse, urban sample. Reyes’ research makes a total of eight qualitative studies that have been conducted on weight maintenance (Barnes et al., 2007; Bradshaw, 2008;
Brynes et al., 2003; Epiphaniou & Ogden, 2010; Hindle & Carpenter, 2011; Kayman et al., 1990; Reyes, et al., 2012; Sarlio-Lahteenkorva, 2000).

However, additional research on experiences of weight loss maintenance is needed to further understand how behavioral changes are incorporated into daily life and to address how socio-cultural and environmental factors impact weight loss maintenance. Furthermore, additional research is needed to examine the journey of self-discovery and self-awareness that occurs during the recognition of the problem and readiness to change (Hindle & Carpenter, 2011).

Impact of Obesity

Health agencies such as the WHO (2010) and the CDC (2011) report that the prevalence of overweight and obese adults has steadily increased globally over the years among gender, age, race, ethnicity, and educational levels. Two-thirds of US adults are overweight or obese (WHO, 2010). Despite research, education, advocacy, and policy, the CDC has reported that national rates of obesity have steadily increased over the past 20 years and these rates continue to remain high (CDC, 2011). For adults, overweight and obesity diagnoses are determined by using weight and height to calculate a number called the "body mass index" (BMI) (CDC, 2011). An adult who has a BMI between 25 and 29.9 is considered overweight (CDC, 2011). An adult who has a BMI of 30 or higher is considered obese (CDC, 2011).

There are many causes and consequences that play a role in an individual gaining weight. Fortunately, there are continuous small successes in the quest to reverse this epidemic. However, the added stresses that arise from this disease are measureable, impactful, and can cause permanent damage. This section aims to discuss the impact of
obesity; including the medical, economic, social, and psychological aspects of this disease. These overwhelming statistics create an argument for additional attention to be placed on not only obesity prevention efforts, but continued research in understanding how individuals can be permanently successful at weight loss.

**Medical Impact**

Increased body weight has been associated with the increased probability of developing other, often life-threatening diseases that may lead to increased morbidity (Stroebe, 2008). Bray (2004) noted the diseases could be classified into one of two pathophysiological categories:

The first category of disabilities arises from the increased mass of fat itself. These include the stigma of obesity and the behavioral responses it produces, osteoarthritis, and sleep apnea. The second category is risks that result from the metabolic changes associated with excess fat. (p. 2583)

Chronic diseases, in particular have been linked to obesity; including diabetes, cancer, high blood pressure, osteoarthritis, and heart disease (Bray, 2004). Diseases of the bones, joints, muscles, and sleep apnea have also been included in the range of medical problems associated with obesity (Bray, 2004). According to Bray (2004), the “etiology or cause of obesity is the imbalance between the energy ingested in food and the energy expended” (p. 2583). The enlarged fat cells that occur from the energy imbalance create the medical problems because of the weight or mass of the extra fat or because of the increased secretion of the fatty acids (Bray, 2004).

Although chronic diseases have been associated with increased body weight, both obesity and chronic diseases are preventable and, moreover, reversible. Studies have
demonstrated that blood pressure, cholesterol, triglycerides and diabetes were
significantly improved with lifestyle changes over time, including better nutrition and
physical activity (Tuomilehto, Lindstrom, & Eriksson, 2001).

**Economic Impact**

Because chronic diseases are associated with obesity, there is an unsustainable
medical cost associated with this disease on a national level. This economic burden
creates a call to action to increase attention to preventative services and weight
maintenance programs. According to the Yale Rudd Center for Food Policy and Obesity
(2011), health care costs for those who are obese are 30% higher than an individual with
a healthy BMI. It is estimated that all of the medical costs in the United States equates to
$147 billion (Finkelstein, Trogdon, Cohen, & Dietz, 2009). Obesity and physical
inactivity account for 9.4% of direct US health care expenditures (Colditz, 1999).

Wolf and Colditz (1999) examined the economic impact of obesity in the United
States. Using a prevalence approach, the authors estimated the chronic disease cost
associated with this disease, including but not limited to diabetes, cancer, and
hypertension. Prevalence is a measure of the total number of cases of a disease in a
certain population. Direct costs were calculated by using costs associated with personal
health care, hospital care, and medications. Indirect costs were calculated by using a
morbidity cost, defined by a loss of productivity, including absenteeism from work. In
conclusion, $99.2 billion dollars could be attributed to obesity; $51.64 billion were in
direct medical costs, $3.9 billion were calculated from a loss of productivity (Wolf &
Colditz, 1999).
The overall economic impact of obesity in the United States is overwhelming. Government officials, health care professionals, and industry need to collaborate to understand the significant impact of this disease, create public policy, and invest in future research that can decrease the burden that impacts not only the individual who suffers from this disease, but for the medical profession, government, and families that are indirectly affected as well.

**Social and Psychological Impact**

In addition to chronic diseases and economic burden that is associated with obesity, research has indicated that there is a relationship between psychological problems and obesity (Ogden & Clementi, 2010). Obesity is associated with a diagnosis of depression, anxiety, decreased quality of life, and low self-esteem (Puhl & Latner, 2007). Increased BMI has been correlated with increased body dissatisfaction (Stroebe, 2008). Obese individuals have been labeled as unattractive, lazy, unpopular, unintelligent, unsuccessful, and un-athletic (Dejong, 1980; Harris, Harris, & Bochner, 1982; Tiggerman & Rothblum, 1988; Weiss, 1980, as cited in Ogden & Clementi, 2010). These implicit and explicit associations create obesity stigma.

Obesity is a highly stigmatized disease that which can lead to emotional and psychological distress (Puhl & Brownell, 2006). Weight bias refers to negative attitudes and stereotypes towards individuals who are overweight and obese, and often leads to unfair treatment and discrimination (Brownell, Puhl, Schwartz, & Rudd, 2005). Weight stigma has become a social norm, and recently there been considerable research on the effects of this behavior. Medical consequences of obesity are often the center of attention, and the social and emotional aspects have been ignored. Negative stereotypes
concerning obese persons are pervasive in American media. As a result, obese individuals face discrimination in employment, education, by family members, in interpersonal relationships and by their healthcare providers (Puhl, Schwartz, & Brownell, 2005). This unfair treatment reduces quality of life and jeopardizes emotional, psychological and medical health (MedScape, 2009).

A landmark study conducted at the Yale Rudd Center for Food Policy and Research (Puhl & Latner, 2007), a leading center on weight bias and stigma, examined experiences of weight bias in overweight and obese women. Of the 2,400 overweight and obese women surveyed, 79% indicated coping with weight bias by eating more, and 75% refused to keep dieting in response to bias (Puhl & Latner, 2007). In addition, adults who experienced weight bias were more likely to engage in binge eating (Puhl & Latner, 2007). The results of this research indicates that stigma does not motivate one to lose weight, but in fact has adverse effects such as prompting overeating and physical inactivity.

There are many barriers to effective treatment of obesity, and this disease is unlike any other medical problem. Importantly, there are structural forces that promote values and happiness through globalized consumption, which at its very roots may lead to overindulgent eating behaviors and sedentary lifestyles. Western society equates “slenderness with happiness, control and social acceptability”, which is directly related to social discrimination (Grogan, 2008, as cited in Epiphaniou & Ogden, 2010, p. 888).

There is the force of public health officials and organization that gear their efforts to promoting healthy environments and implementing obesity prevention programs. The literature indicates that adults and children who are already obese are continuously
stigmatized and discriminated against (Carr & Friedman, 2005; Maclean et al., 2009).

President and CEO of the Obesity Action Coalition, Joseph Nadglowski, stated:

Obesity carries with it one of the last forms of socially acceptable discrimination. We, as a society, need to make every possible effort to eradicate it from our culture. One important step would be enacting meaningful public policy to protect those who have been subject to weight discrimination. (Friedman, 2010, pg. 2)

Although public health practitioners have sought to design interventions to reduce the prevalence of obesity, there is increased evidence that some interventions have created program participant discrimination (Maclean et al., 2009). New research has identified that weight bias is common among healthcare professionals, such as physicians, nurses, and dietitians (Puhl & Brown, 2006). Over half of the 2,000 overweight and obese women surveyed reported that doctors had stigmatized them on one or more occasion (Puhl & Brown, 2006). Anti-discrimination agencies such as the National Association to Advance Fat Acceptance are urging policy makers to establish legislation that protects the rights of people, independent of their size, and promotes equal rights for employment and education (National Association to Advance Fat Acceptance, 2010). Health professionals argue that legislation that mandates protection, specifically policies that provide larger seats in airports and restaurants, could have a negative effect on the public health goal of reducing the prevalence of obesity (Rudman, Ashmore & Gary, 2001).

As the obesity epidemic continues to grow, it is important to understand what a culture that is obsessed with being thin does to prevent the adoption of healthier
behaviors among the obese population. Practitioners have an important role in developing interventions and communicating effective medical care strategies that lead to better quality of life for this population. Research has indicated that “Patients who feel stigmatized about their weight are more likely to avoid routine preventive care, and when they do seek health services, they may receive compromised care” (Amy, Aalborg, Lyons, Keranen, 2006, as cited in MedScape, 2009). When patients feel stigmatized, they are vulnerable to depression and low self-esteem, they are less likely to feel motivated to adopt lifestyle changes, and they are more likely to turn to unhealthy eating patterns for comfort (MedScape, 2009).

**Negative impact of mass media.** The mass media is a compelling example of the social acceptability of weight stigma (Heuer et al. 2011). Stigma through this medium is often seen in a multitude of forms, from the constant ridicule of persons with obesity in television and film, to the media’s portrayal of blaming individuals for their obesity in the majority of news coverage, magnifying the individual level causes of weight gain (Heuer, et al., 2011). Research has demonstrated that the news media frames the obesity as personal responsibility, widely ignoring the socio-cultural and environmental contributors and misinforms the public about this health issue (Bonfiglioli, Smith, King, Chapman, & Holdings, 2007; Giles, 2003; Lawrence, 2004). The implications of this type of portrayal in media will assist the continuation of weight bias, which has been linked to increased food intake and sedentary lifestyles (MedScape, 2009), thus causing a rapid cycle of unhealthy behaviors.

To date, the research about obesity portrayal in the media has largely been that of written analysis. However, Heuer et al. (2011) found that photographs used to support
the majority of these new stories can communicate bias. They conducted the first content analysis that examined the types of images that accompany obesity in the news and determined how these individuals were portrayed in these stories. The authors selected pictures associated with obesity articles from five major news Web sites. Ultimately, 549 images were used in the analysis (Heuer, et al., 2011). Results indicated that over half of the photos of obese individuals were that of only their lower bodies, and 23 times more likely to be displayed with their heads cut out of the pictures (Heuer, et al., 2011).

Overweight/obese persons were also 3.5 times more likely to showed consuming food, as compared to non-overweight persons who were shown exercising and 50 times more likely to be shown as experts (Heuer, et al., 2011). The authors concluded that this research confirms the phenomenon of the “headless stomach”, which is “the tendency for news reports to show obese people with their heads cut out of the images”, which evokes a sense of disgust (p.8).

Critics argue that if obese persons were seen more positively, this would normalize obesity. However, evidence suggests that stigma or any kind does not motivate one to lose weight, in fact stigma and discrimination increases the likelihood of eating poorly, decreased preventative medical screening, and the avoidance of physical activity (Puhl & Brownell, 2006; Puhl & Heuer, 2010). The news of obesity reinforces the entire blame of weight gain on the individual which can influence public policy by shifting the public’s perception of social issues which can impact policymaker’s agendas (Crandall & Reser, 2005, as cited in Heuer, et al., 2011). Giles (2010) argues that instead of seeing all media representations of health as potentially distorting and misleading,
there is an opportunity for professionals to identify outlets for positive messages and photos to be shown.

A deeper exploration of “Fattertainment”. Dumenco (2012) powerfully summed up how Americans view obesity in his recent Details magazine article entitled, “What’s so funny about overweight people getting hit in the groin with footballs? Everything”. He went on to note that millions of Americans everyday turn on the television to degrade obese participants, “We have developed an insatiable appetite not only for mammoth cupcakes but for fatness itself” (Dumenco, 2012). The article clearly states that “TV fatties” make regular TV watchers feel like celebrities. The opposite of what happens when regular folks watch, say, the Victoria’s Secret lingerie show. On some psychological level this may be true, but there is an opportunity for media to play an important role in reducing the societal stigma that change the overtones of TV shows and promote ethical guidelines about obesity (Heuer et al., 2011).

American news has made obesity a sexy topic to discuss. Because of the attention that sparked dialogue, media’s solution to educate the public was to create a series of reality shows like The Biggest Loser. These types of programs successfully “transform” the body shapes of the super obese. However, these popular reality television shows depict the de-humanization of persons with obesity that are trying multiple avenues to escape their dreadful overweight bodies developed from extra pounds which are not acceptable by the dominant ideology of beauty. Along this journey, contestants take full blame for their failure to reject the neoliberal politics and the responsibilities to govern themselves by (Hoeschsmann & Poyntz, 2012).
The “winner” of these shows have transformed themselves by “embracing self-governance, regulating and reforming themselves on behalf of their family and the nation” (Hoeschsmann & Poyntz, 2012, p. 71), all built upon the artificial environment created by the show which is comprised of fitness experts, therapists, and dieticians that work together to establish a bullet proof environment with little room for error. Yet, what we don’t see is the unhealthy environments that the contestants go back too, nor does television follow these contestants over a period of time to see the most likely inescapable weight gain due to the frames of references and perspectives that were not challenged or changed along this usually one-dimensional process.

**Impact of Obesity Summary**

There are many societal and environmental pressures that all have causes and consequences that play a role in the obesity epidemic. Research in the areas of the medical, economic and psychological consequences of this epidemic have created hard evidence that suggests the urgent need to reverse this epidemic. Over the last decade, there has been a wealth of research dedicated to understanding the effects of weight discrimination and the role of the media. Together, there are continuous small successes in the quest to reverse this epidemic. However, the added stresses that arise from this disease are measureable, impactful and can cause permanent damage. Further research is needed to explore how successful weight loss individuals made meaning of the weight stigma and discrimination that they faced personally and how obesity discourse in the media impacted motivation for change. Specifically, how does the context of media influence living with obesity, and whether media is eventually reflected upon?
Weight Loss Treatments

In order to better understand the complexity of the weight loss struggle, it is important to recognize the current environment of weight loss strategies available for individuals in America. This weight-loss focused environment impacts the public’s decisions on how to approach their weight loss plan. Most of these programs revolve around the concept of dieting. Dieting is defined as “the intentional and sustained restriction of caloric intake for the purpose of reducing body weight or changing body shape, resulting in significant negative energy balance” (National Institutes of Health, National Institute of Diabetes, Digestive and Kidney Diseases, 2000, as cited in Stroebe, 2008, p. 4). Weight loss avenues include industry, medical interventions, medication and surgical options. The next section aims to discuss the different strategies used in several different environments.

Industry

The American culture has created a fear of fat and the lack of medical success to this epidemic has leveraged market demand. Combined with the sheer desire of the individuals that want to lose weight, this recipe has resulted in a plethora of commercial weight loss programs in the United States (Cleland et al., 2001). It is reported that millions of Americans each year enroll in a commercial or self-help weight loss programs (Tsai & Wadden, 2005). This weight loss industry is estimated to be worth $586.3 billion by 2014, leveraged from foods and beverages, dietary services, drugs, and equipment (Markets and Markets, 2011). However, there seems to be a divide with what the weight loss industry is marketing and the empirical evidence that has been established through research. Because little research has been established on commercialized programs the
medical profession is less satisfied with their ability to feel comfortable giving patients advise that ask them about these types of programs.

The multi-million dollar weight loss industry has developed and marketed a large amount of packaged products, which promise to quickly solve the weight loss problem. Because of this, the public remains confused and skeptical of the mixed messages. There has been a “rogue’s gallery of rascals and snake oil-salesman, a library of junk science and nutritional gibberish, and a catalogue of nonsense cures and commercial hustle” (Goldstien, 2005, p. 385). The most popular commercial programs in the United States are Weight Watchers, Jenny Craig, and LA Weight Loss (Tsai & Wadden, 2005). All programs are costly, averaging $107 for an initial membership fee with additional periodic fees associated with food purchases and meetings (Tsai & Wadden, 2005). Key components to these programs are the approach to a restricted calorie diet, behavioral counseling and recommendations for exercise (Tsai & Wadden, 2005). All programs offer behavior modification counseling, either in a group or individual setting or document format. Program staff are usually company-trained counselors or had success on that specific program in the past, using their experiential learning experiences as a measure of professional qualification (Tsai & Wadden, 2005). Even with continued popularity a systematic review of such programs by Tsai and Wadden (2005) concluded Weight Watchers was the only commercial weight loss program whose efficacy has been demonstrated in a randomized controlled trial.

In addition to commercialized weight loss programs Internet-based interventions are the most recent development in the weight loss industry that incorporates privacy aspects that are associated with at home technology. For example, eDiets.com offers
client’s low-calorie recipes and an online chat forum to communicate with other clients (Tsai & Wadden, 2005). In 2002, randomized controlled trial reported that participants in eDiets.com lost 1.1% of their body weight at one year (Womble et al., 2004). However, the study participants also received at home weigh-ins with study staff and consultations with a psychologist the participants could have had an increase in motivation and treatment adherence. Therefore, at-home technologies were not enough to produce efficient body weight changes.

Given this information, it is important for weight-centered industries to evaluate and create relative changes in practice and products that offers enhancing the individual on not only physiological perspectives, which is currently the center of the modern medical paradigm, but a well-being, holistic approach that can lead to lasting change.

**Medical Interventions**

In addition to the commercial weight loss environment, medical professionals aim to treat obesity, and obesity related diseases. However, current research has indicated that many medical professionals hold bias and discriminatory attitudes and beliefs about obese individuals and feel relatively unprepared to counsel on lifestyle changes (Medscape, 2009). These feelings can have an overall negative impact on the patient. In fact, it is reported that overweight and obese adults skip regular preventative screening due to the feelings of discrimination in the primary care setting (Medscape, 2009). The medical paradigm can take small steps to include patients on a personal level to better understand the complicated components of the behavioral patterns that have led to weight gain. Brendel (2009) noted that “A picture of meaningful medical care must not only focus on improving diagnostic and technological capabilities but should also aim to invite
a patient’s narrative into dialogue, in line with a medical practitioner’s objective expertise, not beneath it, to empower the patient to embrace a more robust understanding of illness” (p. 28). It could be that this type of narrative driven medicine could lead to prolonged weight maintenance, which is the main objective of obesity treatment.

The National Heart, Lung, and Blood Institute has recommended that individuals who are in need of treatment inquire about programs with lifestyle modification components. This includes behavioral therapy, diet, and exercise that is consistent with the weight loss programs in the commercial environment (Goldstein, 2005). The most popular self-reported methods for patients to modify weight are increasing physical activity and modifying food intake (NWCR, 2012). Yet, many individuals who engage in weight loss programs usually lose an unassuming amount of weight and often regain the weight overtime (Wing & Hill 2001; Wooley & Garner, 1991; Lean, 1998, as cited in Elfhan & Rossner, 2005).

Because of these statistics, behavior modification is a key component of weight loss therapy, which examines aspects of eating and exercise behaviors. The LEARN Program for Weight Management 2000, offers a treatment manual often as cited in clinical trials (Goldstien, 2005). The key elements of the LEARN Program include self-monitoring, stimulus control, problem solving, slowing the rate of eating, and cognitive restructuring (Goldstein, 2005). Goldstein (2005) addresses that there is new research that is offering a direction to traditional weight reduction approaches. These new grounds being explored include areas of social support, motivational interviewing, and technology aspects, including the Internet (Goldstein, 2005). Little research is aimed to investigate learning processes, or how personal assumptions and beliefs have changed
due to being enrolled in these types of programs or if this learning is associated with the weight struggle. In fact, little is known about how healthcare providers can be positive forces that facilitate perspective transformation in chronic diseases (Dubouloz et al., 2010).

In addition to traditional medical approaches, surgical options and pharmacotherapy (drugs) are becoming more credible and prevalent choices to aid in the battle of obesity. Both approaches are discussed below.

**Introduction to surgical options.** In addition to those who voluntarily enroll in a weight loss treatment programs either commercially or with medical supervision, bariatric surgical procedures are becoming more prevalent (Lopez, 1997). Bariatric surgery is a medical procedure used to aggressively induce weight loss, often recommended for individuals suffering from severe obesity (Sutton, Murphy, & Raines, 2009). There is a body of knowledge focused on the physiological outcomes of these procedures and bariatric surgery has become the most effective measure of sustainable weight loss (Sutton, et al., 2009). This surgical weight loss intervention requires a rapid number of physiological and behavior changes following surgery, including eating patterns. A surgical option to reduce weight should not be taken lightly. This is a serious surgery, and with any surgery, there are many risks. In addition, the cost of bariatric surgery is high, ranging from $18,000-$35,000. However there are more insurance companies, including Medicare that is now covering costs of this surgery (Consumer Guide to Bariatric Surgery, 2011).

Patient selection for this surgery is a process for the attending physician. The exemplar candidate would be a patient that has the following characteristics:
Age <40 years, being employed, being married, having a strong social support system in place, being able to reliably keep appointments, having realistic expectations, complying with a prescribed dietary regimen, being female, achieving preoperative weight loss, having higher education, being aware of eating rules, and not smoking. (The Permanent Journal, as cited in Kral, 2001)

Another key component that leads to a higher rate of success with this surgery is the preoperative education sessions that many clinics mandate patients to attend prior to surgery. Kral (2001) notes that pre-counseling sessions to inform the patient of the procedure outcome, expectations, new rules of eating, and potential complications of the surgery increases the likelihood of success.

**Introduction to pharmacotherapy.** In addition to surgical options, dietary supplements and antiobesity medications are becoming more common for the reduction of body weight. Using medications to treat a disease is called pharmacotherapy. The majority of dietary supplements are over the counter, but a physician must prescribe pharmacotherapy. As of 2010, there were only two drugs (orlistat and sibutramine) approved for weight loss and weight maintenance in USA (Isidro & Cordido, 2010). These adjunctive treatments are marketed to assist patients in carrying out changes needed to produce and sustain weight loss (Yanovski, 2005). Fundamentally, weight gain and weight loss occur through energy imbalance which is comprised of calories and energy expenditure. Pharmacotherapy assists individuals in losing weight by interfering with normal physiological functions that impact energy imbalance, including: a) reducing energy intake by stimulating anorexigenic signals or by blocking orexigenic signals, and b) increasing energy expenditure (Isidro & Cordido, 2010). The majority of
these drugs work by suppressing appetite (anorectics) through central nervous system mechanisms (Blanck, Khan, & Serdula, 2004).

Internationally, in 2002, there were eight prescription weight-loss medications on the market (Encinosa, Bernard, Steiner, & Chen, 2005). Although a few of these drugs have been approved for long-term usage, the average number of days patients adhered to the prescriptions was 110 (Encinosa et al., 2005). This may imply that the side effects of these drugs reduces adherence. In addition, evidence shows that the average patient spent $304 each year on weight-loss medications, with health plans covering up to 74% of these costs (Encinosa et al., 2005).

One of the most popular drugs used for weight loss was the mass marketed fen-phen, or fenfluramine. Often prescribed through physicians’ offices, the use of fen-phen also appeared to be popular at commercial diet clinics (Blanck et al., 2004). In 1997, this drug was removed from the market because of concerns that it was linked to heart disease (Wadden et al., 1998). A study conducted by Blanck et al. (2004) concluded that one third of the users of fen-phen stopped taking the drug immediately after the public health announcements of associated risks were released. The remaining one third continued use for a substantial amount of time. The authors speculate that those struggling with obesity “were willing to risk a cardiac valvulopathy for the real or perceived efficacy of the pharmacotherapy” (Blank et al., 2004, p. 1247). This study, which was the first to conduct a population based survey to document the public’s response to the fen-phen withdraw, concluded that lack of oversight from health care professionals can make these unregulated products dangerous (Blanck et al., 2004).
Though obesity carries with it an increased risk of developing chronic conditions, it should be noted that with the misuse of pharmacotherapy there is also increased risks to physical health. In 2005-2006, a survey assessed individual beliefs and practices of dietary supplements used for weight loss (Pillitteri et al., 2008). GlaxoSmithKline, a pharmaceutical company, which develops prescription weight loss drugs, funded this study.

In addition to prescription drugs used to lose weight, there is an array of dietary supplements, which are largely unregulated prescriptions, are not needed to obtain these supplements from local convenient stores. However, one study found that there are many misconceptions about use of these products, including myths about safety and efficacy by the (Pillitteri et al., 2008).

**Weight Loss Treatment Summary**

There is substantial literature and attention given to obesity prevention efforts and weight loss approaches; one could assume that these approaches are dedicated to the goals of individual maintaining weight over time. However, the literature fails to deeply explore the lived experiences of weight loss and how these experiences impact weight maintenance. Industry, the medical community, and drug companies are fighting to find the key to successful weight loss, yet no program or empirical study has succeeded to date. Weight cycling exponentially costs the individual time, energy, and the consumption of products and services (Cleland et al., 2011).

With little known about the experience of successful weight loss, science cannot make strides in understanding how treatment plans can impact weight cycling and media will continue to produce non-factual messages that continue to ploy individuals
desperately searching for the ‘skinny pill’ or obesity cure. With further investigation weight loss experience can lead to a deeper understanding of the experience that can assist in developing multidimensional approaches to obesity prevention education, weight loss treatments, and the communication of effective medical care strategies that could help individuals towards a lifelong journey of recovery. In conclusion, there is a wealth of information and research aimed to treat obesity. Yet, weight loss and especially weight maintenance, is still an uphill battle.

**Summary**

Empirical evidence suggests the urgent need to reverse the obesity epidemic. Science has made strides concerning metabolic and genetic influences that may impact weight and the majority of research in obesity has employed quantitative research methods. Furthermore, the review of the literature revealed that although there is both a physiological and emotional component to losing weight and keeping it off, the question of why maintaining weight loss on an individual level is often short term remains unsolved. Although there has been a wealth of research in obesity (medical, economic, social impact, weight loss treatments, and weight maintenance), researchers in the fields of adult education and health need to further explore the intersection of the successful weight loss experience and learning within the socio-cultural contexts.

Among the variety of lifestyle interventions and transformative processes that were mentioned throughout the chapter, several common factors connect all of them: self-monitoring, stimulus control, positive reinforcement, education, counseling techniques, supportive relationships, critical reflection and improving coping skills. Regardless of the type of weight loss intervention, the review revealed a need to expand
current weight loss treatment approaches beyond what has been done due to the empirical evidence conclude that many of the approaches do not have lasting effects; individuals lose weight and then gain weight back over time. Losing weight and maintaining weight are two different processes and clear weight maintenance predictors, or weight maintenance learning processes have not been clearly identified.

Information currently available revealed that the majority of obesity research focused efforts on quantitative methodology. Even with self-reported behavioral changes, predictors of long-term weight-loss maintenance have not been clearly identified because, in large part, there is a lack of longitudinal data to test hypotheses (Anderson et al., 2001). With a plethora of quantitative studies addressing weight loss and weight maintenance, there is a lack of studies dedicated to the qualitative methods. Furthermore, there is an absence of research that is grounded in any theoretical framework, many of which completely disregards an adult educational theoretical perspective that could explore weight loss maintenance learning outcomes and processes. Additional research is needed to understand what it takes to enable individuals to sustain lifestyle changes that are needed for weight maintenance. There are only eight qualitative studies addressing this issue (Barnes et al., 2007; Bradshaw, 2008; Brynes et al., 2003; Epiphanio & Ogden, 2010; Hindle & Carpenter, 2011; Kayman et al., 1990; Reyes, et al., 2012; Sarlio-Lahteenkorva, 2000).

Each of these studies revealed similar results that added knowledge to the field of successful weight maintenance and even intended long-term behavior change. However, there is still an opportunity to conduct weight maintenance research in the theoretical groundings of transformative learning and critical media literacy and critical public
pedagogy. Moreover, there are only a few studies that focus on the impact of learning and only one study using an adult learning lens to examine the transformative process of weight loss; though, the research participants were adolescents (Bradshaw, 2008; Liberman et al., 2009).

Because obesity is a multi-dimensional disease there has been considerable research dedicated to understanding the effects of weight discrimination and the role of the obesity discourse in the media. Researchers need to complement this work with deeper examination of the meaning-making and learning processes that occur as adults experience successful weight maintenance. An obvious gap in obesity research is further exploration of weight maintenance experiences that may explain the learning processes that occurred through social contexts that create permanent change for certain individuals. It is suggested that these successful learning measures can assist in the development of treatment programs that may potentially result in long term outcomes and better communication between patient, health care team and the de-construction of environmental media messages.

Weight cycling costs the individual considerable time, energy, money and the consumption of products and services (Cleland et al., 2001). It should be noted that with little known about the experience of successful weight loss from a learning perspective, science cannot make strides in understanding how treatment plans can impact weight cycling. Exploring the weight maintenance dynamic can lead to a deeper understanding of these experiences that can assist in developing multidimensional approaches to obesity prevention education, weight loss treatments, and the communication of effective medical care strategies that lead towards a lifelong journey of recovery. The need to understand
the meaning-making processes of those who successfully lost weight and kept it off is a crucial step toward understanding this disease. This study would add significance to both the knowledge and practice of clinical weight management and also the field of adult education.

Secondly, there is a need to study the transformative experience among adults who have been successful in long term weight loss. Identifying factors supporting this process, and establishing the meaning of this change or shift, could potentially lead to further understanding of what is most meaningful in terms of treatment plan development, as well as the appropriate support that individuals will need. Developing a new dimension of transformative learning in a weight-loss context can help identify barriers to the change process and help clinicians and educators become facilitators of change (Dubouloz, et al., 2010).

Additionally, this study aims to expand the research in critical transformative learning to disease in adults. Current research in transformation in chronic illness seems inconsistent with a definition of transformation and often lacks a theoretical framework (Dubouloz, et al., 2010; Paterson et al., 1999). Even with the physical ‘transformation’ that occurs through surgical procedures, antiobesity medications, and commercial weight loss programs, the review found no articles that focused on an adult education theory in an adult population.

Mezirow (1991) believes meaning-making is the process of making sense of experiences, or to construct an interpretation of that experience. Educators, physicians, and other individuals on a multi-disciplinary weight management team “who understand the centrality of meaning-making in transformational learning and who understand the
nature of the process can maximize their role as facilitators of change in people’s lives” (Courteney, et al., 1998, p. 15). Further, learning how weight loss maintenance impacts overall meaning perspectives can add significance into the development of weight loss programs, and educational curriculum interrelated with the processes associated with TLT and TTM. Exploring the meaning-making experience of weight loss maintenance can help “accelerate the pace at which a medical culture in the United States shifts its expectation to create critically reflective patients” (Brendel, 2009, p. 29).

Dubouloz’s et al. (2010) work illustrated that patients make meaning through the process of not having a disease define them. Nonetheless, obesity is often not diagnosed in a traditional way, and there are many other factors from a socio-cultural perspective that influences individual decisions which creates a gap in the literature that this study addresses. Integrating these processes into the care pattern can accelerate the process of change. The social, cultural and personal context of individuals influence how that person transitions through the transformative process and if a perspective transformation occurs is a crucial step in understanding weight maintenance.

Exploring these experiences of the meaning-making journey of weight loss and maintenance is of interest to health researchers, health educators, nurses, and physicians. The medical community can find purpose in helping patients engage in meaningful, healthy behavior change. Paterson et al. (1999) noted, "The idea of transformation is fundamentally pleasing to health care professionals who struggle to find purpose and reason for the suffering and loss that they witness in those who experience chronic illness" (p.799). Facilitating perspective transformation and a critical consciousness
among primary care patients is a crucial step in developing critical reflective patients that take a role in the shared decisions of their healthcare and well-being.

Lastly, this study addresses the gap in the literature that fails to address how successful weight loss individuals made meaning of the weight stigma and discrimination that these patients may have faced along their journey. This study also assesses how media portrayals of obesity and obesity discourse have impacted motivation for change. Studying the weight maintenance experience through the lenses of TLT, TTM from a critical media literacy and critical public pedagogy perspective can provide critique to current weight loss treatments and encourage alternative approaches to obesity treatment. Seeing that weight loss maintenance is rare, successful weight loss maintainers are a unique group of individuals which useful information can be discovered.
CHAPTER 3

METHODOLOGY

The purpose of this study is to explore how weight management patients make meaning of the lived experience of successful weight loss and how those meanings can impact behavior changes and promote transformative learning. The central aim of this study was to gain a better understanding of the meaning-making process of patients who were once enrolled in a medical weight management treatment program which, appropriately, calls for a qualitative methodology. The research methodology must match the particular phenomena of interest, which in this study are experience, learning, and meaning related to substantial weight loss. Therefore, narrative analysis was chosen to study the personal accounts, or stories, that bring meaning and worldview shifts to the weight loss experience. Research questions that guided this study were:

1. What are the dynamics of the weight loss experience, including behaviors, cognition, perceptions, and self-image?

2. How do individuals make meaning of their successful weight loss experience and does that meaning-making lead to a perspective transformation?

3. What are the key learning outcomes and learning processes of the successful weight loss experience that facilitates transformational learning?

The purpose of this chapter is to explain my research methodology and I begin with a discussion of the chosen research paradigm and research type. I provide a description of the background of the research, focusing on the relationship between the methodology and the study. I follow with a section to discuss participant selection,
procedures for data collection, and analysis. An explanation of considerations used to verify, ensure trustworthiness, and confirmability of the data conclude the chapter.

**Qualitative Research Methodology**

Commonly, health care research, specifically that of health behavior change in a medical paradigm, focuses on disease through an epidemiological lens, or the study of “distribution and determinants of health-related states or events, and the application of this study to the control of diseases and other health problems” (WHO, 2011). This often occurs through studying a disease among a population often focusing on cause and effect relationships, through statistical power, as well as a priori information to form and test hypotheses. This approach, generally using a quantitative research approach, does not lend insight into how an individual makes sense of an experience with a given disease, nor does it allow the research problem to be viewed from the perspective of the local population or through a learning lens.

The Hippocratic Oath, which all United States physicians are required to swear upon to uphold medical ethical standards, posits “It is better to know the patient who has the disease than the disease which the patient has” (Ray, 2004, p. 30 as cited from Wesley, 2003). However the majority of research in a medical paradigm is quantitative in nature and contradicts the previous statement by concentrating on the disease, rather than the individual with the disease. Therefore, this study attempts to better know individuals by forming relationships, establishing trust, and having the research take place in the field where participants experience the issue at hand (Creswell, 2009). It is qualitative research that better creates these relationships and seeks to understand the experiences through a social or learning lens, set in a particular context. Qualitative
research has the unique goal of facilitating the meaning-making process. In essence, understanding meaning is the task of qualitative research and reflects the specific methods used in the qualitative data analysis process. Qualitative research is “effective in identifying intangible factors, such as social norms, socioeconomic status, gender roles, ethnicity, and religion, whose role in the research issue may not be readily apparent” (Mack, Woodsong, MacQueen, Guest, & Namey, 2005, p.1). In order to fully understand the function and appropriateness of selecting a qualitative methods approach, it is important to describe the method, including the philosophical assumptions.

Qualitative research in education specifically that of the social sciences, explores the learning outcomes, learning processes within the experiences of individuals through the lens of a particular social problem (Johnson & Onwuegbuzie, 2004). Qualitative research methods are situated in the post-positivism paradigm. This paradigm views knowledge as culturally embedded and recognizes that knowledge can exist in many forms (Guthrie, 2010). Post-positivism is largely derived from works in the fields of anthropology and sociology. Several characteristics define the post-positivism viewpoint. Post-positivist research is “largely subjective in nature; views data as dependent on the relationship between the knower and known; is naturalistic, non-experimental research; and considers scientific methods as social constructs” (Guthrie, 2010, p. 43). Rather than importance of scientific rules, it is what the research does that is of importance in this paradigm (Guthrie, 2010).

Frequently, qualitative research takes place in the field where participants experience the issue at hand (Creswell, 2009). Qualitative researchers believe that the best way to understand a situation is to view it in the context, or in its natural setting
rather than by approaching it from a structured questionnaire or fixed instrument. A qualitative approach serves a researcher who wants to understand a phenomenon or an experience rather than making a scientific exploration using basic science (Kramp, 2004). In this study, the natural setting is the weight management treatment program and qualitative research seeks to understand the perspective changes and the reality of these experiences that occur within this setting.

Qualitative researchers believe that all individuals construct their own reality/knowledge within the context of their lived experiences, relationships, and communities. Context refers to the “complete fabric of local culture, people, resources, purposes, earlier events, and future expectations that constitute time and-space background of the immediate and particular situation” (Hathaway, 1995, p. 548). This individual reality and co-constructed knowledge comes from the human experience, which is “inherently continuous and nonlogical, and may be symbolically representable” (Hathaway, 1995, p. 548).

A second component of qualitative research is the researcher as one of the primary research tools. With all research methods, the interests of the researcher, the audience of the study, and the overall research question guide the selection of the appropriate research strategy. In this study, the goal of the research is to investigate the phenomena, or explore the meaning-making experiences of substantial weight loss.

There is significant empirical research on perspective transformation and chronic diseases that is largely qualitative (Baumgartner, 2002; Bradshaw, 2008; Courtenay et al., 1998; Dubouloz et al., 2010; Fielden, 2003; Kessler et al., 2009; Paterson, et al., 1999). However, there is little known about how individuals successfully lose weight and keep it
off over time and whether this process leads to a perspective transformation. Moreover, there is little research surrounding the conceptualization of transformation of chronic diseases or the elements that contribute to this process and only one study to my knowledge has been conducted in the area of weight loss (Bradshaw, 2008; Dubouloz et al., 2010). Because, for many, effects of obesity can reach social, psychological, and emotional levels, which creates the need for a patient-sensitive approach to research. Utilizing a qualitative approach to study the experience of successful weight loss could provide additional evidence needed to make affective changes in a medical environment, where the paradigm is mostly quantitative in nature.

Moreover, qualitative methods can be more flexible, allowing for greater spontaneity and adaption to the interaction between the researcher and research subject. The ability to have the flexibility to personalize and tailor open-ended questions based on the information that the participant has provided can capture rich data that is meaningful and culturally relevant to the participant. These data help to create meaning surrounding how the participants make sense of the world and how they experience certain events (Willig, 2001).

The process of this qualitative interviewing research involves flexibility on the part of the researcher so that questions may emerge and the researcher can change direction if necessary (Rubin & Rubin, 2012). The data collection setting can vary; and data analysis is adapted to a flexible structure (Rubin & Rubin, 2012). Those that engage in qualitative research honor the research participants by focusing on retaining and reporting their stories in an ethical manner by engaging with the participants throughout the research process to ensure accuracy (Creswell, 2009).
However, to better understand, “which is the outcome of interpretation rather than explanation,” narrative inquiry is the specific qualitative research method that I use in this study (Kramp, 2003, p. 1). Specifically, narrative inquiry, a research type within the qualitative research paradigm can examine in depth the lived experiences of individuals who have successfully lost weight and maintained the weight loss. Furthermore, Kramp (2003) explains the particular importance of narrative inquiry for such research. She asserts that qualitative researchers, in general, are concerned with context, time, and place. In terms of narratives, the researcher will use the storyteller’s use of context to connect to specific experiences (Kramp, 2003). Through these narratives, or stories, individuals experiencing events create meaning. By understanding the meaning participants make of their lived experiences an individual, social, cultural, and learning context I hope to gain insight into permanent health behavior change through individual worldview change. The next section provides detail on narrative inquiry as the chosen research method.

**Narrative Inquiry**

Narrative inquiry argues that people understand and explain their lives through stories (Hones, 1998). The process of story is a vital human activity that structures experience and helps to assign meaning. In addition, the narrative structure and process helps in individual identity formation and adult development (Rossiter, 2002). Reissman (1993, p. 78) explains narrative inquiry as a “systematic study of personal experiences and meaning: how active subjects have constructed events” (as cited in Kramp, p. 1). A narrative is defined as a personal account or story that brings meaning to a given situation (Patton, 2002). Narrative inquiry can provide a window into the connections between
psychological, sociological, cultural, and the political dimensions of human life (Patton, 2002). Narrative analysis attempts to relate the narratives of an individual to a unique experience. It is the study of epiphanies, rituals, routines, metaphors, and everyday experiences (Clandinin & Connelly, 2000). Narrative inquiry focuses on studying and analyzing personal experience as it is storied or restoried by the participants. Since the story is centralized in human experience, teaching and learning is powerfully connected to the process of narrative inquiry (Rossiter, 2002).

Separating narrative from other qualitative methodologies is that it is both the process and product (Kramp, 2003). The process is the narrator or research participant telling or narrating, and the product is the story or narrative told (Kramp, 2003). Therefore, it is how the researcher gathers the data and the end product of the gathered data. Through this type of research method there is an opportunity to gain access to those intimate, personal experiences of the research participant. In narrative inquiry the unit of analysis is the story. Connelly and Clandinin (2006) used this definition to define narrative inquiry:

People shape their daily lives by stories of who they and others are and as they interpret their past in terms of these stories. Story, in the current idiom, is a portal through which a person enters the world and by which their experience of the world is interpreted and made personally meaningful. Narrative inquiry, the study of experience as story, then, is first and foremost a way of thinking about experience. Narrative inquiry as a methodology entails a view of the phenomenon. To use narrative inquiry methodology is to adopt a particular view of experience as phenomenon under study. (p. 375)
Key Components of Narrative Inquiry

This section reviews the key components of narrative inquiry. Experience and stories are central to qualitative research approaches and “can excavate deep understand and meaning embedded in our lives” (Barton, 2004, p. 519). One component of narrative analysis is the story. From stories, the researcher can elicit the insight and essence that accompanies the cultural and philosophical expressions and allows the participant to be recognized (Hones, 1998). Stories comprise memories, prompt individuals to reflect, and connect past and the present. Personal stories are active meaning making, and a powerful source of educational information (Rossiter, 2002). Rossiter (2002) stated “…stories enable us to engage with new knowledge, broader perspectives, and expanded possibilities because we encounter them in the familiar territory of human experience” (p. 1). A narrative can link actions and events into a story that can be understood as significant, or a way of knowing. Hones (1998) describes stories as “what the inquirer collects, retells, and writes” (p. 228). These stories help the researcher fill in the blank from “what happened” and “what it means” (Kramp, 2003, p. 4).

The narrative interview is designed to overcome the common tendency to “radically decontextualize and disconnect the respondents’ meaning making efforts from the concrete setting for which they originally were designed and from the larger sociocultural grounds of meaning production” (Mishler, 1986, p. 26). Unlike a quantitative research approach, the process of narrative inquiry is one that is reflexive and fluid. Researchers must balance the need for moving from the story itself, to the field data that is collected, to the final research text. Narrative inquiry is a joint process between
participants and researchers over a period of time. This type of research can take place in a variety of environments and evolve over a multitude of interactions.

Clandinin and Huber (in press) argue that “by attending to the commonplaces, narrative inquirers are able to study the complexity of the relational composition of people’s lived experiences both inside and outside of an inquiry and, as well, to imagine the future possibilities of these lives” (p. 3). There are three commonplaces of narrative inquiry that serve as a three dimensional conceptual framework; temporality, sociality, and place (Clandinin & Connelly, 2000).

Temporality refers to looking, not only to the event being examined but also looking at the past as well as the future possibilities. Sociality refers to the personal and social dimension of the narrative. The third dimension of place is within the environmental condition, which is referred to as the physical and boundaries of the inquiry landscape (Clandinin & Connelly, 2000). When an inquirer uses this set of terms any particular inquiry can become three-dimensional and the inquiry can come alive (Clandinin & Connelly, 2000). In practice, the researcher will ask questions, take notes, interpret the findings, while keeping in mind the social and personal issues, examining future and past implications, and considering the environmental conditions that impact and influence the experience of permanent weight loss. In addition, there are several formal components to narratives, including; plot, characters, point of view, time and place.

The plot is constructed by the narrator and represents his or her perspective or point of view (Kramp, 2003). The plot is a sequence of actions and events that are bound together to form a temporal unit, or time (Kramp, 2003). Time is integral to human
experience and it is through narrative that organizes these human experiences (Kramp, 2003). Another component is point of view. A point of view is the angle of which the narrator is speaking from. An experience reflects a point of view. The story will have a plot that orders actions, events, and experiences. This exact portrayal is from the narrator’s perspective. The narrator will situate these events and experiences within his or her socio-cultural perspective.

Assumptions of Narrative Inquiry

Narrative as a research method carries with it the assumption that the stories are a cognitive schema, which has a particular form (Kramp, 2003). In addition, Dodge, Ospina, and Foldy (2005) note three assumptions of narrative inquiry. The first is that narratives convey meaning, intentions, values, and emotions. These meanings are situated in the social reality of the individual. The second assumption is that narratives carry knowledge that individuals gain from a given experience. Thirdly, narratives are constructive, “which means that they are not only shaped by individuals, but they also shape individuals” (Dodge et al., 2005, p.291).

In addition to the assumption that meaning is constructed as people engage in the world they are interpreting, there are two additional epistemological assumptions of this interpretive paradigm. Humans make sense of the world based on their historical and social perspective, which means each individual is born into a world of meaning based upon individual culture (Crotty, 1998). Because of this the researcher should acknowledge that their own backgrounds, social history, and cultural worldview could influence their understanding and interpretation of the data.
Learning and Narrative Inquiry

The lived experience of successful weight loss generates meaning for the participants in weight loss programs and these meanings have implications for learning. Stories captured through narrative inquiry have two components for learning in the epistemological and transformative view (Heo, 2004). Stories include knowledge that individuals need in order to construct their experiences and participate in their communities. From a transformative learning lens, stories can provide mental messages that can assist in the transformation of life by helping to represent a problem to be solved (Heo, 2004), which directly relates to the theoretical framework of this study which is situated in transformative learning theory.

Mezirow (2000) believes that transformative learning usually results from a disorienting dilemma, which is triggered by a life crisis or major life transition, although it may also result from an accumulation of transformations in meaning schemes over a period of time. For example, weight gain occurs over an extended period of time, as can dramatic weight loss. The transition to weight loss can arguably be the result of a disorienting dilemma that triggered a perspective transformation. A disorienting dilemma represents an experience that does not fit into our current worldview, or fit into our current meaning-scheme. Thus, this often causes a dilemma, or problem. This triggered response may lead to altered behavior that resulted in an accumulation of small behavior changes and meaning schemes over a period of time, or abruptly led to a change (Mezirow, 2000). However, little is known about how this occurrence takes place within chronic disease, specifically obesity.
To better understand this trigger, narrative inquiry relies on the research participant’s story to gain a deeper understanding of how “meaning is conferred onto experience” (Bamberg, 2012, p. 5), which is connected to “who we are, or who we think we are” (Bamberg, 2012, p. 5). Narrative inquiry implies that all individuals hold subjective meaning of their experiences that are varied, shifting, and multi-layered. Narrative inquiry notes that stories are constantly being restructured and edited in light of the particular context of the individual and the new events that the individual might have encountered recently (Clandinin & Connelly, 2000). Narrative inquiry requires moving beyond a rhetorical structure by examining the assumptions that the story captures. This method rests on the “epistemological assumption that we as human beings make sense of random experiences by the imposition of structures” (Duff, 2002, p. 207). Therefore, it is important to note that individual stories are not stored “in a vacuum” (Duff, 2002, p. 208) but are shaped by lifelong learning.

**Research Ethics and Compliance**

This research study was conducted in cooperation with the Pennsylvania State University and Geisinger Health System’s Office of Research Protection. Approval to conduct the research was obtained from both institutions Institutional Review Boards (IRB) prior to beginning this study, under an expedited status. Pennsylvania State University’s IRB elected Geisinger’s IRB as the lead site, designating Geisinger for review and continued oversight of its human participant research through the execution of an IRB Authorization Agreement. Approved through protocol numbers 2012-0350 at Geisinger and 41742 at Pennsylvania State University verbal consent was given by each
participant prior to scheduling the interviews. Funding was provided by the Geisinger Scientific Review Committee.

Verbal consent was given prior to scheduling interviews. Prior to the taping of the interviews implied consent was provided. The interviews were audio-recorded, transcribed, and restoried. Methods to restorying vary, but in general, “Restorying is the process of gathering stories, analyzing them for key elements of the story (e.g., time, place, plot, and scene), and then rewriting the story to place it within a chronological sequence” (Ollerenshaw & Creswell, 2002, p. 332). For this study, which was based on the understanding of the weight loss maintenance experience oriented the process of restorying was the following:

1. Each interview was audio taped, de-identified, and transcribed.
2. I read and reread the transcript to become familiar with the data.
3. I then organized the data (color-coded) transcripts into events, or sections.
4. After the transcripts were deconstructed, I reworked the story by reorganizing the events to make the narrative flow and provide chronological sequence.
5. The narratives were member checked by the participant.

I then collaborated with six out of the nine participants by involving them in the member check process. The participants reviewed their narratives and we went over changes, discrepancies and other suggestion over the phone. Additionally, all participants were made aware of their rights and that participation was voluntary and any questions that made them feel uncomfortable could be skipped. In addition, all participants were informed about how their data would be protected, shared, and presented. All identifiable
information was removed through the transcription process, pseudonyms were used, and interview data were storied and analyzed.

**Participant Selection**

In order to capture the lived experience of successful weight loss, a small purposeful sample was appropriate for this study. This study is descriptive in nature and collected narratives that were analyzed within the context of the individual’s personal, cultural, and historical experiences (Creswell, 2007). Sampling decisions are theoretically informed, should be consistent with the research plan, and are crucial for the study’s soundness (Marshall & Rossman, 2011). A purposeful sample, or a sample that was selected because it can inform an understanding of the research problem, provided rich information and was chosen as the recruitment strategy for this study (Patton, 2002). The sample, which is relevant to the study, recruited individuals from an integrated health system’s weight management program via a waiver of authorization following an opt-out recruitment strategy. This purposeful sample of individuals yielded descriptive information significant to the meaning making experience of successful weight loss maintenance.

Furthermore, criterion sampling, a type of purposeful sampling, was used to recruit participants that met specific weight loss maintenance operational inclusion criteria and who were enrolled in a specific weight management treatment program. Criterion sampling helps to meet quality assurance measures and enables the researcher to carefully execute a recruitment strategy to capture the intended audience (Marshall & Rossman, 2011; Patton 2002). A research rationale is needed for criterion sampling and should help build the case for the intent of the study (Marshall & Rossman, 2011). For
the purposes of this study, the criterion was influenced by the weight management literature and the Transtheoretical Model maintenance phase, which states individuals are in this stage, mandates the health behavior lasts for ≥ 6 months (Elfhag & Rossner, 2004; Prochaska, Norcross, DiClemente, 1994).

Data Extraction Plan

Adult patients eligible for this study were identified through a query to Geisinger Health System electronic health record. The initial data request was intended to identify all remotely eligible patients. This pull included all living weight management patients that are currently active in the health system. The initial extraction cohort was limited to patients that meet all of the following criteria:

- Age between 25-65 at time of contact
- Had an office visit encounter at any Geisinger outpatient clinic during the year 2012
- Has ever had an office visit encounter at the Danville GI Nutrition Clinic (weight management clinic)
- No bariatric surgery and not consented in the NASH bariatric research study
- Alive at time of data extraction
- No research Opt Out codes

The study team then used the data extraction above to identify a set of patients to contact for study recruitment. The first pass at the selection was limited to the patients that are most likely to be eligible (e.g. obese patients that lost >20% of weight after enrolling in Weight Management and maintained the weight for 12+ months, very active
in Weight Management clinic, no pregnancies, no cancers, no mental health disorders, no medications that are associated with weight changes).

Selection of Eligible Cases

The following specific step-by-step exclusions were as follows:

- 4352 patients were in the initial data extraction (as defined above)
- 4344 had a height available
- 3444 had a BMI between 35-70 kg/m2 at their initial visit with the Nutrition and Weight Management clinic (median height was used in all BMI calculations)
- 1496 had at least 2 visits with the Nutrition and Weight Management clinic that were 90+ days apart
- 1384 were not pregnant within the year prior to their initial visit or during any time after their initial visit
- 1312 had no sign of cancer (defined as ICD9 140-209 on problem list or on 4+ outpatient visits)
- 1105 had no antipsychotic medication (prescription order or on medication reconciliation list)
- 100 had at least 2 weight measures with >15% weight loss that occurred 365+ days after their initial visit with the Nutrition and Weight Management clinic AND their most recent weight measure indicated >15% weight loss

These 100 patients were sent to the data broker to extract contact information for mailing and interview purposes. The following data elements were requested: MRN,
name, age, mailing address, phone number. To identify the subset for mailing and phone screening, the weight trends for each of these 100 patients were manual reviewed using a longitudinal plot of their weight loss trajectory (see Figure 1).

![Example of longitudinal plots of weight trends](image)

**Figure 1.** Example of longitudinal plots of weight trends

The initial pass was used to identify and exclude patients that obviously do not qualify (e.g. severe weight cycles, patients with obvious data entry errors). This resulted in the exclusion of 13 patients. The study biostatistician and I manually and independently reviewed the remaining 87 plots. Each reviewer examined the longitudinal plots to determine the likelihood that the patient experienced >15% weight loss as a result of the visits with the Nutrition and Weight Management clinic and whether the weight loss was maintained for at least 12 months. We assigned a score of 1-4 (1=Yes, 2=Maybe, 3= Unlikely, 4=No). The scores were compared with the following results:
- Phase 1 recruitment (n=19): Both reviewers scored “Yes”
- Phase 2 recruitment (n=9): One reviewer scored “Yes” and the other scored “Maybe”
- Other:
  - Possible cases to reconsider (n=33): At least one reviewer scored “Maybe”
  - Exclude (n=26): Both reviewers scored “Unlikely” or “No

**Participant Recruitment**

Patient recruitment used Phase 1 and Phase 2 as described above to interview a total of nine participants. Once the list of participants (which is what I called the patient roster) was identified, I mailed one recruitment letter (Appendix A) to each potential research participant in batches with the help of a research assistant. I signed the pre-notification letter along with the Director of the Weight Management Clinic. The letter outlines patient participation expectations, confidentiality measures, types of patients the study is interested in, compensation patients received for their time, and detailed instructions on how patients can opt out of the study. Participation in this study was completely voluntary and care was not affected by the individual’s decision to participate.

Research participants were recruited for study with a pre-notification letter, rather than in-person recruitment as this provided patients the opportunity to consider the study in the privacy of their home and decline with less pressure than they might feel if offered the opportunity to participate in person. The letter also notified individuals that participation in the study is voluntary and provided the patient with an option to opt-out
of the study: it included a toll-free number that individuals called to opt-out. A research assistant and I were responsible for retrieving opt-out messages and documenting responses. Those who opted-out were excluded from the study.

If the patient did not opt-out using the toll-free number within ten days of receiving the pre-notification letter, a call was placed to each patient using a phone script to participate in the interview. From there, I coordinated a date and time for the interviews. One day prior to the scheduled interview a reminder call to each participant was placed. As compensation for the time required participating in the study all study participants received a $20.00 gift card.

**Data Collection**

Semi-structured, face-to-face interviews were the main data collection method used in this study. Semi-structured interviews function under a set of questions that are used to guide the purpose of the interview. However, this form of interviewing is flexible and allows both the researcher and interviewee to ask and answer additional questions in a responsive fashion (Rubin & Rubin, 2012). Given the a priori knowledge of transformational learning and chronic disease, an un-structured interview allows exploring specific themes, but still holds the flexibility to gain insight into individual experience. An unstructured format has a lesser degree of control from the perspective of the interviewer (Rubin & Rubin, 2012). Interviewing in a qualitative research study allows the researcher to get insight from the participant’s perspective, which in the qualitative research paradigm is valued as meaningful (Patton, 2002). The stories that arise from the interviews are central to the qualitative approach and can reveal deep meaning (Barton, 2004). An interview guide was created to ensure that all participants
received the basic set of questions, which are provided in Appendix B. The interview
guide also provided me with areas in the interview that may need probing, or sub-
questions (Patton, 2002).

Using the interview guide, each participant was interviewed at the medical center
or at another suitable location selected by the participant, including their homes or phone.
Initial interviews lasted 45 minutes to 1.5 hours, were taped recorded by two recorders,
and later transcribed. Each participant was asked to member check their narrative to
clarify information and to check for validity through a second conversation, which lasted
10-40 minutes. For completion of the member check, all participants received an
additional $10.00 gift card.

All interview audio files are stored in a locked cabinet in a locked office, in a
locked suite. Only IRB-approved study staff members have access to the audio files and
transcribed results. All electronic data are stored in a database that is password protected
on a secure network; only IRB-approved study staff has access to the database. All other
data will be kept for an indefinite period after data collection is complete. Moderator and
co-moderator notes were also taken during the interviews to provide insight to the
participants’ context.

**Participant Characteristics**

In total, 4353 participants were screened, 29 were invited for participation and
nine participated in the study. Of the nine interviews, two were conducted at the
participant’s homes, five on the telephone, and two at the Geisinger Medical Center. The
participating adults were of variable ages, with a mean age of 51. Participants were
mostly female (78%) and the majority lived in an observed rural, lower socioeconomic
area. All participants had substantial clinical success in weight loss and weight loss maintenance without the aid of surgery. Participant characteristics including age, gender and race are provided in Table 2.

Table 2

*Study Participant Characteristics (N = 9)*

<table>
<thead>
<tr>
<th>Name (pseudonym)</th>
<th>Gender</th>
<th>Age</th>
<th>Race</th>
</tr>
</thead>
<tbody>
<tr>
<td>John</td>
<td>M</td>
<td>33</td>
<td>White</td>
</tr>
<tr>
<td>Jane</td>
<td>F</td>
<td>48</td>
<td>White</td>
</tr>
<tr>
<td>Gail</td>
<td>F</td>
<td>48</td>
<td>White</td>
</tr>
<tr>
<td>Nicole</td>
<td>F</td>
<td>55</td>
<td>White</td>
</tr>
<tr>
<td>Pam</td>
<td>F</td>
<td>62</td>
<td>White</td>
</tr>
<tr>
<td>Mike</td>
<td>M</td>
<td>54</td>
<td>White</td>
</tr>
<tr>
<td>Betty</td>
<td>F</td>
<td>59</td>
<td>White</td>
</tr>
<tr>
<td>Amy</td>
<td>F</td>
<td>36</td>
<td>White</td>
</tr>
<tr>
<td>Nancy</td>
<td>F</td>
<td>61</td>
<td>White</td>
</tr>
</tbody>
</table>

The distribution of the participated weight loss maintainers interviewed for the study is described in Table 3. Table 3 describes length of time a percentage of weight loss was kept off and the age range of the participant. All participants lost at least 15-19.9% of their initial weight and kept this off for at least one year, and two participants kept a weight loss of >20% for over two years.
Table 3

Distribution of Weight Loss and Weight Loss Maintenance (N = 9)

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Percent Weight Loss</th>
<th>Age Groups</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>12 months</td>
<td>15.0-19.9%</td>
<td>25-34</td>
<td>0 (N=2)</td>
<td>1 (N=2)</td>
<td>1 (N=3)</td>
</tr>
<tr>
<td></td>
<td>&gt;20%</td>
<td>35-44</td>
<td>0 (N=2)</td>
<td>0 (N=2)</td>
<td>0 (N=2)</td>
</tr>
<tr>
<td>24 months</td>
<td>15.0-19.9%</td>
<td>45-54</td>
<td>0 (N=2)</td>
<td>1 (N=2)</td>
<td>1 (N=3)</td>
</tr>
<tr>
<td></td>
<td>&gt;20%</td>
<td>55-65</td>
<td>0 (N=3)</td>
<td>1 (N=3)</td>
<td>1 (N=3)</td>
</tr>
</tbody>
</table>

Data Analysis

Data that is collected through qualitative research can be “messy, ambitious, time-consuming, creative, and fascinating” (Marshall & Rossman, 2011, p. 207). Qualitative data analysis calls for a process to bring about organization and structure to the voluminous collected data. According to Marshall and Rossman (2011) there are seven phases in the analytical processes of qualitative data analysis: organizing the data, immersion in the data, generating categories, coding, offering interpretation of data, searching for alternative meanings, and writing the final report. This section addresses how the collected narratives were organized and analyzed to communicate the findings.

Narratives or stories are the primary unit of analysis. A narrative is “understood as a spoken or written text giving an account of an event/action or series of events/actions, chronologically connected” (Czarniawska, 2004, p. 16, as cited in Creswell, 2007, p. 54). The stories or narratives are what were analyzed and deeply understood to better understand narrative knowing, or “What is the meaning of experience?” (Kramp, 2004).
Narratives collect a large volume of data. It is important to organize all narratives. This organization can occur in the early data collection process by taking notes while collecting the narratives. In addition, each transcript was labeled with a unique study ID and interview date and time. Then the primary responsibility of the researcher is to immerse themselves in the data, which means to read and re-read the data to ensure comfort and familiarity with what was collected and that so that generally concepts are recognizable by the researcher. After the data is recognizable, restorying and analysis can begin (Clandinin & Connelly, 2000; Creswell, 2009). The stories report personal experiences (what the individual experiences) as well as social experiences (the individual interacting with others) (Clandinin & Connelly, 2000, as cited in Ollerenshaw & Creswell, 2002, p. 331). In the case of narrative inquiry, the stories represent the data and the data is usually collected through interview or conversation (Ollerenshaw & Creswell, 2002). After the data was collected, the process of restorying began. Methods of restorying vary, but in general, “Restorying is the process of gathering stories, analyzing them for key elements of the story (e.g., time, place, plot, and scene), and then rewriting the story to place it within a chronological sequence” (Ollerenshaw & Creswell, 2002, p. 332).

There are several types of analysis most used in narrative analysis. This study used a blended combination of narrative analysis methods that allowed me to fully engage in the participant’s story. These frameworks include Gee’s (1990) sociolinguistic method, Alexander’s (1988) pyschobiographical approach and narrative knowing (Sutton-Smith, 1986). Gee’s (1990) sociolinguistic method examines the meaning behind the words used throughout the narrative. This method analyses the pitch, stress,
loudness, and the hesitations of the research participant. Each sentence was analyzed for consistency, and looked at how larger themes of text are organized throughout the participant’s story. Alexander’s (1988) psychobiographical approach concentrates less on the meaning of language, but more attention is drawn to the meaning people create through the words used. This approach uses nine “principle indicators of salience” which helps to manage the data. Baumgartner (2000) outlined the nine indicators as:

- Primacy looks at the first idea mentioned in the narrative. Frequency is indicated by the number of times an identity is mentioned. The uniqueness of a statement is indicated by phrases. Emphasis is brought to one’s attention by placing stress on a certain sentence. The salience indicator of omission generally is seen when people tell a story and neglect to mention their feelings or reactions to an event. When a phrase or series of phrases does not fit with the rest of the story, it indicates isolation. Incompleteness is demonstrated by a story that does not have closure. (p. 1)

- Narrative knowing data analysis method is less textual and structural than the paradigmatic knowing, another type of in narrative analysis (Sutton-Smith, 1986). Narrative knowing data analysis results in a story, as the researcher interprets the meaning behind the narrative of the weight loss experience. The last phase in the data analysis is providing interpretations and meanings around the themes and stories and restorying the narratives is key to find meaning (Marshall & Rossman, 2011). Through narrative knowing, a story emerges through the narratives. Each story, although may not be told chronologically, but will have a plot, a setting, characters and reflects a point of
view. It is the role of the researcher to understand what the story means in the particular context, which in this case is weight loss and behavior change.

Because the stories are not told in order this calls for restorying, a process of reorganizing the stories into a framework was also used (Creswell, 2007). Using the narrative, key concepts like time, place, and plot can emerge from the story in a non-sequential order, and should be reorganized in a sequence, which sets apart narrative analysis from other qualitative data analysis methods (Creswell, 2007). The story can provide meaning, epiphanies, and historical and social context that can include important information on the lived experience (Creswell, 2007). To the length of the narrative, the analysis attempts to reduce the story to a set of elements that may reveal a particular case in a certain time or place. Through data analysis, the voices of the participants are illuminated to provide a full description and interpretation of the meaning of their experiences (Clandinin & Connelly, 2000).

Several participant narratives in full are presented in Chapter 4 to grant the reader access to the aspects of weight loss maintenance and adult learning. I selected the narratives, which I believed to provide the richest data. The narratives are presented in first person and restoried for ease of reading and structure. My words were deleted from the stories and I used [ ] to add context, I de-identified personal information, replaced missing words to increase readability, which is a technique used by Gee’s (1990) sociolinguistic method. Additionally, there is a wealth of data in each narrative and because of this there is a need to look at each narrative individually and collectively. In addition to each narrative in Chapter 4, individual analysis using narrative coding is also presented (Saldana, 2009). There are headings and sub-headings throughout the
narratives to make it easier for the reader. These headings and sub-headings were emic and etic in nature. Narrative coding was used to “explore intrapersonal and interpersonal participant’s experiences and actions to understand the human condition through story, which is justified in and of itself as a legitimate way of knowing” (Saldana, 2009, p. 109). Chapter 5 provides details on the collective content analysis. To help with this collective content analysis, all transcripts were managed using Atlas.ti (version 6.2.23, GmbH, Berlin), a qualitative data management software. Each transcript was read two to three times in entirety before beginning to assign codes. The process of reviewing audio, field notes, and transcripts was taken to increase familiarity with the data. I used a first cycle of coding called narrative coding to break down the data responsive to text and phrases in the transcripts that were driven by “intrapersonal and interpersonal participant experiences” (Saldana, 2009, p 109). After this initial pass at the data, I used the Atlas.ti qualitative data management software were a total of 65 codes emerged. Next, pattern coding, the second cycle of coding was used to identify and organize patterns across the data (Saldana, 2009). Through ongoing discussion and revision with the thesis advisor, consensus on the underlying meaning of the codes was reached and the categories were more fully developed into fix themes, which are presented in Chapter 5. Data analysis was completed when all narratives were constructed and member checked and individual and collective content analysis was complete. This robust data set was analyzed to consider the story structures, research questions, and to inform theoretical frameworks and implications to practice.
Data Quality and Trustworthiness

There is a framework that outlines the components of qualitative data quality and trustworthiness, although much different than the validity and reliability concepts that are generally used in quantitative research. Because qualitative research is still emerging as compared to other types of naturalistic research, there is rarely an agreed upon definition to what qualifies the research as trustworthy. This study has chosen to discuss four constructs that can be employed in a constructivist research design to increase data trustworthiness and data verification as outlined by Lincoln and Guba (1985); credibility, transferability, dependability and confirmability. This section discusses how the four constructs correspond to the specific components of apparency and verisimilitude, (Connelly and Clandinin, 2000) that combined create high-quality narrative inquiry.

Credibility

A key component of all qualitative research is to ensure credibility, transactional validity, to ensure that the research measures actually capture what was intended (Shenton, 2004) and helps to establish data trustworthiness. Connelly & Clandinin (2006) use the word apparency that is the clear, representable display of data as an important component of narrative inquiry. Apparency in the data can add to the credibility and data trustworthiness by allowing the research audience to clearly understand the themes, meanings, and constructs of the narrative analysis.

There are several other research methods that can be used to foster apparency and ensure credibility. For example, a research method chosen to understand the phenomenon of interest, weight loss maintenance, should be derived from other literature in the field (Shenton, 2004). As the researcher has a credible list of questions developed
by critiquing the literature, the theoretical frameworks that are situated in the study, and context of the research, it is also favorable to become familiar with the natural setting of those who are being studied (Shenton, 2004). Prior to data collection for this study I visited programs within the weight management treatment center and also met with several key multidisciplinary team members to gain a better understanding of the key treatment components. This assists with gaining trust between the researcher and the organization of which the research took place, as well as allowing me to better understand the culture of the weight management team.

The next credibility method is the technique of saturation. There were up to 15 individual semi-structured interviews planned, however, the semi-structured interview format is flexible in nature. For example, if saturation occurs prior to the 15 interviews, meaning no new themes emerge from the field, data collection will conclude (Merriam, 2002). This study concluded data collection after nine interviews due to the low number of patients that qualified for the study.

Other methods to help ensure credibility were also implemented in this research. Each participant was given opportunities to opt-out of the interview process, thus only those participants who were willing to offer information on their experience were involved. Prior to the start of the interview process, I reviewed the participant’s rights as well as reviewed the rules of engagement, which include reinforcing the participants to offer their honest thoughts and that there are no right or wrong answers to describing their weight loss experience (Kramp, 2004). These discussions were used to establish a rapport with each research participant.
In addition, reviews by members of the research team could add a “fresh perspective that such individuals may be able to bring may allow them to challenge assumptions made by the investigator, whose closeness to the project frequently inhibits his or her ability to view it with real detachment” (Shenton, 2004, p. 67). Comments and questioning around certain assumptions, meanings and initial data analysis will be discussed.

Lastly, member checks with interviewees during the second interview were used to increase credibility and appearance of the data. Each participant was asked to comment on the initial narratives, the contextual meanings, and interpretations of the data (Lincoln & Guba, 1985). This ensured that there is an agreement between the researcher’s interpretations of the narratives and the actual meaning of participants weight loss experiences (Merriam, 2002).

**Transferability & Dependability**

The second aspect of data trustworthiness is transferability. Transferability refers to having the results of the study apply to a broader population base. In qualitative research, where the sample size often small, the responsibility falls on the researcher to provide contextual factors and details describing the boundaries of the study (Shenton, 2004). A purposeful, criterion sample was executed in this research which added validity to the transferability of the data. In addition, a limitations and strengths section of the research reports added to ensure that other researchers are aware of the details to which the research was implemented.

Dependability, the third component of qualitative data trustworthiness addresses the issue of reliability in qualitative research to show that "if the work were repeated, in
the same context, with the same methods and with the same participants, similar results would be obtained" (Stenton, 2004, p. 71). In this study all operational processes are communicated in detail through the research protocol and audit trail. An audit trail is documentation in a field journal, for example, that includes the details of how the researcher came to particular details of the findings. The interview guide, participant recruitment methods, and the inclusion and exclusion criteria, were also documented. This documentation allows other researchers to optimize the same procedures in other research studies (Merriam, 2002). These details add value to other researchers who may be interested in the successful weight loss experience and enable them to make a connection to similar environments. Given the context of this study, transferability can be proven if other studies using similar methods are conducted in different environments (Stenton, 2004).

**Confirmability**

Confirmability, the fourth quality indicator of qualitative research, is the degree to which a study’s findings are the product of the inquiry itself as opposed to the subjectivity of the researcher (Lincoln & Guba, 1985). Similar to confirmability, but more appropriate for narrative knowing is verisimilitude, or “the appearance or likelihood that something is or “could be” true or real (Kramp, 2004, p. 105). Narrative inquiry relies on the researcher to understand the meanings, and alternative meanings that the research participant shares, which is different than other types of qualitative research where the main objective of the researcher is to gather information. To add verisimilitude to this study, or confirmation that the results were that of the research participant interviews, an audit trail was created. This audit trail could be used to track
back to the exact interviewee, interview time, and length. In addition, the field notes were taken. These notes included what I believed to be important to the key concepts of the research question. In addition, the voices of the research participants were highlighted in the results section by using verbatim quotes. Using quotes from the research participants can communicate the specific components of the weight loss experience.

Data trustworthiness and validation in qualitative research is difficult. A known limitation to this type of work is the transferability to larger populations. The researcher will have to manage large amounts of data when using narrative analysis and the process and be slow and tedious. With careful attention to the participant’s speech, meaning, context, and eventually the transcriptions, narrative analysis can be a powerful research tool to deeply understand experience.

**Background of the Researcher**

The objectives of qualitative and quantitative research are not mutually exclusive; each method is comprised of different approaches, data collection techniques, and separate skill sets of the researcher. It is that of qualitative research which allows the researcher to become invested with the participants. Working in a dominantly quantitative driven research paradigm, situated in an integrated health system’s population based health research center, obesity research is quite common. This work, however, is outcomes-driven, often developed with a priori information. My research provides a unique opportunity to establish a qualitative educational research perspective that can be embedded in research that often is established through a behaviorist perspective. Learning how individuals make meaning of the lived experience of
successful weight loss can provide powerful findings that can ultimately impact the clinical work flow and make measurable changes to the way current weight management programs are developed. It is at this point where my research is centered.

Currently, I am at Operations Leads for Clinical Innovation Research & Evaluation, which is a dual role in a health research center and division of clinical innovation; part of my time working in operations, the other as a researcher. My main responsibilities in operations is implementing all aspects of research studies in fields ranging from evaluation, health outcomes based studies, qualitative patient engagement studies, to comparative effectiveness and health services research. I manage study teams, capacity, strategic planning, develop protocols, implement data collection techniques, and assist with the writing of the results. In my research investigator role I am largely responsible for the independent development of studies, scientific input of research protocols and the implementation of research including qualitative and survey methods and analysis. Prior to joining the health research center, I worked as a campaign coordinator and developed school and community health promotion materials. I identified as a health educator. Combined, these unique positions have allowed me to expand my current role into a health services educational based practitioner, utilizing my skills to develop adult appropriate curriculum and research studies that most importantly, can be translated into practice.

The National Institutes of Health (2011) strategic plan on obesity research calls for research that informs the development of more effective lifestyle interventions that reflect individual behaviors and to create novel prevention and treatment plans associated with this disease. This study explores the behavioral, social, and cultural factors that may
impact successful weight loss, and which will add to the national obesity research agenda. In my experience, little research is conducted to understand the experiences that a patient undergoes from a learning perspective. I believe that in order to develop effective patient interventions and clinical reengineering to the way health services is conducted additional qualitative work should be conducted.

I have a great deal of personal and professional investment in the educational outcomes that resulted from this study. With an exercise science background and a passion for living a healthy lifestyle, I personally wish to add to the literature by adding value to the learning contexts that are a central component of learning irreversible health behaviors that lead to permanent weight loss. I hope that this research can add value that can be translated into practice that can help individuals lead happy, healthy lives. Professionally, understanding how individuals make meaning of their successful weight loss maintenance experience in a traditional medical paradigm will allow me to foster a research agenda that will consider the patient’s perspective, aid in narrative-driven medicine and shared decision-making models of care delivery in an outpatient setting.

Summary

This study set out to explore how successful weight loss maintainers made meaning of their experience. The purpose of this chapter was to provide an overview of the methodology employed in this study. I chose a qualitative approach using narrative inquiry and constant comparison techniques to present the findings. The participants for this study were purposefully selected, based on criterion sampling. I used an opt-out method of recruitment and each member participated in a 45-60 minute semi-structured interview. Each interview was transcribed, restoryed, and member checked. The process
of each stage of analysis was clearly defined. The research ethics at both institutions were discussed. Finally, the chapter concluded with an introduction to my background.
CHAPTER 4
NARRATIVES AND INDIVIDUAL ANALYSIS

This narrative inquiry employed conversational and semi-structured interviews to elicit stories from nine adult participants who successfully maintained a weight loss of 15-20% for at least one year, and who were once enrolled in a medical weight management program. The interviews were transcribed, de-identified, restoryed, and member checked. Six out of the nine narratives were selected to be presented in their entirety due to their robust details and story development. Participant stories of successful weight loss maintenance were viewed from multiple perspectives and theoretical frameworks relating to adult education: Transtheoretical Model of Behavior Change, Transformational Learning Theory, and Critical Media Literacy as informed by Critical Public Pedagogy.

After each interview was recorded and transcribed, the transcript was restoryed. The restorying process began with reading and rereading the interview to become familiar with the details of the story. I reframed and reordered the information and focused on the meaning-making and learning processes of each participant’s weight loss and weight loss maintenance journey. I was the co- constructor of these narratives. Methods of restorying vary, but in general, “Restorying is the process of gathering stories, analyzing them for key elements of the story (e.g., time, place, plot, and scene), and then rewriting the story to place it within a chronological sequence” (Ollernshaw & Creswell, 2002, p. 332). For this study, which was based on the understanding of the weight loss maintenance experience, the process of restorying was the following: a) each interview was audiotaped and transcribed, b) I read and reread the transcript to become familiar with the data, c) I then organized the data (color-coded) transcripts into events,
or sections that were relevant to the research questions and theoretical frameworks, d) after the transcripts were deconstructed, I reworked the story by organizing the events to make the narrative flow and provide chronological sequence, and finally e) the narratives were member checked by many of the participants to ensure accuracy. The process of restorying is important to narrative inquiry. Working within the text in the transcripts the process of restorying helps to structure the narrative into events that are situated into a specific setting or context (Creswell, 2008).

After each transcript was restoryed, I mailed each narrative to the participants. I then placed a phone call to each participant. Six out of the nine participants who participated in the original interview process engaged in a member check conversation with me and reviewed their stories and made suggestions to the narratives. Throughout each narrative, emic and etic sub-headings were used, brackets were inserted to add context, replace missing words, de-identify personal information, geographical subdivisions, and to increase readability (Gee, 1990). Participant characteristics including pseudonym, gender, age, marital status and trigger are represented in Table 4.

Lastly, following each narrative is a brief analysis of each story. The individual analysis used a narrative coding technique (Saldana, 2009). Narrative coding was used to “explore intrapersonal and interpersonal participant’s experiences and actions to understand the human condition through story, which is justified in and of itself as a legitimate way of knowing” (Saldana, 2009, p. 109). I broke down each story into text and phrases in that were driven by these experiences. The individual story analysis combines insight into addressing the main research questions that guided this study with my assessment of how each interview went. Each story is organized by various
subheadings, unique to each participant and primarily driven by emic and etic driven data.

Table 4
Narrative Participant Characteristics (N = 6)

<table>
<thead>
<tr>
<th>Name (pseudonym)</th>
<th>Gender</th>
<th>Marital Status</th>
<th>Trigger(s)</th>
<th>Pre-medical weight management (lbs.)</th>
<th>12-months post (lbs.)</th>
<th>24-months post (lbs.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>John</td>
<td>M</td>
<td>Married</td>
<td>Birth of Daughter/Diabetes/ Blood Pressure</td>
<td>418</td>
<td>362</td>
<td>386</td>
</tr>
<tr>
<td>Jane</td>
<td>F</td>
<td>Divorced</td>
<td>Divorce</td>
<td>314</td>
<td>252</td>
<td>292</td>
</tr>
<tr>
<td>Pam</td>
<td>F</td>
<td>Married</td>
<td>Son’s Wedding/Clothing</td>
<td>234</td>
<td>169</td>
<td>146</td>
</tr>
<tr>
<td>Mike</td>
<td>M</td>
<td>Married</td>
<td>Physician/Co-workers/Sleep Apnea/Blood Pressure</td>
<td>360</td>
<td>232</td>
<td>234</td>
</tr>
<tr>
<td>Amy</td>
<td>F</td>
<td>Single</td>
<td>Multiple failed attempts to lose weight – wanted help.</td>
<td>201</td>
<td>165</td>
<td>158</td>
</tr>
<tr>
<td>Nancy</td>
<td>F</td>
<td>Married</td>
<td>60th Birthday</td>
<td>235</td>
<td>188</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

**John**

John is a 33-year-old male who lives in a lower socioeconomic area in the central part of the state. He currently works two jobs, both in the food industry. Through his journey of weight loss and weight loss maintenance he found what worked for him, adopted these behaviors into his daily life and has been determined to maintain these behaviors that led to long-term weight loss maintenance. His primary reason for weight loss was his daughter and being healthy for his family. I had the pleasure of interviewing John at his home.

**John’s Story**

I’ve always been overweight most of my life, starting around six years old. When I was five I had my tonsils out, and my mother told me [I was gaining weight] after that. She kind of made a joke about it and said, “Your tonsils always blocked your food from going down.” But once I had my tonsils out everything just flowed freely. It was kind of funny. But from the time I was in grade school, all the way through middle school and
high school I would gain weight. It [weight] wasn’t serious until I was in high school because that was when I around 300 pounds when— I was a senior. I used to lift weights all the time. My brother and I used to go to the gym. I went to college, and then I went to culinary school [location].

Like I said, I went [to college] for Culinary Arts and I was always around food so it was always like a struggle for me, to try and keep weight off, because I was always around that. Even when I was in high school I was at my vocational-technology school and I went to the food program there. From 10th grade, even to like present time, I worked with food. When I was a senior I was around 312 pounds — yeah — about 312 pounds when I graduated, and then it just progressively got more and more and more. I eventually hit about 425 pounds — and then that’s when I decided that I wanted to really do something about it [weight] because I was afraid because I became a diabetic, and my blood pressure was high, and it just really worried me, because I had a lot of family problems. Mainly on my dad’s side with high blood pressure, diabetes, weight loss, and stuff like that. My dad had open-heart surgery in [year] when I was in college. He had valve replacement, and he’s had heart problems ever since. Currently he’s in the hospital for his heart. I was over to see him yesterday, so probably sometime this afternoon I’ll go over to see him again.

But when I entered the program [weight management program] to get the bariatric surgery I was around 425 pounds, and we met with different doctors and people that were doing studies and educators, and they would give us packets of information. They told us the best way to eat properly, smaller portions, how to scale your food, chewing a certain amount of times, just to slow down the process. The goal was to lose 10% of our body
weight before the 6 month program was over, and I remember thinking in the back of my head that that was going to be extremely difficult for me. So basically I had to lose about 42 pounds in 6 months and I started off really slow. We had to go back I think every two weeks to check, and they wanted to see how you were doing, and then every time you would go they would weigh you. I lost like four or five pounds in the first two weeks and then a few more pounds the next week, but then I managed to put some of that weight back on. So it was like for the first month it was just like up and down, and I really didn’t see a whole lot of progress, and I wasn’t sure what I was going to be able to do, so somebody said, “cut down sugars, especially being a diabetic.” Don’t drink so much, um, soda, juices…just focus on water. And, especially with being a diabetic, I was thirsty a lot, because it was uncontrolled. I was always really, really thirsty so I just started drinking a lot of water and I was going for walks.

I was at the point where this was in [year] when I was going through the weight loss program and – I can’t remember the exact month – it might have, it started in the spring, and then it went to the fall. I was working at [location] and I was starting off drinking almost a gallon of water a day, and then it just became almost like an addiction – I just couldn’t drink enough water. No matter where I went I had a bottle of water with me; if I didn’t I would stop at the store and buy one; until eventually I was drinking about two to three gallons of water every day. I was in the bathroom constantly…but the weight just started to pour off. Literally I was losing like up to 15 pounds in one week.

It just was just really easy after that, because drinking all the water was keeping me full so then I wouldn’t really eat as much. So instead of eating like two or three sandwiches I would eat like one, or just half of a sandwich. Portions were really small
because the water was keeping me full all of the time, and I was satisfied with that. It seemed to be working for me, and it was working really well. By the time I was finished with that program they were even surprised. [They would say] “Like, how did you lose?” because it was like 80 pounds by the time that 6 months was over. And I told them there wasn’t a whole lot of exercise involved. It was basically just drinking lots of water and the occasional walks. I would take my daughter out with me and we would go for walks. She was only like 3 years old at the time. I would just take her for walks around [location]. It seemed like I got down to about 320 pounds, and then that’s where I kind of stopped. It [the weight loss] just stopped. Because there wasn’t a whole lot of exercise other than a couple walks. Without doing some like real exercising, it seemed like I just hit that plateau and it was really difficult for me to lose any more weight. So that’s when I made the decision that I really didn’t want to get the surgery done. Because I wanted to try and keep the weight off on my own without having something so invasive done to my body. I told them that, I wasn’t going to do it, and they were okay with that, since the weight loss was so successful for me. I was just going to continue to try to exercise and do what I needed to do to keep that weight off. And the weight went back on a little bit, and I think I went back up to around 345-350 pounds but then after that, like, I knew in the back of my head how I could just very easily lose the weight. If I just wanted to keep drinking lots of water and then go for walks I could always get back down and the lowest I was at was last fall – I was down to, I was about 310-312 pounds and that’s where I’m at [now].

It’s just been even harder because I work two jobs and I’m working about 60 hours a week. So today [Monday] is my only day off, so between having to work all
those hours and trying to balance a life with my fiancé and my daughter it’s hard for me to go to a gym or to go anywhere. But, I really would like to lose more weight than I’m at right now, but my diabetes is more under control than it was. I have to take shots, but it’s still under control, and I take medication for my blood pressure. Otherwise everything seems to be going okay as far as just trying to maintain where I’m at without gaining it back.

**I Feel More Confident**

[Before I lost all of the weight] I didn’t feel real good about myself because I didn’t like the way I looked. I wouldn’t say I was real sloppy big, because I was taller and I was like kind of in proportion, I was really broad, like my shoulders were broad, my stomach stuck out but I didn’t like the way I felt because I just felt sluggish all the time and I got tired easily. I probably only have a few pictures of what I even looked like, but I should’ve gotten them out just to show you – it was a lot different than I look right now. Now, I feel better. Not as good as I could, but I still…I feel better about the weight loss and just overall. Mainly, because I know it [weight loss] can happen…and just in the way my clothes fit, because I was up around a – like my jean sizes were like a size 50 and I’m right around a 42/44 right now, so I mean I know that can happen for me, I just have to really work towards it. And my shirts were around a 4x/5x, I can wear about a 2x, or 2x/3x depending what it is. But, that was one of the biggest things, is I remember trying clothes on that I never fit into and then just after the weight loss I was able to fit into them and they’re actually kind of loose on me, so that was real nice. I also had more energy. I had much more energy, yeah. And just the compliments from people – they
were noticing, “Hey – you look like you lost some weight?” – “Yeah I did”, it was nice just to have other people see it.

I feel better now because I – I feel a little more confident than I was when I was much bigger, and it seems like I’m able to buy nicer clothes, because it’s harder to buy the really stylish name brands that I wanted to buy when I was bigger without spending $100 on a pair of jeans, because they were specially made or something. Now I can buy jeans and shirts, whatever I want! It’s still harder to find certain things but, like, it’s just much easier. I can buy what I want to and not really have to worry about it, and I like the clothes itself is one of the biggest things – it just changes the way you feel about yourself. If you can look nicer you’re going to feel nicer.

**I Was Looking For a Quick Fix**

[I knew I was ready to change] right around the time that my daughter was born. I wanted to be able to live my life with her. I was married at the time, and I just wanted to be able to focus on her and have the energy that I was going to need to be able to do things with her, and I didn’t want my life to be cut short because of my stupid decisions. So I wanted to be there, to do all the stuff that she wanted to do, to see her grow up. It was mainly because I’ve seen the success of that, the gastric bypass surgery from other people, because my own brother-in-law had it done. He went from almost 500 pounds to almost 220. He lost more than half of his body weight. He looked really good, but like his skin really hung on him a lot, but otherwise like his health has improved and he looked really good. And even to this day, he put some of the weight back on but nowhere near, like, I think he’s probably around 250 now and he was like really serious. And then my, one of my supervisors, like, when I worked at [location] one of my
supervisors, he had it done when I worked with him. He weighed about 400 pounds and then he had this surgery done, and I saw how successful it was for him. My aunt, she had it done, and I’m like, I might have been looking for a quick fix on how to just lose it because it was too much work otherwise. So, that’s kind of where I was at. I wanted to lose weight, but was having a hard time doing it on my own, and that’s when I went to find out if I would be a candidate, and they said that I definitely was.

Yes, I have tried to lose weight before, but it was never anything that I felt serious about, like it was just, my mom was like “You need to lose weight” so I would try going to the gym or burning off some weight and I lost 5-10 pounds, which always went back on real quick. But otherwise, I was never too serious about it. I just think because I kind of got in my mind that I need to do it and I wanted to do it, because I’m not getting any younger, and I have to worry about the rest of my life and, like, my daughter was the biggest factor in trying to lose the weight and keep it off. That’s – that’s basically the whole thing right there.

I’m Pretty Much the Same Person

[Weight loss maintenance] is hard because even today, I can’t (I shouldn’t’ say I can’t), I just don’t have the time to go out and exercise like I want to. I would like to go for walks more often, or I would like to go to the gym, but I’m working over 60 hours a week, and it’s just really difficult, mainly on the weekends, I don’t have any weekends off. Fridays and Saturdays I work from 4am to 8pm, so I’m getting up at 3am and not getting home until 9pm.

[Through this weight loss] I guess I feel better about going out around other people, but I was always a social person to begin with. I never let the size of me, be like
my downfall as far as being social, because I was what I was. If people didn’t like me, that’s their loss. I wouldn’t say my attitude really changed. Maybe within my own mind it did, but it didn’t like impact other people. I just had it within me that I wanted to, I just really wanted to do it [lose weight], and nothing was going to stop me from doing it. Once I saw that I could lose the weight on my own without the help of the surgery, maybe I didn’t need to have the surgery anymore. And I just wanted to try it on my own. I mean the thought…and even since then, the thought has even crossed my mind about going back and I considered it, but I just really don’t want to.

I think I’m pretty much the same person I was before, just a smaller version. I wouldn’t even say a whole lot smaller, I’m still big. But I don’t, I don’t go around and, like, I don’t know what I’m trying to say, I don’t try to, I don’t have a big head about it. They would just say “Wow, he’s the biggest guy in the room”. At work I would probably be one of the smaller people compared to some of the guys I work with. And I’m not just talking about muscular; I’m talking about fat big. And we’re, I work part time over at [location] and just for some extra money and I literally, I probably am the biggest person over there. So whenever something needs to be lifted, something big or whatever, they’re like “Hey, can you help me do this?”, because they know that I’m capable of doing it, but otherwise like, to me I’m the same person I was before. I don’t really feel any different other than just, like I don’t feel better, like any better like emotionally, physically I feel better, but, I’m always, I just feel like I’m the same person. Now, I’m more willing to do more stuff. I really wasn’t motivated to do much of anything because I just, I didn’t feel like I had the energy to do it, but I’m more energetic now than I was before. I’m more willing to go outside and cut the grass, or clean the house, help out,
wherever needed. Before I would just rely on my wife to do it, and I think after so long of so many years of her asking and me not doing – she just kind of stopped asking. So, we’re divorced today.

I personally never really looked at it [media] too much, in that respect, but I think that since I lost the weight I noticed more. I don’t like the way that they portray the perfect model as 5 foot 5, 115 pounds. I was reading an article on the Internet about manikins, I think this was like over in England, their manikins are full-figured women. This drew a lot of criticism because it’s not what people are used to. I sometimes used to think “Would more women like me?” or whatever, but it just is what it is and I can’t change what’s on TV, that’s just the way they’re portraying it.

I don’t think I never really had any negative reactions, everything was more supportive, like “Wow look at you, you lost a lot of weight, how did you do it?” and I basically just told them, I just drank a lot of water and I was going for walks. I never went in any great detail, but it was just nice to see people noticed.

It did a lot – I think a lot was that if it wasn’t for that – if it wasn’t for the people that would take notice and say “Good job” or “Hey, you see that cookie that’s in your hand maybe you ought to put that down?”, or because they were always there to remind “Do you really want to go back to 425 pounds, or do you want to stay where you’re at?”

Nobody was really like ignorant, but there were just comments like, “Hey you’re pretty big” or “Don’t you think you ought to lose some weight?” One of the biggest things that I hated like, going to like [amusement parks] – because it was mainly like when I wanted to get on something with my daughter I couldn’t do it because I couldn’t fit on anything. It was hard for me in that particular setting. I still went places, but I
didn’t like going there because it was a lot of walking and it was just hard for me to do what my daughter wanted to do. But people weren’t really rude or anything to me and I didn’t get stares or anything, because I was still kind of, I was tall, so I didn’t look ridiculously bad or anything. But if I would’ve been about six inches shorter I probably would have looked like a beach ball.

I think they’re [women] looked at much different than a 300 pound man. A 300 pound woman is going to be [looked at] totally different. My fiancé is overweight. Right now, I think she’s around 200 pounds, and she hates it. I mean I tell her every day “You’re beautiful, I love you the way you are. I would never ask you to lose weight.” She feels great when I tell her that stuff, but it doesn’t matter because I’m the only one that tells her that. She doesn’t go to work and hear it from her coworkers and stuff like that, and she’s constantly saying that she wants to lose more weight. She has a treadmill downstairs that’s collecting dust right now, and she keeps telling me “I’m going to get the treadmill out and I’m going to this and I’m going to do that.” I’m like well that’s great I’ll support whatever you want to do, but you’re never going to hear me ask you to do it, because I know what it’s like. I think if she wants to lose weight she has to want to do it on her own. I can’t force her to do it, and I feel that if I’m going to ask her to do it, she’s going to think that I’m telling her that she’s overweight, and I don’t want her to feel that way. [Weight management program] is a lot of paperwork. They were just bombarding you with paperwork, and it was kind of overwhelming at first, but it was nice because I didn’t feel alone because we were in a group setting and everything was mainly in a group. Like we had our one-on-one with the doctors and stuff where they would check you physically – your blood pressure, your weight, but it was nice to hear everybody
else’s story too. That – maybe it’s not as bad as I thought because there’s always somebody, and I don’t like to say that, but there’s somebody that’s worse. That was a lot of – just that were teaching you how to prepare food healthy, a lot of – use portion control, chew your food a certain amount of times before you go to the next bite, only fill the center of your plate, use a smaller plate because then it looks like more food, it’s a lot – a lot of it is all in your head because if you chewed more and took your time while you were eating then you would fill up faster than if you just woofed your food down really quick because your body doesn’t register.

Yeah, we got a chance to talk a little bit, but a lot of it was just a lot of question and answers, with the person that was doing the educating, and that was really helpful. But there wasn’t a lot of one-on-one time because there were so many people. If I wanted that, then I would just have to make a special appointment or wait till I saw [doctor] because he was the main person who was involved in that clinic. So yeah, it was really nice when I got to see him. Yeah, probably – if you would have just got your chance to talk and then go to the next person and get everybody else’s feedback, yeah that probably would have been pretty helpful.

My health changed. It changed better – not a whole lot better but it definitely changed. My diabetes is better controlled; my blood pressure’s better controlled. I had constant headaches and that was because of my blood pressure being high and they told me that if I would have had the surgery done that I probably, because I’m Type 2, I didn’t develop it until [year] and that was right around the time that I was like really, really, really big. If I would’ve got that surgery done and lost much more weight than I had, then I probably wouldn’t have high blood pressure and the diabetes probably just
would’ve corrected itself. That would have been really nice, but I never had the surgery done and I stopped around 315 pounds. So here I am and I still have those health issues, but I’m just maintaining them and controlling it better.

It’s hard at times [to stay motivated]. It’s just that I really have to focus because I have –like our family is really close. Mainly on my mom’s side of the family, my dad’s family a lot of them from [location] and [fiancé’s] family is mainly from [location], so I’ve never met anyone on her side of the family except for her cousin because he’s in the military. But my mom’s side of the family we have big ‘get-togethers’ at every holiday-weekends. Like if I don’t have work I try to get around to visit some people, and like with Easter coming I just saw my aunt yesterday and she’s like “Hey are you coming down for Easter because we’re having a big Easter dinner?” - “Yeah, I’ll have off on Easter so…” … everything is centered around food, I just have to really watch because I’m at the point now where they expect me to know and watch on my own so I don’t’ get the people saying, “Hey do you really want to gain all that weight back?” - so now that kind of just stopped and it’s up to me to do it on my own. I’ll grab a glass of water and if I’m going somewhere, where if I know that I’m going to be down there for a couple hours and it’s just going to be centered around a huge, like island full of food – I’ll drink like two big glasses of water before I go, so then if I do have something I’ll fill up faster and I won’t be reaching for the next thing. I’ve tried explaining that to other people. I’ve tried because [fiancé] was always into weight loss, like trying to lose weight, and she’s like “Well how did you do it?” and I told her, and she tried it and it don’t work for her. She doesn’t like water. She can take it or leave it. She might drink like one glass a week. Me, I was drinking two gallons a day. And her son, he’s worse than I was. He’s 17 years
old and he’s like 375 pounds. He’s huge, and there’s no definition to him whatsoever. And he’s tried I can’t tell you how many different diets. He tried the Atkins diet, the Weight Watchers where they have the points and all that stuff. I used to tell him all the time. He always wanted to lose weight because he has no self-esteem whatsoever. He’s the most anti-social person that I’ve ever met. Even when he’s home, he just like stays in his bedroom. He plays computer games – super intelligent, like ridiculously intelligent. Most of his friends are online friends. So then the only people he associates with is a small group of people that he goes to school with, and I used to tell him, “Hey if you want to lose weight, this is what works for me.” He tried it, it doesn’t work for him, and so it’s going to be different for everybody. I found something that works for me, it doesn’t work for him, it doesn’t work for her, but it works for me. They just have to find their own thing and stick with it.

I think [about the obesity epidemic] a lot. It is all centered on the way everything is like portrayed on TV. I think it’s you look at a commercial from McDonald’s and they glorify fast food – it’s all, they make everything look so good that you want to go out and buy it. You look at the circulars and the newspapers and there are more coupons for food and advertisements for food than anything else so it makes it so appealing that you want to go out and buy it. And you can do that, but it’s, you have to prepare it a certain way too. I just, like myself – I just bought an indoor/outdoor George Foreman grill. I went to culinary school so I know a lot of, what’s going on with food and everything, so it’s easy for me to pick out what the ‘BS’ is and what’s really helpful and stuff. So, for me it’s easy. For [fiancé] she comes to me and asks me, basically how do you, want do you want, or I’ll explain something to her and she’ll be like “I don’t know how to do that, you
can do it?” So mainly when it comes to the cooking in the house I do probably 85% of it. But it’s all depending on work schedules and I would think the worst part of it is, I’m off today so I’m going to cook later today. She has off every Saturday and Sunday. She works for the school district. She works around food. Right now, she worked at [location] as a supervisor in the kitchen, now she just started with the [company] and she’s training to be the Food Service Director for all of [school district].

I think they’re brain-washing people. I think they should focus on more healthy stuff if they’re going to put it on TV and they want America to be healthy then they should promote healthy eating more than all this stuff they’re trying to promote now. My time that I spent in the gym was very slim and it wasn’t because I watched it on TV, or it’s always because it’s something that I wanted to do or I had encouragement from my brother because my brother was always huge into lifting so we used to do that all the time. And it was fun for me, because he was my half-brother so I didn’t see him a lot. A lot of it was because I went I got to see him, not because I really wanted to go lifting, but I got to see him so because that was just a bonus getting to lift at the same time. So, um – a I think exercise could be portrayed more in a positive fashion than what you see in a lot of movies and stuff. They advertise all those things on regular TV on commercials and stuff. I just think it needs to be portrayed a little bit better than it is now. And it’s all so expensive – exercise equipment is expensive like home equipment. I would love to have some of the stuff that they have on TV, but it’s not something that I can really pay for.

I Want to Control My Health

I think it’s gotten worse. I don’t think it changed for the better. I think it’s upsetting for me because I know firsthand what it’s like. Just going through the whole
process being overweight my whole life, I look at it and sometimes it’s just – it’s overwhelming. I’ve had times in my life where, and this is probably only within the last 2 years, I just felt really bad and I just sat down and I had tears in my eyes because I just want to make sure that I’m there for my daughter. That’s the number one thing, I want to control my health and be there for my daughter. Everything else is going to come and go but if you don’t have your health and you don’t’ take care of yourself; you’re not going to be there for your family. It bothers me a lot because I went through it. Like I don’t think that I was extremely overweight when I was a kid but I was definitely overweight. But I see it firsthand because my nephew – he is really overweight. He’s, I think only 12 years old. He’s probably close to 200 pounds and it bothers me, and I hate to see it. Because he’s taking after his dad and his dad is the one I was telling you had the gastric bypass surgery. I look at him and I’m like “You’re going to be your dad in 20 years”, and it bothers me, because he’s so young if he’s going to do something – start doing it now. It’s hard to tell a kid that because they don’t understand, because that was my mom telling me that when I was a kid. It’s hard and they don’t understand it. They just, they just do what they want, they see what they see, and you can’t make them do it – like you have to want to do it on your own. My mom can tell me until she’s blue in the face “You need to lose weight, you’re going to be unhealthy”, But until you actually start experiencing things firsthand you want to make that change on your own, it doesn’t matter what everybody else says to you.

I think that the whole [weight loss] experience was an eye opener. I’ve seen the pros and cons. Not a whole lot of pros to being overweight. Um, there’s the good definitely outweighs the bad and I – if I could go back and do it again, I would have
made my choices a lot sooner, and I would’ve listened to my mom back when I was in my teens. I would’ve been a little bit more serious about it because then I probably wouldn’t have the health issues that I have now. I’m just dealing with it the best that I can and just taking it one day at a time.

Analysis

There were several key aspects to John’s story that influenced his learning and weight loss maintenance success. These aspects include; weight identity, improved self-concept, and his reflection on messages from the media. All three concepts will be discussed in detail.

**Weight identity.** John always remembered having weight issues. These experiences created a weight identity very early in life. He reflected on a story from when he was only six years old. He said, “When I was five I had my tonsils out, and my mother told me [I was gaining weight] after that.” She kind of made a joke about it and said, “Your tonsils always blocked your food from going down.” But once I had them out everything just flowed kind of freely.

This is a simple story, but it clearly illustrates the negative reinforcement from his mother regarding food consumption that implicitly gave permission for the overeating to occur. Food began to play a symbolic role in John’s life. His chosen profession was to work in the food industry, which he has done since high school. Working around food was a struggle for John and weight gain continued into his twenties. He eventually began to have health problems including high blood pressure and diabetes. He was always aware of the impact his family history could play in health because his dad had also struggled with high blood pressure, diabetes and weight. In fact, at the time of the
interview, John’s father was in the hospital due to ongoing heart problems. This weighed heavily on John during the interview and he referred to his father often throughout the course of our time together.

A critical incident that occurred in John’s life was the birth of daughter. Mezirow (1991) would describe this as a disorienting dilemma, the first phase in transformative learning. His daughter made him realize that he wanted and needed to change his weight. He stated:

[I knew I was ready to change] right around the time that my daughter was born. I wanted to be able to live my life with her. I was married at the time and I just wanted to be able to focus on her and have the energy that I was going to need to be able to do things with her, and I didn’t want my life to be cut short because of my stupid decisions. I wanted to be there, to do all the stuff that she wanted to do, to see her grow up.

This statement exposes two important aspects to John’s weight loss. The first represents the trigger which was the birth of his daughter. This trigger led him to sign up for weight loss surgery which led to the eventual education from the weight management clinic that gave him the skills and confidence to change his life. The weight management clinic is where the education such as “eating properly…smaller portions, how to scale your food, chewing a certain amount of times, just to slow down the process” impacted John’s weight for the better. These small changes occurred through these learning experiences. The second aspect of the story exposes overtones of blaming the victim mentality and his positionality with the obesity epidemic. Language such as, “my stupid
“decision” uncover this position. Another example of this language includes “I would have made my choices a lot sooner”.

**Self-concept.** When John was ready he self-referred himself to the weight management clinic, where he learned that he was a candidate for weight loss surgery. He went ahead and signed up for this elective surgery. However, through his personal success of weight loss and his increased self-efficacy in just knowing that he could lose weight, he decided not to undergo the surgery. Instead, he continued on his personal journey, incorporating healthy habits into his daily lifestyle. John now feels physically and emotional better and has gained more confidence. One of the main aspects of John’s new self-confidence was his ability to shop and purchase nicer clothing. John stated,

I’m able to buy nicer clothes because it’s harder to buy the really stylish name brands that I wanted to buy when I was bigger without spending $100 on a pair of jeans because they were specially made or something. Now I can buy jeans and shirts, whatever I want! …it just changes the way you feel about yourself. If you can look nicer you’re going to feel nicer.

**Media reflections.** Prior to losing weight John never recognized a personal impact that media played on his behaviors or the way the media negatively portrayed persons who are overweight. But since he lost the weight, John has reflected on the dominant messages that are advertised. He said:

I noticed [media] more. I don’t like the way that they portray the perfect model as 5 foot 5, 115 pounds. The everyday woman is going to be not perfect, just like the everyday guy isn’t perfect – everybody doesn’t have a 6-pack abs and huge muscles and everything else. The average person just isn’t what they portray on
TV or in a movie or on the radio. It made me feel bad. I would think, “What if I looked like that, would I be more attractive?

He now has some emerging awareness that media, specifically advertisements, have a large force in the purchasing behaviors and self image of individuals. He stated, It is all centered on the way everything is like portrayed on TV. I think it’s you look at a commercial from McDonald’s and they glorify fast food – it’s all, they make everything look so good that you want to go out and buy it. You look at the circulars and the newspapers and there are more coupons for food and advertisements for food than anything else so it makes it so appealing that you want to go out and buy it.

However, John explicitly stated that he had no power to change representations of beauty and the promotion of unhealthy foods in mass media. He said, “It just is what it is and I can’t change what’s on TV, that’s just the way they’re portraying it.” However, he did mention that media did impact other people’s behaviors:

I think they’re brain washing people. I think they should focus on more healthy stuff if they’re going to put it on TV and they want America to be healthy then they should promote healthy eating more than all this stuff they’re trying to promote now.

John’s story reveals how invasive industry’s creative and harmful tactics to market unhealthy products can be and the impact on culture, purchasing, and eventually behaviors. There is potential that his new awareness of messages from industry may lead to reflective behaviors in the future. However, critical reflection was not overwhelmingly evident in John’s story; instead content and process reflection was apparent.
Jane

Jane is a 48-year-old female. Her employment was not discussed and she currently lives with her mother. During her interview, Jane was reflective on her learning that led to successful weight loss maintenance, which, certainly impacted her self-worth and confidence that continues to influence her will-power to sustain healthy behaviors.

I interviewed Jane on the telephone. And throughout the interview it became evident that the weight loss was a learning outcome that resulted from adopting instrumental knowledge, largely of which she learned from the weight management clinic. For example, learning proper portions sizes was very helpful to Jane. In turn, her weight loss led to a dramatic increase in her self-worth which motivates her to continue her weight loss maintenance and healthy journey despite or continuous struggles with her physical health.

Jane’s Story

[Weight] has been a battle my whole life. I’m 48 years old and ever since I was a young child, like 4th grade, I’ve been battling my weight. In 4th grade there was a time where, the teacher set aside time to weigh every student. We would go stand in a line outside the nurses’ station at the school and each child would go into the nurse’s office get weighed and, somebody would say their weight out loud and somebody would record it. That’s the first time, I think, when I was in 4th grade, that I just, I hated being heavy. See, in 4th grade I weighed 140 pounds [long pause]. My teacher was a wonderful teacher. He kept noticing that I would move from one child to behind another. I kept moving back to the end of the line so I wouldn’t have to get up there, get up there to go get weighed. Finally he noticed that and he came over to me and said, “Jane, what’s,
what’s wrong?” and I started to cry. He said “What’s wrong, why do you keep moving back in the line?” and I said, “Because I don’t want anyone to hear my weight” because I was so upset about. It’s just, 4th grade is really when I think it really hit me because kids were mean and they said a lot of nasty things and, I, uh, uh, have had a terrible time with weight, gaining and losing, gaining and losing…and I think 4th grade was the starting point of me really noticing, that this isn’t right. I would have to go to school and sometimes wore my mom’s clothes. We called them Gumby pants, but here I am in 4th grade weighing 140 pounds and wearing my mom’s clothes to school. A lot of times she had to make me my clothes because back then, and uh, let’s see I was born in [year], so back in the 1970’s or so they didn’t have the nice clothes that they have today for full-figured girls. My mom made all my clothes and I would wear these pink dresses, [laughing] it was sad. But I think as I grew up it just kind of, I ballooned as I grew up, and I was in high school I was probably the heaviest that I’ve been except for, let’s see I got married, hmm…probably back in [year] I got married and I was married for 17 years and um I was a pretty good weight then. Um, I was probably smaller than what I was since probably maybe, 15 years ago. I got divorced 10 years ago. But at the end, my husband came to me and said that he loved me but he wasn’t in love with me anymore, that’s when, I just, it just, uh, I knew that I had to do something.

I pleaded with him to stay with me because I thought it was my weight, and it wasn’t that at all. It was just that he wanted out of the marriage, but I realized that if I’m going to do this, I’m going to do this. I heard of the program that [doctor] had and I was going to have the bariatric surgery, and it came to the point though when I started, uh, when I went to him to talk to him about the stuff that we had to do, I went through the
whole, the whole program and I was within probably 2 weeks of getting scheduled to go to surgery and I backed out because by that time I had been walking 10 miles a day, uh, and in 13 ½ months I had lost 92 pounds. Yeah, 92 pounds in 13 ½ months. But before that I had done yo-yo dieting and I went to Weight Watchers – you name it, I did it. But until I got it in my [deep breath] my head, that once I started losing the weight, I thought “Now what the heck – I don’t have to go under the knife for this, I can do it?” So that’s what kept the weight off. I definitely I don’t walk as much; well actually I’m disabled because I just recently lost some toes, uh, due to being diabetic. But I have, I have kept all that weight off. Now a little bit, maybe a couple of years ago I gained like 30 pounds back, but then in the time I gained it, I realized that “Hey, your clothes don’t fit anymore, something’s going on?” and I took it back off. I just really watched what I ate and more or less, oh I know what I did [remembering]. I went on Slimfast is what I did. But I used Slimfast to get those extra pounds back off. I used to have two Slimfasts a day and one meal I think it was.

I wanted to go [to the weight management program]. I was tired of being heavy and I saw other people go. I saw a couple girls that I used to work with and they had had that surgery and I just couldn’t believe that they dropped all this weight in a little amount of time. I saw good results, but then after, after I didn’t go to see [doctor] and that, after several years had gone by, I also would run into the people that had this surgery, and saw that they gained… they gained their weight back plus, and it was like “Oh my God!” – That was just very surprising to me. I was thinking how the heck if they go on and reduce the size of your stomach, how could you gain weight plus more weight? That didn’t sit very well with me and I thought “Thank God” because that probably definitely
would have happened to me because I was just, I ate, I was a binge eater, I ate if I was upset, I ate if I was happy, I mean I ate whenever. But I think that after I saw that, that kind of really set the tone that why would I want to go under the knife and have this surgery and then just to, if it did work, because you have to go through all that psychiatric testing, and not psychiatric, well I mean you talk to a psychologist or and they work with you to make sure that you have the right mindset, but I would think that anybody, I mean, sitting there in front of somebody answering questions they could agree and probably tell them what they wanted to hear. It was just weird after I saw people that had this surgery and gained weight back plus more; it was just really weird for me.

My heaviest weight, um, when I was, uh, still married, oh my gosh I think it was 336 pounds and once I lost that 93 pounds I was just ecstatic. To this day, I mean, I fluctuate within 10 pounds at times having my monthly and stuff like that, but I can tell, it’s like, I get, not anxious, but it’s like okay, I gained a few pounds you got to watch, follow your diabetic diet. It’s not that I don’t eat sweets or don’t eat things that are not good for me, but I’m more into, you don’t want to go back to the other sizes. I don’t have any bigger clothes. I have my wardrobe is limited to the things that I can wear. Before I had like, sizes from, oh gosh, from like 18 to 28 or even 32 and now I’m like in a 20… depending on how the clothes are made or whatever. The size does not matter, as long as the clothes fit me. That is what I go by.

I feel better about myself – my blood pressure and things are a lot better. Um, and let’s see, my diabetes is more under control now than it’s ever been. Again, that has to do a lot with how I feel and what is transpired in my life. Last year was a hard year for me because I had lost a gentleman that was very dear to me. He was in my life for 12
years. After my husband had left, well actually before my husband left I had this Down syndrome individual that lived with me and him and I were just inseparable. He just added so much to my life. And along with me losing weight, when he moved into our house, he weighed 260 pounds. Well he had lost 100 pounds as well after we went through the divorce. God love him, he was just so, he was so affected by that and I really think that, I really think that your life, whatever is happened in your life, definitely affects your weight. Maybe some people don’t feel that way, but I know I do, because it always did. I mean if I was having a bad time of it, it affected my weight. I was either binge eater or whatever, and the loss of my husband and the loss of this gentleman. Last year, it was, I know that I was like, like I said a 10, 12, 15 pounds, and after he passed away it was just very devastating to me, I had dropped that weight within weeks.

I’ve Always Been a Jolly Person

I’ve always been known as a jolly person [laughing]. But I don’t think that I was very happy with myself, um, because all my friends were always a lot smaller than me – everyone of them – all my girlfriends were always smaller than me and I always felt why am I the one, the heavy one or whatever, um, but now the compliments, I’m just, I’m really over, I don’t know how you’d want to put it. I’m very excited about everyone notices it, noticing me smaller. I mean, they’re like “Oh my gosh Jane oh my gosh I haven’t seen you for years, what did you do you lost so much weight?” and they’re always so, they’re complimentary whenever they see me now. Not that they weren’t before, they would always comment on something else like your hair or you got new glasses or something like that. When people lose weight and when there’s a small person standing in front of you, you notice that and you compliment them, or you ask, there’s an
action to that. Or there’s a reaction to that, whatever’s going on. It’s just nice to hear people notice you and say that you look good or what did you do, what’s different about you, or whatever. It is nice to be complimented now.

Well, the difference is, I think the difference is within me. I mean, I would, I could, uh see myself in a mirror and think, “Oh, before you were really heavy.” Now it’s like, “Well you’re heavy, but not…” I was just talking to my mom a little bit over supper tonight and I said, “Mom, do you, do I look my weight, do I look my weight?” and she said, “Well heavens no!” Well your mom’s always going to…[laughter] but I mean at 200 and some pounds, and I’m 5 foot 7, and I am proportioned, I think I am proportioned better than most people turning that much weight. I have the thin legs; my family is always telling me I have chicken legs. It’s funny…I do carry most of my weight in my middle section, in my belly section. The more I’m gaining; if I am putting on a couple pounds I notice it right away in my neck. I’m saying, “Okay, you’re getting double-chin again [laughter]” and it has to come off, it just bothers me. But I’m really, I really am aware a lot more to how I look in my clothes and to have my hair done, and everything.

I think it was everyone else wanted it [weight loss] for me, and I would do it because everyone says, “You need to lose weight, you need to do this because of this, and you should lose weight because your blood pressure will come down and you’ll look better.” I even had my father; my father years ago say, “For every pound you lose I’ll pay you $5.00.” I mean, and it wasn’t, I mean he did it…he didn’t do it in a mean way, and he did it lovingly. But still it’s like, that was how I guess I don’t know. It was how people looked at me I guess and yeah I would lose, I would lose…it was called Take Pounds off Sensibly one at a time, and I had lost 60 pounds, and it was wonderful. I felt
great. Even when my husband and I were married we went to [weight loss location] and he had lost all this weight. I never did as well as he did, because, I guess, men have fast metabolism, I hate to compare men and women, but it just seemed to be always that he lost more weight than I ever did. But um, I don’t know. I just think that before it was to please everybody else and I think that when it came to the divorce and to me, and to knowing that my husband wasn’t going to be around, and I needed to do something for me, I think that’s what the whole difference was. It was I was doing it for everybody else before, but when I finally decided, “Hey, here I am out there walking busting butt 10 miles a day”, and I was in the frame of mind where I’m going to show everybody that I can do this and keep it off, and that’s how, that’s how it was. It was just, I… I also used the Slimfast too when I was doing that. I would, I think back then I would eat one meal, or squeeze two meals and drink a Slimfast. But people always said “How can you just drink, how can you just drink your meal?” I said, “This is what I have to do to keep the weight off if I’m going to do it.” So that’s what I did.

I had this bad thing happening in my life [divorce] and I thought after 17 years if he doesn’t want to be around me anymore, I’m just going to show him that it’s not going to get me down. I mean it really…it’s a little bit of everything really. Well, him leaving me and me thinking okay if I’m going to be alone I want to look better. Not that I didn’t want to look good for me, but he had already made up his mind that he was taking off, so I couldn’t talk him out of it, although I did want him to stay around until after I had my surgery, but I never had the surgery so, him being around didn’t matter, it didn’t make a difference anyway. Whether I was going to do it or not, I knew that this was it; I was just going to do it.
The moment I decided to change I think, I was gone full force, full tilt, and this is what I’m going to do…THIS is what I’m going to do, but that’s how I had always looked at it. Until I really started seeing the pounds come off, I mean that’s when it got my attention. I was like “Oh my gosh!” I just walked ten miles and I never thought of it. I mean I, because I was so distraught and upset about the marriage and stuff I just constantly, every night, every night I had to walk those ten miles, every day.

Once I got to a point where ‘Oh my gosh, these things are making me lose weight’, which was the walking, the drinking the water, the little meals, the Slimfast, and all that – those are what was making me lose the weight. Maintaining it, um, is when I would be going, through life or whatever and if I noticed that my clothes were getting tighter or like I said if I’m up a couple pounds and I notice “Hey you’re getting a little flabbiness up in your chin”, especially now that I’m 48 years old and that just doesn’t bounce back, that just kind of hangs there [laughter]. So, things like that are the things that make me maintain. They’re the things that put me…back on track. I would say, “You better watch what you’re doing or you’re going to balloon up again. You don’t want to do that, you don’t have any bigger clothes. You don’t have bigger clothes to fit in. You need to stay at this weight you’re at.”

After this weight loss, I still have my “happy go lucky” attitude, um, and people, my friends always, they’ve always thought of me as happy go lucky. I know that, I don’t know, I know that when people notice me and my size has changed or my figure’s changed, that makes you feel good. I don’t know, if I, I don’t know if I really, I don’t know if I really would describe myself differently.
Well, right now I, a year ago I had to move in with my mother to help take care of her because she had a seizure last year and it’s just her and I in her house. Maintaining I think is easier when I’m with her, when I’m with someone. After the gentleman passed away, I was always kind of, I don’t know how do I say it…having my mother in the house, me living with my mother, she notices if I’m eating something that I usually shouldn’t, or eating after six o’clock at night or something. “Now are you sure you should be eating?” She questions me [laughter]. So she kind of makes me responsible for what goes in my mouth. Or she’ll say, now if it was a piece of candy or whatever, she’ll question it – “Now do you think you should eat that?” or “You’re not going to fit your clothes.” or she doesn’t do it mean, she doesn’t do it to cause trouble or anything like that, because I don’t get upset with her. I don’t get upset with it because I know that she does it because I have lost all that weight and she knows I don’t want to put it back on. She does it in a way which is nice, she does it in a way which it makes me responsible but yet I am kind of like, “Oh yeah, that’s true, I don’t want to eat all that” Or, if I get a bigger portion than usual I won’t eat all of it, which is nice. It’s kind of like I’m responsible to her.

I Think Society Sets the Standard

I was just talking to my mom about that [media]. Yeah it upsets me because there’s no, I don’t think, I think society sets the standard and says the perfect size woman is like a size 8. What’s a size 8? My God, most women, most normal women, I think normal size is a 10-12, or 12-14 really for most women, I don’t know. Anything above that they think is a plus size, which I think that’s a joke. A plus size to me is size 20 and above. I don’t think that a woman up to size 20 is a plus size; I think she just has a little
more meat on her bones. I think that the twiggy look, I can’t stand it because it’s like there’s no curves, there’s no form, I mean, I was just talking to my mom last, no today. I said to her, “Mom, I think it’s called the Bachelor, there’s this new show coming on, there’s this three men looking for the perfect wife or whatever.” Yeah, and it’s like, there’s never, ever any heavyset people on there, ever. You never see somebody that’s heavier set or maybe doesn’t have the best look or whatever, but they’re always blonde and long-legged, or dark hair and dark eyes, and there’s just beautiful. I’ve never ever once seen a heavyset woman on any of those shows. It makes me angry, because it isn’t real. I mean life like that isn’t real. Not at all, because just like I said, any movie like that, or any show like that, there is a never a heavyset woman on. And hello, I mean heavier people are married [laughter]. It drives me nuts.

[Now that I lost weight] men are definitely tuned in. I mean more uh, I don’t know what you want to call it. They’re more responsive to what you look like and how you hold yourself and, I don’t know. They’re more attentive, they’re much more attentive to than when I was heavier. [Before I lost the weight] They were, they weren’t mean, but they weren’t…they’re like the jolly Jane, saying oh “You’re my buddy, you’re my friend” which is fine…but if they see me now they’re like “Oh my God Jane, oh my God you look great!” , and it’s like, well the thing of it is, I haven’t changed. The only thing that’s changed is my body, the size of my body her. I haven’t changed at all. I mean, I don’t know. That’s something that bothers me too, because if I was good enough to be your friend when I was heavy, what makes me any different now that I lost weight? Maybe I might be more pleasing to the eye, but I still haven’t changed, what I mean. I’m
smaller physically, but I haven’t changed my personality or anything like that. I don’t know.

Women were the ones that said “Oh my God you lost so much weight.” They’re the ones that really told you that. The men, the men were a lot more, um, they didn’t really come out and say it, you just knew by their actions that you look good, and it was more of that kind of stuff. But the women were the ones that always said “Oh my gosh you lost so much weight!” and it’s like, you lost so much, “How much do you think I’ve lost [laughter]?” It was always funny because I’d always say, “Well how much do you think I’ve lost?” “Ooh… you’ve had to lose over 100 pounds”. Which now it is over 100 pounds, but it’s the women are always the ones that said that. The men were the ones that more, the men were the ones that kind of just said “Oh my gosh you look so good”, but then the women were the ones that commented on how much [weight was lost]. They wanted to know numbers [laughter]. But that was funny.

[The weight management clinic] was good. [Doctor], I didn’t realize when I went to him, I didn’t realize for a couple times when I went back to see him that he had lost all this weight, and I thought oh my gosh. I felt good about going, because I knew that this is what I wanted to do. But then after I, like I said after I started the walking and all that and decided that hey, I don’t need to get my stomach cut up or whatever, I learned a lot through going to see [doctor], just because whenever, every time that he met with me, he would ask what gave me the momentum to do what I was doing and to drop the weight because there were times that I would go and there wasn’t a weight change. I got very discouraged. But then he said “Okay what we’re going to do now is we’re going to start, we’re going to see if you do better on what we call the liquid diet, or whatever” and that’s
why. I think they have a type of liquid that they had but I chose, but I chose to use Slimfast. Once I went to Slimfast, I actually saw, the weight coming off plus all the exercise that I was doing, all which just gave me much more momentum to keep going.

Well I think that – I think that just knowing your portions. Portion control is definitely a big one. Where I would just go ahead and eat a piece of meat and not, whereas really a piece of meat that you’re supposed to have is the size of a deck of cards. It was like “Oh is that all you’re supposed to have [laughter]?” Portion control is a big one. Even though I was diabetic, um, yeah I was diabetic back then because it was 15 years that I’ve been diabetic. Yeah, even though I was diabetic it was like eh, I wasn’t really into that either. I mean I wasn’t really into watching my sugars and that kind of stuff because they weren’t as bad as what they are now, but they’re more controlled now that I’m on insulin and all that. But um, yeah the portion control is definitely a good one. The exercise is a big one too because once I started the weight coming off I had to exercise every day because I knew that was a lot of the things that made me keep going. That sticks out that I had to do differently. Um, I think [sigh].

My Disability is Temporary

I learned to love myself. I really do think that you have to take a step back and take a look at yourself, and think am I valuable enough to do this for myself? Was it valuable enough to do this for me, instead of everybody else saying “You should do this” and “You should do that”, I had to really step back and say “It is time for me to do it for me because this is my health.” You only get one chance in life to be healthy or not healthy. It’s not that I’m ‘Miss Health-nut of the world’ by any means, I’m just more aware of if you don’t take care of your body, nobody else will.
How do I stay motivated? Well I think that for what I’ve been through lately, like I said I recently lost 2 of my toes, and that wasn’t, that wasn’t due to diabetes, that was due to me actually purchasing a pair of shoes that were too small, not wide enough for my foot because my one foot. I’m still recuperating. Like I said, for the past 4 years I’ve been more or less in a wheelchair and the motivation has come from, even in a wheelchair I had lost weight, which is surprising, but well-being in a wheelchair you have to wheel yourself and do this and do that. All of the times I’ve been in a wheelchair I have maintained my weight and there was a time probably about 3 years ago where I had lost 25 pounds and I was just surprised that here I am – that’s what people say “How the heck can you lose weight in your wheelchair?” and I say, “Well push yourself around once.” Push yourself around and use the muscles in your shoulders, in your legs, whatever you have to do to get from here to there. The motivation is also because I’m 48 years old, I’m pushing the 50 mark, and I want to be healthy, I want to feel good, and to do that I have to wheel myself around a little bit more. And I do, right now I go from my house to my vehicle, and from my vehicle to, I go to the [location] to go in the barometric chamber with 100% oxygen in it to help heal my feet and when I get to the hospital the valet has a chair, I get the chair, and I take myself up to the 4th floor and I do all that. I’m still moving a lot of, my arms and my legs to get me from here to there. The motivation I guess it’s just there. Being disabled has not made me any worse for wear I guess, do you what I mean? I look at my disability as being temporary. Like I said, it’s been on and off for 4 years now, and losing a couple toes just makes it seem that I better get back to being healthy again and get back on my feet. That’s what motivates me.
Well I even think that I’ve been through a lot in the past 4 years being in and out of a wheelchair, and just having my two pinky toes cut off, and at the same time I just have to tell you something, this is funny. At the end of [month], I had all my teeth removed except for 4, because the diabetes was affecting my teeth so bad that I would just go to brush my teeth and they would break off. I thought to myself, I thought what; I have never ever had a beautiful smile, never. Ever since I was little I always had a gap between my front teeth, and my teeth weren’t perfect. Well I decided that the end of [month] that I was going to go have my teeth removed and I was going to have dentures made. I’ll tell you what, it’s the neatest thing I’ve ever done, because not only do, am I healing, my feet healing, and my mouth is healing. My other foot, my other toe was taken off…on [date] and my mouth is healed, my toes are almost healed, and I probably look better than I’ve ever looked! My family is like “Oh my God you’re beautiful, you’re beautiful”! It’s weird, it’s really weird. Because I know that, I’m presenting myself a lot different than what I was before because now I have a nice smile that goes with the bod

Portions by restaurants [are causing the overweight problem]. I mean, no I think that people, well no, what I think is causing it is the uh, the children, children nowadays are all sedentary; they don’t go out and play. I mean, when we got home from school, that’s what we went out and did. We went out and rode our bikes, and played baseball and now kids come home, they look for their iPads, their phones, their computer; all they do is sit and veg. I really think that has to stop because our, the kids now a days aren’t getting enough exercise. The extra large everything – when you go to McDonald’s, do you want to super-size that or whatever. It’s not even just McDonald’s – it’s all the fast-food restaurants. I think that it’s good that um there are clothes now for heavier people.
The clothes today, are really uh trendy. I could go into wherever and get some nice clothes for a bigger body.

I think that since I’ve lost weight I’ve noticed more people in society and how they look. And I think, “Oh my God how could that person let themselves go and be that big”? I don’t mean that meanly or like I was never that size, not at all. I’m just saying that really you just need to stop and take a look in the mirror at yourself. And I do, I could be sitting in the mall or whatever, and I love to look at people, I do. I could sit in the mall all day long and just watch people walk by and observe what people look like, what they have on, and think to myself if you didn’t wear your clothes so tight you’d look a lot better. Or if you wore, if you wore a little bit larger size pants you wouldn’t look like you’re poured into them? And I definitely am a person that notices that all the time. Now I have an older sister who was heavier when she was young and she’s pretty much thinned right out and all that. She’s the type of person that, the tighter the clothes the…better off she likes it. Now not me, it’s like I, my clothes, I don’t care what size they are, if they fit me that’s all I care about. Now she’ll say, “Oh my gosh, no you should get a small shirt that will be tighter” and it’s like no, I’m not comfortable in that. Even though it might be a little looser on me, I feel that, um, the appropriate size, it doesn’t matter what the size is, want what fits me. Has to be a looser size, it can’t be skintight or I won’t wear it. I guess I’m proud of myself, but I don’t think that anybody else sees it that way for me, and that’s okay because I’m the one that did it. I don’t need somebody else’s okay or “Atta boy” to make me feel good about myself. I’m very opinionated as it is, and I think that, I think that just being more aware of, I felt that the better I feel about myself the better things will be. The better life I’ll have, and I always,
the amount of faith that I had really shone through too. [Weight loss] is a life-changing thing for me, even though I’m still a loner [laughter] it hasn’t gotten me another man or anything, but that’s not why I did it. I did it because I wanted to do it. I needed to do it for myself, to make me feel better.

Analysis

Through the process of weight loss Jane learned to love herself. Her self-esteem dramatically improved. There are several key aspects to Jane’s story including; early identity with weight, disorienting dilemma, and her self-esteem. All three aspects will be discussed.

**Early identity with weight.** Jane spoke about her experience of weight that began in 4th grade. This experience was largely based on the negative feeling of weight stigma. It was evident that the pain from this experience still exists. Jane got emotional when telling this story several times. She stated:

We would go stand in a line outside the nurses’ station at the school and each child would go into the nurse’s office get weighed and, somebody would say their weight out loud and somebody would record it. That’s the first time, I think, when I was in 4th grade, that I just, I hated being heavy.

As she continued to tell her story I understood that this was only one aspect of her experience in adolescents that impacted her into adulthood. She went on to state:

…4th grade is really when I think it really hit me because kids were mean and they said a lot of nasty things and, I, uh, uh, have had a terrible time with weight, gaining and losing, gaining and losing…and I think 4th grade was the starting point of me really noticing, that this isn’t right. I would have to go to school and
sometimes wore my mom’s clothes. We called them ‘Gumby’ pants, but here I am in 4th grade weighing 140 pounds and wearing my mom’s clothes to school. A lot of times she had to make me my clothes because back then, and uh, let’s see I was born in [year], so back in the 1970’s or so they didn’t have the nice clothes that they have today for full-figured girls. My mom made all my clothes and I would wear these pink dresses [laughing]. It was sad.

This combined experiences of a bad school policy that publicly induced weight stigma and the lack of options for children who were a larger size that led to name calling created a very early lack of self-worth for Jane.

She also talked about how everyone else wanted her to lose weight in her youth. Her family would say, “You need to lose weight, you need to do this because of this, and you should lose weight because your blood pressure will come down and you’ll look better.” She went on to describe how her father years ago say would bribe her to lose weight for money. He would say, “For every pound you lose I’ll pay you $5.00.”

This story demonstrates the need for an internal drive, or willpower to maintain such behaviors. Her attempts to lose weight for her family only temporarily would provide a weight loss. In fact, she talks about the moment she decided to lose weight. She said, “I was gone full force, full tilt, and this is what I’m going to do…THIS is what I’m going to do, but that’s how I had always looked at it.” When she cognitively made up her mind that she wanted to lose weight – she did.

**Disorienting dilemma.** Her divorce about 10 years ago was the disorienting dilemma that motivated Jane to action regarding her weight. She said, “Well, him
leaving me and me thinking okay…if I’m going to be alone I want to look better”. She went on to explain:

My husband came to me and said that he loved me but he wasn’t in love with me anymore. That’s when I knew that I had to do something. I pleaded with him to stay with me because I thought it was my weight and it wasn’t that at all. It was just that he wanted out of the marriage but I realized that if I’m going to do this, I’m going to do it.

She talked about her divorce as making her feel distraught. Because of these feelings she started to walk at night. She said:

I just walked ten miles and I never thought of it. I mean I, because I was so distraught and upset about the marriage and stuff I just constantly, every night, every night I had to walk those ten miles, every day.

During this process she self-referred herself to the weight management clinic where she signed up for bariatric surgery. However, after losing 92 pounds by walking, just two weeks from her scheduled appointment she cancelled the surgery. She said, “Now what the heck – I don’t have to go under the knife for this, I can do it?"

Jane’s divorce was a disorienting dilemma that sparked a process that forced her to begin self-examination of assumption and beliefs. This disorienting dilemma was triggered by an external life crisis and major life transition that led to change. Her physical transformation increased her self-efficacy.

Self-esteem. Jane’s story is one of personal development and improved self-efficacy. Self-efficacy research conducted by Bandura (1977) showed that the perception a person has about his or her own ability to act out a specific behavior is important in
determining behavior change. Prochaska and Velicer (1997) also found that new found self-worth has led to increased self-efficacy and increased ability to perform on a task, and also a commitment to maintaining behaviors.

The beginning of Jane’s story had overtones of self-blame, pity and low self-esteem. For example, she stated, “I don’t think that I was very happy with myself. All my friends were always a lot smaller than me – every one of them – all my girlfriends were always smaller than me and I always felt why I am the one, the heavy one or whatever?” Even present day, Jane struggles with multiple health problems including diabetes which recently led to amputation of her toes and a wheelchair. Yet, she has a tremendous sense of self-worth that developed through weight loss. She even sees her disabilities as temporary. She noted, “I think the difference is within me. I mean, I would, I could, see myself in a mirror and think, “Oh, before you were really heavy.” Now its like, “Well you’re heavy, but not….” Her new found self-worth, despite her ongoing health problems has transformed Jane physically. She said:

Well I even think that I’ve been through a lot in the past 4 years being in and out of a wheelchair, and just having my two pinky toes cut off, and at the same time I just have to tell you something, this is funny. At the end of [month], I had all my teeth removed except for four, because the diabetes was affecting my teeth so bad that I would just go to brush my teeth and they would break off. I thought to myself, I thought have never ever had a beautiful smile, never. Ever since I was little I always had a gap between my front teeth, and my teeth weren’t perfect. Well I decided that the end of [month] that I was going to go have my teeth removed and I was going to have dentures made. I’ll tell you what, it’s the
neatest thing I’ve ever done, because not only do, am I healing, my feet healing, and my mouth is healing. My other foot, my other toe was taken off…on [date] and my mouth is healed, my toes are almost healed, and I probably look better than I’ve ever looked! My family is like “Oh my God you’re beautiful, you’re beautiful”! It’s weird, it’s really weird. Because I know that I’m presenting myself a lot different than what I was before because now I have a nice smile that goes with the body.

The sense of “healing” that Jane explains is not only physical; emotionally Jane has learned to love herself once again.

**Pam**

Pam is a 62-year-old woman who has a spunky personality, and a southern accent. She and her husband are originally from the south, their immediate family still live there. During the member check she told me she had earned a doctorate and was a college professor. I interviewed Pam via telephone.

Pam originally wanted to lose weight for her son’s wedding. But sudden high blood pressure led her to ask for help from her primary care doctor. Her doctor referred her to the clinical weight management center where she learned the skills to incorporate healthy eating into her lifestyle. Pam’s support from her husband was a key factor in her success. However, integrating circumstances led to profound learning and long-term weight loss maintenance. These circumstances did not appear suddenly, instead “they are more subtle and less profound, providing an opportunity for exploration and clarification of past experiences” (Taylor, 2000, p. 299).
Pam’s Story

Well, I had been overweight most of my adult life. I would go on diets and exercise and walk miles a day, and lose weight – I could lose weight pretty quickly. But then I would gain it all right back. When I went back to eating what I would consider to be normal, I would gain all the weight back. I did not know at the time that I had Graves’ disease. I think that the Graves’ disease was related to my inability to do anything about my weight, because I would – I would just get extremely hungry. Most people lose weight on Graves’ disease but I actually gained it – I gained a lot. So that I weighed about 240 pounds and I’m just about 5 feet tall. That was a lot of weight. I just sort of assumed that was the way it was and I didn’t feel bad. I didn’t have any particular health problems related to the weight, and I’m a fairly sturdy person, so I just figured well okay, I’m chubby. I’m just going to do this. Several things happened. One was all of a sudden I started having high blood pressure and I had never had high blood pressure in my life. I mean I weigh 240 pounds and my blood pressure was perfect – okay, then it wasn’t. And I thought “Well that just isn’t good.” I have family members that had strokes and heart disease runs in the family, so I was thinking, “Oh geez I’m going to have to go on blood pressure medicine and I don’t want to do that.” I also was having real serious aches in my legs, particularly in the winter time. I think it was related to vitamin D, but I considered it to be related to weight. I thought “You need to get some of this weight off because getting older it’s getting harder for you to walk.” So that’s all the reasons why I thought I ought to lose weight but I have to say probably the biggest reason was my son was getting married and I did not want to go to a wedding in a size 22 petite dress. I mean, have you seen the clothes for size 22 petite? And I thought, “Well okay I want to lose
some weight.” I think I said to my doctor who’s a very good guy – I think I said, “I want to lose weight, can you refer me?” So I went to [hospital] and they gave me a….they were very helpful. They weighed me and they gave me a program. I lost 55 pounds this summer. I mean at various points [doctor] has said, “You really, you’ve got this weight thing” and I said, “Well that’s not going to happen, come on.” He wasn’t pestering me about it or suggesting it. It was me that went in and said, “Please refer me.”

So anyway, I’m supposed to be on a diet – 1500 calories a day. How much each, how big a portion is, and how many calories there are in a portion. Okay? So I came home with this. Now here’s where something happened that made all the difference. My husband, who also was really overweight, said, “If you will do this – I will do it with you.” And so there are only two of us, and rather than us having to cook a diet meal for him, for me, and a regular meal for him, we ate the same meals and he really – I kept telling him, you shouldn’t do this because you’re like over 6 feet tall. You really ought to be, even if you’re on a diet, you should not be on this diet – this is for a small woman – but he did it. Both of us lost a huge amount of weight. You don’t see him there because he didn’t go to [hospital], he just did my diet. But he lost about 200 pounds. And I would never ever have been able to do it without my diet partner. This was a huge big deal. The two of us were keeping each other honest. Every now and again we would overeat, we would know we were overeating, and we would just go back on the diet the next day. Which is another thing…you say “Okay, well that’s okay now I’m going to go back on the diet” rather than going, “Oh my God I’ll never be able to do this” – just to bounce back and keep going. You’d go to family dinners and you would try not to overeat, but you would not come out, you can tell I’m from the south, okay? You don’t
go to a southern family reunion and come out, like 1500 calories [laughter], okay? But trying not to eat 3 pieces of pie [laughter]…but for the most part, we didn’t eat out much. We never did eat out much. When we did eat out, we would try not to overdo it. We now only go out to eat; typically take about half of what we get home – at least the meat. We’ll take a big serving of meat and we’ll get a box and take it home. But yeah, just kind of constantly watching…I measured everything. I found out much to my shock how big a tablespoon really is. It is a pretty good amount – it’s a lot. And the measurement for this food, I measured. I got cups and spoons and I measured everything. I measured it onto the plate and we just kept doing that. My husband said, “We need to not use the big dinner plates because studies have shown (of course went and researched it) that it will help if we use the smaller plates.” We used the dessert plates and we still do. I look at the dinner plates and I think, “Who in the world can eat that much food?” They’re huge! And I notice of course now all the restaurant portions are way too big. Why don’t you just give me, enough, instead of giving me too much? But little things like that. We drank a lot of water. I always drank a lot of water but, I kept saying to him, “You’ve got to drink more water because it will keep you from being so terrifically hungry.”

By the time my son got married I was in a size 16 dress that was too big for me. And really should have been taken up. I think I just couldn’t believe it – there’s a lot of that. There’s a lot of sort of reverse denial, “I can’t believe I’m really that small.” Now I’m a size 14 and I could probably wear a 12 – but to quote a girlfriend of mine “I am stacked”, okay [laughter]? And she said that to me. She said “you wear both like sixties, girl, you are just stacked.” And I am, and that was kind of neat too in a way, that I didn’t suddenly become flat chested. I still am a round person. I’ve never been anything but
stocky and I still am, but I’m a size 14. I have stabilized at – on my scale 140 pounds. Now I weigh myself every two or three days per week. I have this thing its like, “Oh I feel bloated I feel like I’m too heavy” and I go in there and I weigh 140 pounds. So we just kept losing weight, and losing weight, and kept losing weight. I tell my husband – this first time I walked out of the woman’s section of clothing in a store and over to the misses – I said, I wanted there to be music in the air like there would be in a movie that just went “ahh” [laughter] because this is just a miracle to me. I’m over here now and I haven’t looked at clothes this size in 15 or so years, and all of a sudden I’m going and saying, “Oh, well that’s too big”, an 18 is too big, a 16 is too big – sometimes a 14 is too big. And that was really cool. But I had to keep buying clothes [laughter]. I would go in and say okay size 18, no, now I’m down to 16. I would go to JCPenney and buy plain black polyester pants and then 2-3 months later I’d go get another pair just like it – kind of keep moving down. My husband was going through the same thing. He kept saying, “I’m not losing weight, I’m not losing weight, I’m not losing weight” until it became obvious and his clothes were literally falling off. Then it was like I’ve got to, because he hates to shop, I had to go buy him smaller clothes, right? So I had boxes, and boxes, and boxes of like 15 years’ worth of clothes. So I’ve been cycling these out through church rummage sales and Salvation Army for about 2 years now. I think I’m finally down to the point where I’m going to be able to say, “I don’t really have to keep this. I’m really not going to wear it again”, which is a nice feeling. I still can’t believe that – I still keep thinking that I’m going to gain the weight back, but I don’t.

I lost 100 pounds – yeah. And kept it off and when I got down to 145 pounds and I went out to see [doctor] about something else and my doctor, and I told him, he was of
course just thrilled, right? My cholesterol dropped, my blood pressure went down, he said, “You don’t have high blood pressure anymore. You just flat out don’t.” So that diagnosis no longer exists - that has been resolved – didn’t have to go on medication for that, and I told him, I said, I want to get down to 140 pounds because I’ve always thought that that was the weight I ought to be at. To be honest, because that’s what my mother was – we were basically the same size. He said, “Okay well you can, I don’t mind if you get down to 140 but you’ve got to stop because you’re just going to keep losing weight.”

So I started, I thought okay, it’s pretty obvious that I ought to be eating about 300 more calories a day. He said, “You need to eat. If you’re eating 1500 you need to go up to about 1800.” So I started eating about 1800 calories a day. I would guess that there are days now where I eat 2000 calories a day. But I guess there’s also days where I eat 1500, but at 1800-2000 calories a day, I’m not gaining weight.

I have one more tip while I’m thinking of it, okay? You’re going to hate this. Well actually there’s more than one – I have two. The major one is – don’t exercise. We did not and nobody believes this. But we did not go walking. We did not lift weights. I’ve done that before. I don’t like lifting weights. I used to go to the gym and lift weights. I could do 20 pound curls. But I was as hungry as a horse. It never helped me lose weight except that it turned it to muscle. So this time, mainly because of various other issues, we just, well mostly because we didn’t want to, but we just didn’t do that stuff. We did not go to the gym – we did not exercise, and here’s why I think it’s important. Because you are deluding yourself if you think anybody’s going to go to the gym for the rest of his or her life. If you’re not athletic you hate it. If you are athletic, you’re doing it already. So the only thing a plan around a behavior that requires you to
spend hours a day doing exercise means that when you stop doing the exercise (and you will stop doing the exercise) then the weight’s going to come back. So I do think that not exercising was the key. Now if you want, I think when you’re done if you want to exercise it is good for you. Obviously you should. I think that’s just a huge, huge mistake. And I know there have actually been studies that said that, right? When those came out we just kind of looked at each other and said “Yup that’s probably right.” I found this kind of, it seems like almost self-evident. The other tip I have is I allowed myself treats. And the first part of the diet, I ate so many vegetables I got sick of vegetables. I honestly have to make myself eat vegetables. But I allowed myself off all things, for example, coffee creamer – which is the most disgusting processed food imaginable. But I found that I could get the sugar-free coffee creamer. I’m Southern – I crave sugar, but this is stuff that has stuff like Splenda in it, right? It tastes very sweet but it doesn’t taste that great. Every morning I have coffee creamer in my coffee and I don’t measure the coffee creamer, okay? That helped, having figured out that you can have all the mayonnaise you wanted if it’s Miracle Whip [laughter]. And we’re like “We like Miracle Whip. Why didn’t we understand that Miracle Whip is not anywhere near as fattening, right?” Little things like that that gives you treats. For a while I was eating tuna and not making it into tuna salad. There are some limits on how much tuna you can stand, right [laughter]? Anyway those are my tips.

I Doubt That I Act Differently

[Prior to weight loss] I would see pictures of me and I would look at how big I was. My sister weighed about 100 pounds and we’re the same height. I would look at myself and say “man, I am so big.” But I didn’t think I was unattractive. I didn’t think,
“Oh God I’m fat”. I just didn’t. I said, “I’ve got whatever the reverse that anorexics have.” I just don’t really think I’m that big. Until I see a, I look in the, this is really funny, because I’d look in the mirror and I’d think, “I look good”. I would not even notice how big I was until I saw photographs.

And I’d look at the picture of myself on my driver’s license now and for whatever reason I’m particularly puffy that time the picture is made, and I just look like a different person. But I didn’t have the feeling of detesting my body. That may have helped… I don’t know. I didn’t feel like I was ugly or worthless or any of that kind of stuff – I just thought I was overweight, which I was. I mean you’d be stupid not to know that.

Oh they always say, “Oh my God look at you” [laughter]. Some of relatives “Oh you look better than you have in your whole life”, which is really scary because I’m 60 years old [laughter]. Most of them though are smart enough not to overdo the praise for someone who’s lost weight. They’ll say things like “You look very nice” and sometimes they ask, you get to testify, people ask you “How did you do this?” So the two of us together, my husband and I, get a lot of that. We just sit down and we sound like diet counselors. We did, this is why it’s been easy for me because I’ve been doing it now for months. People ask me over and over again.

I doubt that I act any different at all. Part of the reason is I’m a grown-up, okay? Your personality I don’t think changes all that much. If anything has changed me, it probably has been due to menopause. Now I’m on the other side of that great divide and I laugh about the testosterone went with the estrogen – that I’m not as combative as I used to be. I’m in a profession where argumentation is part of what we do, and I’m probably not as pushy as I used to be. But I don’t think that has anything to do with
weight loss, I think that has to do with hormones. I don’t think that I act that differently. [Now I would describe myself] as small again. To be honest now I think I’m smaller than I really am, I mean I’m a size 14. At the same time, some of the things were kind of interesting. When the weight went off my face, I saw the face I had when I was 30 years old, except old. I remember thinking “This is what I looked like, this is what that 30 year old looks like with 30 years added” – if that makes any sense?

Instead of looking like I did, it was like a weird time warp of some sort. I’m Scottish-Irish ancestry and I actually do have cheekbones. I really have that very Southern looking face. Um, I all of a sudden have wrinkles [laughter], which I didn’t have, which I don’t like. I have wrinkles. I look at myself and I think, “You look like your grandmother. You look like the people in your family”, which is okay.

The other thing that’s kind of freaky, thinking this is what I’ve looked like is that I am, you’ll have to take the name out, but I am ‘little Pam’ again. This is way more information than you need for a study, but when I was – I went through puberty early for someone in my generation – I was 11 years old. By the time I was 13 years old I had roughly the same build that I have now, only I was 13 and I weighed about 115 pounds. I didn’t have the middle age spread. I was big for a 13-year-old girl. I was bigger than all the boys in the class. I thought of myself as a big person. I thought of myself as a tall person, even though I’m 5 feet tall. It wasn’t until I was in college that people would refer to me as ‘little Pam’. I’m 5 feet tall and I weighed 110 pounds. Well yeah, I was ‘little Pam’. I don’t think I liked that. I really don’t think I liked that at all. When I gained weight, my husband said, “You’re putting on body armor”. As the body armor came off, I felt more vulnerable in some ways.
We Changed our Lifestyle

I’m still on the diet, sort of. No, we just changed our lifestyle. I’m sure another part of it was when I was younger I used to like me my beer. I quit drinking. I quit drinking years ago but I had put on the weight drinking. I was gaining weight, putting on the weight I was having way more beer than I should have had, okay, and I quit. I didn’t go to AA or anything like that. I just quit drinking. My husband never drank. So we don’t drink. He gave up his sodas, what we call down South ‘Cokes’, they’re all ‘Cokes’, whether they’re Dr. Pepper or not they’re all ‘Cokes.’ He gave that up, that was hard. That was one of his big treats. He gave that up. I don’t make desserts. Soda [is causing the obesity epidemic]. I think its soda, I think its sugar. I think it is we eat a whole wheat bread and once in a blue moon we’ll have biscuits. But I mean it’s like once every 3 or 4 months. We just don’t eat the processed foods all that much. My husband’s treat is he eats Little Debbie cakes. He has that as a treat. But as a rule we avoid all that. We don’t eat ice cream because I love ice cream, but I have to think that a major way you put on the pounds is through drinking them, pardon me the word cola. You’re having another 150-300 calories with the meal. You don’t notice you’re doing it. So I think that’s a big deal.

I don’t make cakes. I don’t make pies. I don’t fry foods. Um, we don’t have [bad foods] in the house. If I go on a binge here, what it would mean would be toasting bread and putting honey on it. You just don’t have it around. In that regard, it is kind of like quitting drinking. You just don’t have in the house stuff that you shouldn’t have. I eat a lot of fruit. I like sugar. I eat a lot of fruit. I crave fat sometimes.
Did I mention that I’m a vegetarian, okay? Except for eating fish. I would eat dairy and eggs and I finally realized I wasn’t getting enough protein so I added fish. But you just don’t get any fat when you eat low-fat dairy, eggs, and fish. Every now and again I fix a piece of toast with margarine on it because my skin’s drying out or something, I got to have some fat. But most of it is just lifestyle; you just don’t have the stuff around. I could not climb the stairs at my office. I couldn’t run up the stairs. I run up the stairs now. Three flights of stairs. Now my legs hurt because I need to get more exercise…but I’m not really out of breath. I would have been puffing to the point where I would scare people, and now I’m not. So that is one of the biggest changes, that I move, and I like that.

**If You’re Watching Law and Order, It’s Not Really an Issue**

I’m sure [media had an impact on me] when I was younger, but if you’re talking about during that loss, it really didn’t. Because we just don’t want, we just didn’t watch television where that was an issue. If you’re watching Law and Order it’s not really an issue. Oh yeah, I did when I was – I did before I think. But I don’t think it had any particular influence on me so to speak. I think it teaches people you have to be a size 2. I think that a lot of people do not – by genetics have bodies that would look good at size 2. I wouldn’t. I have big bones. I would look skeletal. And I think that it teaches us to disrespect our bodies. There is this, “I will never look like this. I’m going to go have more ice cream because it doesn’t matter anyway. There’s no way I can win.” I really think that’s a big part of it – the level of skinny propaganda, so to speak. I think it really probably was helpful those Dove ads that showed women of all different sizes. I think those were like, well those were actually made you feel better. Um, the time that I
actually went on the diet, it’d been years since I put the weight on. I was just maintaining the weight, if you know what I mean. I don’t think during the diet media played any role really at all. We had so changed our media watching habits that I guess we really didn’t watch mainstream American TV as much – Netflix. So I don’t think it had a big impact during the diet but I’m sure it did before.

I look at people now [post weight loss], and I think we both do this, and think “Oh, God bless your heart.” It means you don’t have to be this way. It isn’t hopeless. You can do something about this. Your feet hurt and your back hurts. You can’t find clothes. We know exactly how you feel – it’s just a feeling of, for me at least, of intense sympathy and knowing that these people think, “There is no way I could ever lose this.” Because like me they’ve gained weight and lost weight and gained weight and lost weight…people always ask us “What did you give up to lose weight?” And we say “Nothing.” People are disappointed when you say that. We didn’t’ give up anything. We just reduced portions. People just get this disturbed look on their face.

I think a lot of people really do not know [how to lose weight]. My husband was shocked to find out how many calories were in a glass of coke. I knew exactly how much things were because I’d been on diets before. I just needed my husband’s support to be able to do this. He did this to save me. And that has been the most powerful motivation available, was that he, and he’s hungry I think. I’m not really ever hungry, except like normal hunger. Maybe its like suppertime I’m hungry. But he’s hungry a lot – and he still hangs on.
Analysis

Pam had several health concerns that she understood as a need to lose weight, however, the real trigger that led to change was a social event, her son’s wedding. The internal motivator to want to lose weight to look physically attractive in a dress, coupled with the cognitive knowing that her health problems were related to weight led her to change. Although Pam had maintained her weight loss, there was no evidence of a perspective transformation. My analysis indicates that Pam’s weight loss is a result of good learning. She made lifestyle changes that she adapted into her daily life. Three aspects that are vital to Pam’s story include; support system, identity to weight, skinny propaganda. All three will be discussed.

Support system. Pam’s husband was also overweight. After Pam went to the weight management center and learned the instrumental skills in order to lose the weight, her husband said “If you will do this, I will do it with you.” This added support system was the emotional support that led to her long-term success. Pam said “I would never ever have been able to do it without my diet partner.” This is an important element to consider, especially for women. In Pam’s story, her husband’s support broke down gender specific family duties and provided accountability and teamwork. For example, she no longer had to cook two meals for dinner.

Identity to weight. During puberty, she identified with a heavier weight. She remembered feeling ‘big’ for her age and larger than the boys in her class. This reflection created an identity to being strong, tough, and even tall; although Pam is only 5 feet tall. However, when Pam went to college, people perceived her differently. They called her ‘little Pam’. Society would consider this an admiring comment, specifically to
women. Yet, Pam never liked being called ‘little’. She eventually began to gain weight and one day her husband said, “You’re putting on body armor.” During this last weight loss attempt that led to long-term weight loss, she began to feel more vulnerable.

**Shopping for clothing.** The industry around plus-size clothing may have been connected to failure for Pam. When Pam lost a substantial amount of weight she began to shop in the ‘normal’ section of the women’s clothing and she had thoughts success, she said, “I have made it.” The first time she shopped for clothing in the Misses section she said “I wanted there to be music in the air like there would be in a movie, which just went “ahh” [laughter].” She thought of her weight loss as “a miracle.” She began to throw away her old larger clothing and she began to accept that her weight loss was permanent. She would say, “I’m really not going to wear it again.” She said that the level of “skinny propaganda” impacts women of all sizes. Pam reflected on the Dove campaign ads that showed women of all different sizes as a media outlet that made her feel better.

**Mike**

Mike is an educated professional who currently holds a leadership position. He is 54-year-old male who is married with grown children. Mike’s story of weight loss resulted in long-term behavior changes that have made him want to help others by creating a walking program at his workplace. I interviewed Mike in person.

**Mike’s Story**

From a familial aspect, I have a number of relatives that have always had weight problems, including my parents; particularly my maternal grandparents and my parents had sort of struggled with it while I was growing up. Both of my parents were heavy and later in life they were able to control it and lose some weight. I have 3 brothers and 2
sisters and all of them struggle with some type of weight problem. Not as significant as mine. Mine was... after I hit 30 I was probably about 120 pounds overweight at that time. I went through a weight loss program at that time called [name]. I sort of hit 30 and I’m like “I’m 30 years old and I’ve got a couple little kids and I’m way overweight” so I went through this [weight loss program] program which was sort of a liquid type diet, I’m not sure if you’re familiar with it or not. It’s a program where you basically drink these liquid shakes 4-5 times a day and that was it. You were just on this liquid diet and bulking agent for a period of time until you had weight loss and then you started food back up. Of course I lost over 100 pounds with that but of course once the food came back, it came right back on. So from my perspective, at least at that point in my weight loss, I didn’t learn anything other than I was able to lose weight but then, I just continued to increase weight gain.

Then about that time in [year] we moved here to [state]. We moved to [state] and but my weight has continued to increase. About 3 years ago...4 years ago, my operations manager here and my doctoral director told me they were worried about me. We had a couple individuals in the organization here that had some weight problems, I mean maybe not necessarily but we had lost one of our management members in the organization – young guy who ended up having a heart attack. He was probably significantly overweight. So my manager and my operations director in one of my meetings said “We’re worried about you. You’re pretty much overweight.” They were kind of concerned about me. At that point I opted that I was going to go to the bariatric clinic. I asked to go to the clinic. That first experience was again, in all honesty, was they want to do surgery. I mean that was the first thing they wanted to do, “Oh my goodness you’re
a surgical candidate. Look how much overweight you are. You’ve tried losing weight before, you’re a surgical candidate.” I didn’t want that, I really didn’t. After a couple of visits I said I didn’t want that. After a couple visits, not that I felt pressured to it but it was almost like there wasn’t a whole lot they could do unless I wanted to have surgery. I had a couple of meetings with a dietician which was really in my opinion was not helpful. It was “Here are some materials about eating right, here’s a packet about how many of this and that you should have. Here read this and follow it and come back and see us in a couple of weeks.” That didn’t work for me so I sort of got away from that for a while.

Then for the next year or so I was able to get a PCP here. I had not been to the physician for a while. He talked to me about my weight. I ended up I had high blood pressure he put me on blood pressure meds. After a couple different visits with him he just basically sat me down in front of the screen, showed me my weight, got his piece of paper out and on the graph and tipped the paper to show, “This is what your weights been doing Mike for the last 2 years or 3 years. Every time you visit me it’s gone up.” At that point it was like I’ve really got to do something about this. He referred me back to the clinic again and it was the same thing about wanting to do surgery. Well they had a couple of different options, I could do bands, I could do all these, and again I didn’t want that. I sort of pushed that off for a while then it ended up that my wife had gone through…she was a bit overweight probably about 50 or 60 pounds. She went through the [weight loss program] and she ended up losing that weight. This was all probably in the year before I started and basically what I sort of was observing with her was what she was doing was portion control and the mixture of your appropriate diet for the day. So anyway, continue with
my PCP, I ended up; I was having problems sleeping so I went and did a sleep study. I had sleep apnea so I was on a c-pap for a couple of years. Again my weight continued to go up so finally one visit and I can’t remember exactly when this was but one visit with my PCP he basically read me the riot act. He said, “You’ve got to do something or you’re going to…you’re already…you went from here to here, you’re now on a sleep apnea c-pap – maybe you can get off of it if you lose some weight. Your blood pressure continues to rise.” He actually increased my blood pressure meds at the time. He really just read me the riot act and said, “Mike you have to do something. You really need to do something and it’s up to you to do it. He said, “I can do whatever you want, I can refer you, I can do whatever you want.” At that point I said, “Well my wife had this program let me try the [weight loss program] route.” So that’s what I started with that about, it’s been a couple of years ago. I don’t remember exactly when I started but I started with that program. In my opinion, that helped me to learn was its portion control and right-sizing what I eat and the variety over the course of the day. Journaling was the thing that really got me to continue to monitor that. I journal every week – what I ate, um, and my portions, I did a lot of measuring and things with portions and I did journaling and the weight started to come off. The other thing, I’ve always been fairly, I don’t’ want to say athletic, but I’ve always been an outdoors person but very sedentary for the last 10-15 years. So I did start minimally, a very short exercise program. I live just up the road here from [location] so in the evenings I go out for about a half hour and walk around the parking lot. I started out about 20 minutes and gradually kept increasing that. I think it was a combination of the exercise and in doing that consistently. And then recording that, I think to me is one of the big things. I have my journal for the day and I
have listed my exercise times and if I see a blank day in there it’s right in front of me so it’s like “I got to get back on track.” I still do that today. I record everything. I keep track of having my fruits, vegetables, meats, and fats. I don’t measure so much anymore because I’m better at the portion control. So I know like anything else it’s just something that you sort of learn “This is about a cup”, so I don’t have to measure it out anymore I know it’s a cup. My bowl piled up high with popcorn is not a cup of popcorn. I know what that is now. That’s really what helped me. I still journal my food today and I still journal my exercise. I gradually increased that. I’m up to, again I don’t know anything from an exercise standpoint, we do some biking in the summer, we started doing some biking but it’s mostly hiking and walking. We do about an hour to an hour and a half at least 5 days of generally 6 or 7 days a week. I exercise with my wife. And we have a couple of dogs we started walking with the dogs and I think that’s been another thing that’s sort of a motivator for me to do that everyday. It’s getting into that habit of the old me was come home from work, works over, sit down and relax. Have a snack, have a beer, and just sort of relax and then it’s like “Oh my goodness it’s too late to go walking now” or “It’s too late to do anything now” and that really – and now it’s to me the other thing is habits. I go home, I change my clothes and go for a walk. That’s really it. It may sound stupid but the dogs are another thing. The dogs have that routine now so if I don’t walk for the night, I mean they’re like nuts in the house. They think every time I go, I go into the bedroom they think I’m changing my clothes to go for walk. This gets back to making the choices. It’s not that I don’t drink anymore, not that I don’t have a beer anymore, but I limit that. I know I can’t come home every day after work and have a couple of beers. I can’t do that anymore. I mean I can have a couple beers on the
weekend, there’s been occasions that I’ve gone out and probably had more than I should but that’s every once in a while and I can sort of account for that.

**I’ve Changed the Way I Think About Food**

I’ve changed the way I thought about food because I look at now as a healthy food choice. In the past I’ve wanted to make the choice of food that what I enjoyed totally on the taste versus what the outcome is. I sort of...what I’ve come to learn is that I can enjoy healthy food and it tastes just as good as something that’s deep fried with chocolate on it or something or whatever. So I think – that sense and the way that I think about food differently. I think my taste has broadened. I try different things that I probably wouldn’t have in the past. I stuck to the burger and fries because that was easy and I knew I liked that and I sort of stayed away from something that was a little more unique that I might try now differently. So that may be a change that I’ve made with my outlook on food. I do something now that I enjoy and it’s walking and we started biking this last summer. Actually my son got us a kayak for Christmas last year so we’ve done a little kayaking too. So to me it is – I look for activities that I enjoy that someone could call exercise but I’m not. I am not, there is no way you’re going to get me into a gym and walk on a treadmill or ride a bike. I just – I mean I’ve tried it. I just can’t do it. It just is for a variety of reasons it makes me feel, um...when I get off a treadmill I get that sort of a ‘motion thing’. I just can’t do that. So even like walking – I walk year round.

Someone says, “You walk in the winter?” I said, “Yeah, I walk in the winter. I walk outside. I put my boots on and I walk up and do a hike in the woods.” To me that’s my, that’s the difference. I don’t think I can get to a gym. Even when we go away and we’ve traveled, my wife does the gym. She likes the gym. She goes out to the gym on
occasion. She’ll do the gym and I’ll go out for a walk. Because she doesn’t want to go out and it’s just that I can’t do the gym. I think in that sense I don’t view it as punishment because I’m only going to do something that I think is fun or that I enjoy.

**I Had To View It as a Challenge**

I think it was the physician, he just sort of, I mean…he was genuinely concerned about me. I think that really what it was. I mean my wife had talked about it to me but he was genuinely concerned. He said, “Mike something is – you’re going to have a bad outcome if you continue like this”. I think at that point I sort of had developed enough respect for him that he was truly concerned about me. I just think that for me it was, I had to view it as a challenge – I’m going to do this. I think two things too that were also said at the time – if I lose weight, I have a potential to get off the c-pap. Which to me was – I – my sleeping was great everything else but man I go away I’m carrying this stupid device with me all the time – I have to deal with it in the water and whatever else. So I think it was that and also the blood pressure thing. My grandfather had a stroke, when he was…when he was young, well relatively young. I mean he was in his late 60’s when he had a stroke. I’ve had several other blood pressure related deaths in my family and I’m thinking, “I don’t want to do this.” I don’t know if there was one real trigger, one thing I can go back to, but I think it was that I got, I just need to make a change. The other thing that sort of I can tell you it sort of played into this because this was in, I sort of made that decision in um late, and it was in the late spring/early summer that I was going to do this. The other thing that I actually have done for about 12 or 14 years now is I direct a church camp for our conference church group out in [town] near [town]. In the summer I direct a camp of 4th, 5th, and 6th graders. There’s the big hill across the road
that they hike and I wasn’t able to do that. I physically wasn’t able to do it. I just could not get up there. I had missed a couple of things with the kids that I couldn’t do and that was sort of my decision that this next year I was not going to do that. I was not going to miss any of the activities with the kids, so I needed to start losing, losing weight. So I think that may have been another thing – I have to get in better shape so I can continue to do this because it’s something that I enjoy doing in the summers too.

[Before weight loss] I would say that um lazy, overweight, um, and on medications. It was just that I had no desire to do outside activities, to do any activities. Just sedentary, lazy might be a strong term, but that probably was it. I was lazy. I think it has changed. I mean I don’t view myself…to me that was a totally different person that I was…that I was back then. I mean from a health standpoint, I don’t use a c-pap anymore. I went back for another sleep study. I don’t need the c-pap so I’ve removed the c-pap. My blood pressure medicine had after, after some weight loss I think I was at about 80 pounds or 90 pounds at that point. My PCP cut my blood pressure med in half. Today I take no blood pressure meds so I’m totally off my blood pressure meds. I feel totally different. It’s not that I felt bad before, but I feel good now. I feel really good now.

It helps with a partner that’s helping me. We walk together; I have a partner thing. And I think the other big piece is the journaling. I think, to be honest with you, originally I thought that was the stupidest thing, and when I went to the [weight loss program] and they talked about, “Oh some people like to do this, some people don’t, we don’t really make people do it.” I thought, “I’m going to do this.” That’s the biggest thing because I can look back and over the course of time, even during maintenance and
weight loss, I can look back and say, “That’s why I gained a pound or two last week – this is…look at this day here, look at this day here” or “Looks like I ate pretty well but when I look at my exercise, well I had this come up, this come up, this come up – I wasn’t able to get up and walk for 3 days or 4 days last week.” So I can sort of look back and say, “That’s why I’m where I’m at and this is what I need to do now this week or next week to sort of get back into that, to get back into that mode.”

My Everyday Life Changed

My everyday life has changed. We watch less television. That’s one thing. I think that the outdoors thing – the exercising thing, is just… I can’t say enough about just being outside and we generally hike so we’re not walking on the streets. [Location] has all of these great trails back here. We hike back here. So I think that’s changed and I think my meals have changed. A lot less fast foods – a lot less eating out. Again, not that we never eat out or never eat fast food, but that has really changed I think. Prior to this I would say that we would probably get take out, or fast food, or eat out 3 to 4 nights a week out of the 7. Now it’s probably…one a week, maybe none. Maybe two a week, but that’s usually on the weekends or something. I think meal planning is done. That’s a daily difference. We actually talk about what we’re going to have. I’m not a great advanced planner, but we’ll talk about today what we’re going to have tomorrow. So sort of plan a day in advance. I know some people are like weeks and whatever, but we started talking about what we’re going to have tomorrow night so we make sure we have everything ready for that. I think the other thing is not having the temptations around – that is the other big thing for us. That if it’s there I eat it, if it’s not I don’t, and I’m not
going to get in the car and go drive and buy it. Or if I do I’ll walk and that’s probably
good to walk down to the store.

**A Little Vanity Keeps Me Motivated**

A little vanity [keeps me motivated] I think because of the comments that people
make to me. Uh, surprisingly enough I almost hate to say that. I think some of it is
because people are so surprised. Even just today before I came over here I saw one of the
staff, she works at [location] and she was on-site. Her dad was having a procedure and
she walked by and saw me and said, “Oh Mike good to see you. I just can’t believe how
good you look.” She said, “Every time I see you I have to take a double take because I
wasn’t sure.” I’ve seen her now for the last couple years and it’s, I think some of it’s that
um, but like I said I sort of hate to say that. It’s vanity. The other thing that I’ll tell you
to be honest with you the other thing that keeps me motivated is I can shop for clothes in
a regular store. I don’t have to go to the, I don’t have to shop at the JCPenny big man’s
catalog anymore. I can go into almost any store and buy clothes. To me that was a huge
thing. That was a big thing. I don’t have to buy the big man stuff anymore.

I think that it is surprising that some people – that some people noticed, even
when it was early on. I think that was surprising. The disappointing things I think – it’s
interesting you ask that because this is something I’ve talked about a couple of times.
Most of the disappointing comments have come from my family who tell me I look old. I
look older since I’ve lost weight. None of my family is in Alabama. They’re in New
Mexico and Florida for the majority of the time so I don’t see them very often. So
they’ve seen some significant changes in me over this period of time. Last time we got
together which was over the holidays and I had, one of my sisters and brother tell me I
look older. Of course my wife gets mad saying that “You don’t look older” but I think that’s probably…from a disappointing standpoint that’s probably one of the things – they tell me I look older. But I hear others people here that see me a lot of times tell me I look younger than I used to. To be honest with you, some of it may because I probably look more like my dad now. I mean my dad’s passed away a couple of years ago and he passed away in his… in his 80’s and I probably – if I looked at my pictures of my dad in the last 5 years I probably look more like my dad now more than I did. Because again – he had lost a fair amount of weight. Was a really slender man by the time he passed away but I think that may be why they say that.

I’m actually going away to another meeting next week with some people who have not seen me since I lost the weight so it will be interesting to see what their take is. People talk with me more. It’s almost like, not that they excluded me, but it just seems like, they’ll initiate or come up to me, seems like more than what they did in the past. But, I think I would feel more confident. I feel that it sort of gets back to that stereotypical thing. I sort of viewed myself like they’re going to think about me like the stereotypical “He’s a big fat guy” and now that I’ve lost the weight I don’t think I’m any different but I sort of, it’s almost like I have more confidence in the fact that they’re not going to be judging me along those lines.

They Don’t Know the Struggle

Because I think again, sometimes in media the overweight person or the almost – sort of I think at times they equate the overweight person kind of as the goof or the person that’s, kind of the fun goofy guy or girl….or the one that’s sort of the outcast. Nobody likes the overweight person or their sort of the outcast, or they’re sort of the ugly
I think that that’s impacted me because I didn’t – I’ve never thought that way. I don’t treat people that way just because you’re thin and slender, nice-looking, what I treat you any different than I treat anybody else. But I agree. I think that the media does, does portray this somewhat unrealistic body type as the perfect body that everybody should be working towards.

I don’t [feel judged]… no not really. I mean I don’t think to my face, I really don’t. I think I’ve sort of been fortunate in that because I know some others that have or have heard anecdotal comments about how some people are treated. I think I’ve been fortunate and I don’t know what that is, but I don’t think that I’ve felt that.

Wave the wand [laughter]. I think that there’s – there are a lot of things [that are causing the obesity epidemic]. I think some of it is our traditional mealtime is gone away. I think that to me was a big thing. If I go back even as a family with my wife and kids, we sat in front of the TV and watched – ate in front of the TV at times. I see all the time that ‘bigger is better’. the ‘double-stuff’ this and the ‘super-size’ that. Not to pick on McDonald’s, but what I’m saying… everything is ‘the bigger the better’. I remember even when I was younger the advent of buffets and the sort of – you can eat everything that you want. I think that, that’s a lot to do with it.

I view [obesity] more as the struggle that people have. That is to me – I don’t think that unless you’ve been in it, you don’t know the struggle that those of us that are in it have. I work with a lot of great people and to see somebody that “I need to lose 10 pounds” and it’s like “Well, not really.” People struggling with… I feel overweight; I’m 2 or 3 pounds overweight. They don’t know what it’s like. They don’t know the struggle of being 100 pounds over, 50 pounds overweight. Well, I think to me it’s that peace of
not being able to, I think it’s knowing what to do to get to the point that you want to go
to. I think that that’s what it is. To me that was a struggle because I said when I went to
the clinic and they gave me the list, it wasn’t like I didn’t have the tools. I mean they
gave me everything. If I read through this and said you’re supposed to eat this, this, this,
and this, that information was there. It wasn’t the tool that I needed to apply going
forward. So, I think that’s the struggle with those of us that have an obesity problem –
what tool do we have to help us, to help us through that process? And to get us down to
the point where I’m now at weight loss maintenance. I think it was a variety of things,
not just giving me this list of “This is what you should eat”, that isn’t going to do it. I
don’t want to over-simplify it but it was some type of an exercise-dedicated activity. I
don’t even want to say exercise, a dedicated activity program and portion control. [The
clinic] was sort of the reinforcement of “This is what’s important… this is what’s
important.” So instead of grilling up eight burgers and my wife and I sitting down and
deciding how many should I eat and where do I stop, the portion control is you grill up
two burgers for the two of us and that helps drive that portion control. So again I don’t
think it is magical and that’s what some people, I’ve had some people ask me that, “Oh
[weight loss program] people probably think differently” but [weight loss program] was
nothing magical. It’s nothing magical about any of these other things. It’s just that it sort
of clicked with me that these are the couple things that I needed to do to see what really
clicked with me. I think some of that had to do with that I had weekly meetings so it was
almost like I had to sort of have to report. To me that was a driver too. I didn’t want to
go in there and gain one week. So my week was “I’m going to stick with this.” It’s that
accountability thing. To me the other thing too with the [weight loss program] was that
stepping on that scale every week. I didn’t want to step on that scale and have it higher than it was the week before. The same or lower – that was my goal every time – The same or lower than what it was the week before.

I think that for me, not that I’m an expert on this, but I’ve had a lot of other people talk with me about this because I think that other people are wondering “Well how did he do that and is there anything that he can help me with” and it really …other people who are struggling, right? I say, “I keep track of what I eat. I keep the portion control and I walk every day.” I invite people to hike with us after work. I hike in the woods every single day up here. Occasionally I’ve had some people take us up on it. In the [place of work] we’re going to be starting once it warms up we’re going to schedule one day a week, for anyone that wants to come and walk we’ll get a group together and start walking.

**Analysis**

Mike’s story indicates a deep shift in self-esteem. There are several key aspects that will be discussed in detail, including; family weight struggles, the tipping point, vanity, and stigma related experiences. Mike’s changes were initiated by a variety of aspects. His narrative indicated that his physician, co-workers, and health problems were the reasons for wanting to change. Acknowledgment from individuals that he lost weight and being able to shop for clothing continues to motivate Mike. These aspects have directly impacted his self-worth. The changes that Mike and his family have made he can live with for life.

**Family weight struggles.** Mike’s family had always had weight issues. When asked about his experience with weight loss, he immediately told the story of his family.
Mike identified with being the individual in his family who suffered the worst with his weight. He explained:

From a familial aspect, I have a number of relatives that have always had weight problems, including my parents; particularly my maternal grandparents and my parents had sort of struggled with it [weight] while I was growing up. Both of my parents were heavy and later in life they were able to control it and lose some weight. I have 3 brothers and 2 sisters and all of them struggle with some type of weight problem. Not as significant as mine.

Throughout adulthood Mike struggled with his weight. When Mike turned 30 years old, he realized that he was about 120 pounds overweight and turned to a liquid diet program. This diet resulted in close to a 100 pound weight loss, but when he turned to solid foods, his weight steadily increased again. Multiple failed attempts to maintain successful weight loss led to massive weight cycling. The learning process from his first experience with trying to lose weight was the fact that his body could lose the weight. The tipping point.

Mike had multiple events that centered around his weight that eventually led to his last successful weight loss attempt that was about three to four years ago. Medical events, although less significant in relationship to his entire story, including high blood pressure and the use of a c-pap machine initiated a conversation with his physician. Concurrently, Mike’s employees confronted him about his weight problem. He remembers them saying, “We’re worried about you. You’re pretty much overweight.” It was after this conversation or confrontation that Mike’s level of concern increased to the point of self-referring himself to the weight loss clinic. Although his experience at the clinic was not as helpful as he would have liked. He noted:
After a couple visits, not that I felt pressured to it but it was almost like there wasn’t a whole lot they could do unless I wanted to have surgery. I had a couple of meetings with a dietician which was really in my opinion was not helpful.

Mike didn’t find that the materials he was asked to read helpful. He said, “Here are some materials about eating right, here’s a packet about how many of this and that you should have. Here read this and follow it and come back and see us in a couple of weeks.”

Over the next year Mike went to a new primary care physician who openly talked to him about his weight. In fact Mike said:

Basically [he] sat me down in front of the screen, showed me my weight, got his piece of paper out and on the graph and tipped the paper to show, “This is what your weight has been doing Mike for the last 2 years or 3 years. Every time you visit me it’s gone up.”

Eventually, his doctor referred him back to the clinic, with the same result. As he continued to go to his doctor’s for his high blood pressure and c-pap machine his doctor continued to say, “Mike you have to do something. You really need to do something and it’s up to you to do it. I can do whatever you want, I can refer you, and I can do whatever you want.”

Throughout this time, Mike’s wife, who also struggled with weight, joined a popular diet plan where she was finding success. Mike was observing his wife’s behaviors and decided to join the program.

**Long-term behavior changes.** Mike described several behaviors that changed throughout his weight loss journey that was impacted by his choice to join the
commercial weight loss program. His family watches less TV, they are outdoors more often, they eat less fast foods, and a lot less eating out, controlled and measured his portions, and his family plans meals ahead of time. His support system of his wife, daily weighing, and food journaling were noticed as the monitoring tools that helped with weight loss maintenance. Interestingly, he talked about how the way he thinks about food changed. He stated:

I’ve changed the way I thought about food because I look at now as a healthy food choice. In the past I’ve wanted to make the choice of food that what I enjoyed totally on the taste versus what the outcome is. What I’ve come to learn is that I can enjoy healthy food and it tastes just as good as something that’s deep fried with chocolate on it or something. So I think that sense and the way that I think about food differently.

Acknowledgement from others. Mike states that vanity, acknowledgement from others and clothing keeps him motivated. He said:

I can shop for clothes in a regular store. I don’t have to go to the, I don’t have to shop at the JCPenny big man’s catalog anymore. I can go into almost any store and buy clothes. To me that was a huge thing. That was a big thing. I don’t have to buy the big man stuff anymore.

He also added that viewing his weight as a challenge kept him motivated. He wanted to get off the c-pap machine, meet his exercise goals, and he wanted to be healthy. He said:

My sleeping was great everything else but man I go away I’m carrying this stupid device with me all the time; I have to deal with it in the water and whatever else.
My grandfather had a stroke, when he was, when he was young. Well relatively young. I mean he was in his late 60’s when he had a stroke. I’ve had several other blood pressure related deaths in my family and I’m thinking, “I don’t want to do this.”

**No experiences of stigma.** Mike said that he never felt judged for his weight. But, he does notice that people treat him differently since his dramatic weight loss. He said:

People talk with me more. It’s almost like, not that they excluded me, but it just seems like, they’ll initiate or come up to me, seems like more than what they did in the past.

He believes that the behavior of others is related to *his* confidence. Before he lost the weight he identified as “lazy, overweight and on medications.” Now he states,

I think I feel more confident. I feel that it sort of gets back to that stereotypical thing. I sort of viewed myself like they’re going to think about me like the stereotypical “He’s a big fat guy” and now that I’ve lost the weight I don’t think I’m any different but I sort of, it’s almost like I have more confidence in the fact that they’re not going to be judging me along those lines.

His siblings are the lone people that have negatively commented on his weight loss. Mike said, “Most of the disappointing comments have come from my family who tell me I look old. I look older since I’ve lost weight.”

When asked about the media, he quickly talked about how dominant media messages impacted his self-confidence. He explained:

Nobody likes the overweight person or their sort of the outcast or they’re sort of the ugly one. I think that that’s impacted me because I didn’t. I’ve never thought
that way. I don’t treat people that way just because you’re thin and slender, nice-looking what I treat you any different than I treat anybody else. But I agree. I think that the media does portray this somewhat unrealistic body type as the perfect body that everybody should be working towards.

Amy

Amy is a 36 year old, single mother of an 8 year old daughter. She is a working adult with high energy and a story of weight loss that exemplifies both cognitive, reflective, and behavioral long-term changes. Amy began to struggle with her weight in adolescents. She contributes a healthy weight in high school to physical activity and organized sports. But in college, those activity patterns slowed down and were replaced with unhealthy behaviors. She saw her weight increase at this time. After college, she had the resources to get information from a nutritionist and once again began to exercise at a gym. She eventually married, had her daughter, and got a divorce. She was not able to lose the weight she had gained from her pregnancy. Amy reflected on life changes and experiences that had impact on her weight. I interviewed Amy by telephone.

Amy’s Story

I have [always struggled with weight] because when I was growing up I was chunky, then I want to say like high school, I started to lose weight. Also in high school I was in soccer, I was working, I was active. My whole life was just being active. Of course you’re going with friends to different places and we were always active. I’m like I’m 5 foot 2 and I was like 113 pounds when I graduated or something like that. But then I went to college and totally lost everything athletic. Of course you have all your bad habits of food, drinking, and doing nothing. You’re sleeping all day. I gained a lot of
weight through college. Once I left college I started to go to a gym – I joined a gym. I went to a nutritionist, lost weight again. But it always seems like whenever I have a major life change I can gain weight. I need to keep a schedule of food as well as, and when I say schedule, I need to have it planned out. I need to have a grocery list – I need to know what I need and how many calories and a calorie range. Plus also exercise as well and keep that in. If I don’t, I go back up. So after college, though I lost weight but then I gained it, and then I lost weight for when I got married, and then shortly afterwards I had, I would say like within a year, year and a half I had my daughter. Then it was the divorce and moving and new jobs and everything. I never lost that weight then. I’ve been up and down my whole life.

This last time, after having my daughter, who is now 8 years old – at the time that I had started losing weight she was 6 years old, I was not able to lose the weight I had gained. I was trying different things. I was trying to be active and exercise, I was trying to watch what I was eating. I went to my doctor and I had asked for help. Through some resistance, I was finally recommended to go to [hospital] to talk to a nutritionist. We talked over some nutrition plans and we decided to go on some medications as well. So, she was seeing that I was putting an effort through journaling my food, my calorie intake, and also how many calories I was burning in a day. It was basically a formula that I would use on a daily basis. I was able to, with medication, I don’t want to say curb my appetite, but I was able to stay on track more, and I was able to up my exercise. So, I started setting goals for myself. I was limiting my calorie intake from about 1500 to 1200 calories per day. I was also exercising and I was tracking how many calories I was burning as well as how many I was taking in. But I also have to, for my own personal
weight loss, I can’t cut certain things. For instance Weight Watchers, they say “Oh use the points and people can lose weight on it and say ‘oh I can have ice cream and still lose weight.” For me, I can’t. I have to eat a clean diet to lose weight. I have to have nothing extra so I’ve really started to cook clean for my family. We don’t use a lot of prepared foods. I lost about 50 to 55 pounds.

**You Start Asking Yourself Questions**

I started before I went to [hospital]. I started to see movies and documentaries about how foods are prepared and different things that are in food and preservatives and what it does to our body so I was always aware of it. As you start searching for healthy recipes you start reading more and more and it’s like “Whoa I’m going to eliminate that from my diet.” You just start to feel so much better when you realize you’re not having all the preservatives and whatever else is put into boxes of food. Those 100 calorie snacks that people eat all the time, you feel so much better if you just grab an apple.

The first one that ever made me aware of it was years ago was *Supersize Me*. It just amazed me. We all knew how bad it was. We all know how bad McDonald’s is – it’s just disgusting. But to see how bad his health deteriorated in a year and what extra food was being put into salty foods – sugar was being added to it. What? Why? Why is that? Those are some questions you start asking yourself. What’s in the food that you put, you take off of the shelf? What’s in that? So that was the first one, years ago. Now I’ve seen, oh I don’t even know the names of some of the movies but you read about the Monsanto and what’s in corn products – Netflix. I think when you watch one movie other things come up. When you look stuff up on the Internet for healthy foods that are
with no preservatives and you go to the health food store, you’ll see pamphlets out. It just triggers you to Google something.

**I Need Guidance - I Need Help**

Well I guess the feeling that… and I see this a lot, people say, “Oh, I try to lose weight and nothing happened.” Well, no you’re not trying to lose weight. There are people where you’re like, “No, you’re not trying to lose weight because are you doing this, this, and this.” I’m sure that’s what she gets from a lot of people but I went to my doctor and I actually was like “I don’t know what to do.” I was a single parent with a young child and I said I’d take her to the YMCA with me at nights while I exercise and I’m trying to watch my diet. I need help. I don’t know what’s wrong. My thyroid was slightly off but they said not enough to medicate. She said to me, it wasn’t necessarily my doctor – I think it was the physician assistant. She’s like “Oh you just need to go out and walk in the mornings and you need to walk like six miles a day.” I said, “Well I have a child that won’t walk 6 miles a day and I have no one to leave her with. I need guidance, I need something, someone to help me and go through what I’m eating and help me tear apart my journals and show me, guide me, and point things out.” I just felt that she wasn’t willing to help. She was just kind of saying that I wasn’t really trying. Now I went in another time and I gave her a list of all the different diets I’ve tried. She’s like “Oh those are so bad for you” and I finally said to her “Look, I said I’m going to try the next one until you help me. Until you put me on something, because like I have…”

Like I said I have thyroid issues and even though it was just minor, something was wrong. I was desperately trying to help myself and it wasn’t working. So they did put me on the thyroid medication. A real small dose but I felt so much better once they did.
Another thing I noticed was I just mentioned it to the specialist at [hospital] the one day. I said, “The sun came out, I felt so good. I just felt so – like I was so young again and wanted to be outside and have so much energy.” She said, “Well maybe it’s the Vitamin D from the sun.” She said, “Let’s get that tested.” Well my Vitamin D levels were extremely, extremely low. So she got me on my vitamin, she got my Vitamin D back up. By the time I had my Vitamin D up and I had my thyroid back to normal, that’s a big difference.

I’ve Always Been a Determined Person

I’ve been up and down in weight before but I’ve always considered myself, I don’t want to say I’m a natural athlete, but I’m active and when you’re overweight you don’t feel like yourself. You want to get out there and do things you used to do and when you can’t it is frustrating. So with that said, when I started to lose weight, I thought “My gosh, I’m now 35-36 years old. I want to do stuff that I never thought I was going to have the second chance to do.” So I started to run and I started to set goals and I did 5K and then I did a 10K. This [month] I did a half marathon. I’m just starting to check some things off of my life list that I feel like I have a second chance at life and I’m able to do stuff with my daughter now that I don’t know if I would’ve been able to do.

I’ve always been a determined person. I can always take on a challenge. I might not be the best person or the top of the class or anything but I’ve always been a determined person. If you throw a challenge at me, I’m going to try it. That’s who I’ve always been and this was just a challenge I couldn’t get past. I knew I needed help and I know there’s logic behind everything and, so let’s figure it out. So I’m okay to ask for help but I just needed to feel better. Now, I’m still the same in one sense. I’m still the
same in the senses that throw a challenge at me – let’s go for it, let’s do it, let’s figure this out. I love life. I love life. I have this chance now where I am, I don’t have a perfect body but I’m okay. I’m active and I’m able to go and experience things that I can’t, or that I couldn’t before but now I can.

Well right after I had my daughter I, it wasn’t long after that that I had a, that I went through my divorce. It just seems like I had my daughter, then I went through a divorce, I had moved home, which was from [state] to [state] so it was a statewide move. Then I was trying to get myself established again and becoming independent. So I just always had something that I could never put myself first with. I just didn’t feel good about myself, physically. When you’re overweight you’re tired. For a person who has been fit before, to know that you can feel better, it’s just like ugh – get me back to feeling better and how can I do it. So I can’t necessarily say that there was one point, it’s just that I was continually trying but I just wasn’t trying the right way or maybe I didn’t have the right help. But by going into the doctor’s office each month I could show my journal, show my exercise and say, “Oh this is always a problem this time of day.” Of course the one problem I would have would be after I’d exercise on a Saturday, which would be a longer exercise period, I might go shopping afterwards then all of a sudden I’d be famished, and then I’d eat too much. She would say “Why don’t you pack a bar, this would be a good bar to pack…”, like a Cliff bar or you can buy better ones that are not so much preservatives or everything in it.” She worked with me and she made a plan that worked for me. It is good to know that I don’t have to fit into a mold. I’ve learned to adapt this into my lifestyle. Not a lifestyle that can be generally fit into anybody else, but it’s for my lifestyle. Like sometimes people will say, “You should have a smaller meal at
night” and sure I probably should but for me, for my family I feel like that’s when I’m going to be cooking something for them and I can’t cook something for me - that doesn’t work. Sure I can say yes but how many times am I going to want to have a taste of what they’re eating. So I would eat fewer calories during the day and then at nighttime I would find recipes on like Muscle Fitness Hers, runners.com, or Self Magazine. I would make a recipe that my family would enjoy and I would know the calorie count, because online they would give you the calories. I would know that okay, even if there is 600 calories in it, I would know how to adjust it through my day so I could have it at night with them and not feel guilty about it. I knew how to plan it for me, for my life. Sure that might be late at night eating because by the time I get back from the gym I might be eating at 8 o’clock at night. That might not be the best for everybody else but that’s what worked best for me and that’s what could keep me on track.

**I Knew How to Plan For Me - For My Life**

My life is still changing every day. In fact, like right now I can say this year was a big challenge for me. I was still hoping to go down in weight but I just had, with my daughter this year adjusting to school, she had a difficult time adjusting to school so all of a sudden at nighttime, as a mother I have to cut out, I had to cut out exercise a lot so I could spend time helping her with school and adjusting. That’s just what you have to do as a mother. So I had to really watch my intake on food as I cut exercise. Now of course this increases my stress and everything but now that we have her back on track, I’m ready to get back into, I have been starting to get back into my running again that it’s nice outside and the nights are longer. But since she’s stressed out with school too – even though she’s younger – we started a yoga class together. It was a way that I can exercise,
she can exercise, and it just releases her stress. It’s something we can do together. We’re fitting it into our lifestyle.

It’s so easy to Google something. Instead of sitting there stacking up magazines in the house for information I’d like to have a different recipe in the house, I just Google something and of course, like I said the recipes come up and all the information is right there. You don’t have to hold onto it. For me that was nice that I don’t have to have the clutter of everything in the house for that. But the information that comes out, I just think we all have to be aware. I guess I have certain interests. For instance, like for Runners World I started to get into the Runners World because I was training for races and it was “Okay, now I need to fuel myself properly and change my diet for it” so I was reading that. Because of reading all of the antibiotics and different things are going into the meats I cut out a lot of the meat. I’m not a vegetarian, but I’m picky when I do eat meat. So in Runners World there’s an author in there that will give you alternatives to meat. So I started to read that then I’ll look up his name and get other books and other information and it just, it just kind of snowballs. It is interesting though, to see how different people who run who are vegetarian because if I only eat meat a few times a week, I want to see how they fuel themselves properly if they’re not eating meat at all.

Media has always been somewhat unrealistic. I guess shopping, when I shop [laughter]. That would be something – you want clothes to fit the way, the way they would on models. The self-image in the way [media] portrays…I don’t know if I get too caught up into that. I know I critique everything now. I can’t give you an example. I do watch the Biggest Loser. I do like Jillian Michaels. I love her in your face approach. I hate when people are like “Oh she’s too hard” I’m like, “No she’s not [laughter].” She
needs to get in their face. So I am a Jillian Michaels fan. I do read about her as well and I do listen to her Podcast sometimes. She has a lot of information about chemicals and everything as well, so if you haven’t listened to her Podcast she has some pretty good information too.

**People Notice My Weight Loss**

They do tell me that they see a difference. But a lot of people see me gradually, but yeah, I was just with a group of people from college not too long ago and we were pulling the pictures from the last time we were together and they were like “Oh my gosh look at you from back then and look at you now.” So they can definitely tell a difference. It feels great. I feel physically more comfortable. Even just sitting down you feel more comfortable because you’re not – it’s easier to cross your legs, and you’re not worried about if your buttons are pulling, so you do have less of that on your mind. As silly as that might seem, but you can feel more comfortable during conversation without worrying about crossing your legs or a roll hanging here or there. Like I said, I’m not perfect and I don’t plan to be perfect – if I can lose more weight, wonderful – but as long, as I can be active and feel good.

I can’t say I was disappointed at all. I do get a lot of people who tell you what to do. Like they all know what to do. Even though they might be like three sizes larger than you, at home smoking a cigarette, drinking a beer, and having pizza – they tell you what you need to do [laughing]. You’re like “Wait, I’m going for a run and you’re going to hold me up right now because you’re telling me what to do? Hold that thought and I’ll be back.” That’s what’s frustrating – what everyone wants to tell you what to do. You can really get sidetracked by people saying, “Well I did this and this and you should do
this and that.” You kind of have to zone everybody else out and do what feels right for you. I guess that was frustrating. Maybe not necessarily disappointing but it’s frustrating that everybody wants to share what works for them. Maybe I’m judgmental on my part too, but if they aren’t doing anything good for their bodies at the time that they’re telling me, then I really don’t want to hear it. I got to do what’s right for me.

I can definitely tell when I’m not eating healthy. When I was running and training for my half-marathon (I’m not a fast runner by any means), I just wanted to do it to say I ran it without stopping. But I really realized that your body is like a machine. It’s what you put in and how you feel; even if I put something good in my body, when I ran it might not be good for how I ran or how I performed. I really got in the tune of how my body worked. So I know when I feel at my best. If I’m not on track I don’t feel my best. That goes for stress and just how clothes feel too. Clothes are a big thing. You want your clothes to not only fit right – you want them to feel right on you. So that’s a big thing – that’s a big thing as well. I just want to be able to stay active and it’s a stress reliever. It’s just a win-win all the way around.

That has been something though I think I’m pre-wired for because I’ve always had a… I’ve always had an interest in [food]. Years ago I think somebody gave me a book. I think it was called “Eat Right for Your Type.” That fascinated me. It was like eating right for your blood type. I don’t know if you read it or not but it was just, it was just fascinating so I read a little bit about that, and like I said, It just branches out into something else you read into. Anything like that it just interests me and it snowballs. Of course the more you get into it, the more it just scares you. Like I haven’t touched the dairy products because I don’t know if I’m ready to give that up yet [laughter]. Every
time I read something I’m like ugh, I’m not eating that again [laughter]. I just have so much awareness of what you’re putting into your body. The more you read the scarier it is.

I think its preservatives in the food. I think oh…there’s an author and he writes a simple book and it’s so good…it is so simple and everything you read in it you just wish you could just have everybody read it. Don’t eat anything that your great-grandmother wouldn’t have had in your cupboards, just something simple. My daughter came home with these crackers the one time. It was like toast or crackers or something and I looked on the back and I didn’t know any of the ingredients and I Googled it and it was the same thing that was in…a chemical that was in lighters was in her food! I said to her, I said “Look at this, do you want to eat these anymore.” And she was like, “No you can just throw those out.” I just think it’s important that we need to teach our kids. I don’t want to scare her but I want her to be aware of it. We started to go to a CSA [community sustainable agriculture] where we actually went to the farm and saw how they grow things and each week in the summer we can get a box of their fresh vegetables. Kids see that, they know where it comes from. But we need to eat simple stuff and people don’t do that. Other countries that don’t eat preservatives and things from a box – they don’t have the problems we have here. But another thing to add to that my grocery bills are expensive because I don’t buy the stuff that’s cheap. It’s not a new awakening. It’s been just gradual…it’s just been gradual. There’s always been an interest in different things. Some people don’t want to listen. But I think just by showing them what’s on the box…I have that book by Michael Pollen. We pass it along to people. My boyfriend and I we took his kids and we took my daughter to the farm and we explained to them that we
wanted fresh foods and we wanted to have things that didn’t have chemicals in it. Eat healthy – so let’s go see where our food is going to come from. They knew every week, and it has to be visual. I think you have to teach the generations coming up because some of these people just want something quick.

I think people get there for different reasons. For instance after I was on the weight loss program for almost a year we went camping with friends. We went to an island so I could not really take a lot of my own stuff with me and I knew that they were not going to eat stuff I eat. I was like “What – I’m not going to stress about this I’m going to eat everything but just watch my portion sizes and try to eat normal, somewhat – everyone else’s normal and see how that goes”, and I ate smaller portions than everybody else, I was active all weekend. I came home and I had gained 4 pounds. Everyone was going “What! How did that happen”? I said, “Because I am not eating clean and I am eating other stuff.” So can I get obese quicker than some other people? Probably. Is that my metabolism? I don’t know. Some people I do feel are obese and really try, and other people, you just see bad habits and excuses. I think personality has a lot more than when you visually look at somebody.

It’s been a great learning process and I think that through this last time of losing weight hopefully I can stay on track and maintain it and learn to adapt. I think that’s the key though to maintaining is to know when it’s time to adapt. Know when “Okay that worked for you before but that might not really fit into your lifestyle now” so how can I adapt it to my lifestyle today? Just keeping up with news articles and making sure that you are making healthy choices because it seems like every day something that you might have thought was healthy is not now.
Analysis

Amy’s story was the closest narrative that showed evidence of transformative learning. This learning started with life events that caused her to gain weight; including the birth of her daughter and a divorce. She eventually wanted to try to lose weight and she went to her doctor and asked for help. She stated, “Through some resistance, I was finally recommended to go to [hospital] to talk to a nutritionist. We talked over some nutrition plans and we decided to go on some medications as well.” Through trial and error and a persistent personality and showed through her entire story, Amy found a health professional that helped her fit nutrition and exercise into her busy life as a single mom.

Amy’s weight loss led her to change the ways she shops and thinks about food, including the larger food system. Media, including documentaries and movies, helped her learn to question where, how, and why her food is what it is. Amy had the only narrative that demonstrated the powerful positive influence of media and adult learning.

The three main aspects of Amy’s story that will be discussed include; questioning authority, learning to eat clean, learning through media, and how she got back to herself.

Questioning authority. As Amy asked for help there seemed to be some resistance from her medical community. Amy remembered the nutritionist telling her to “…go out and walk in the mornings and you need to walk like 6 miles a day.” Being a single mother this advice just didn’t fit into her lifestyle. Amy said, “I need guidance. I need something, someone to help me and go through what I’m eating and help me tear apart my journals and show me, guide me, and point things out.” Amy felt that her nutritionist just wasn’t willing to help. She felt as if she didn’t believe her attempts to
lose weight. This pushed Amy to the point of saying, “Look, I’m going to try the next one [diet] until you help me. Until you put me on something.” Amy was desperately trying to help myself and it wasn’t working. Amy acted like an active consumer when soliciting weight management advice.

**Eating clean.** Amy learned that what worked for her and her family. She has an all-or-nothing approach. She noted:

I need to keep a schedule of food as well as, and when I say schedule I need to have it planned out. I need to have a grocery list; I need to know what I need and how many calories and a calorie range. Plus also exercise as well and keep that in. If I don’t, I go back up.

For example, she spoke about Weight Watchers and counting points. She said,

Oh, use the points and people can lose weight on it and say “I can have ice cream and still lose weight.” For me, I can’t. I have to eat a clean diet to lose weight. I have to have nothing extra so I’ve really started to cook clean for my family. We don’t use a lot of prepared foods. I lost about 50 to 55 pounds.

She eventually found a medical provider that worked with Amy to develop a plan that worked for her family’s lifestyle. Amy said:

It is good to know that I don’t have to fit into a mold. I’ve learned to adapt this into my lifestyle. Not a lifestyle that can be generally fit into anybody else, but it’s for my lifestyle... I knew how to plan it for me, for my life. Sure that might be late at night eating because by the time I get back from the gym I might be eating at 8 o’clock at night. That might not be the best for everybody else but that’s what worked best for me and that’s what could keep me on track.
She contributes her weight loss maintenance to adapting behaviors into her lifestyle. Finding time to cook healthy meals and participate in physical activity with her daughter were among the key leaning aspects that helped Amy successful lose weight.

**Learning and media.** Amy often talked about the positive role media played in her learning. She started to see movies and documentaries about how foods were prepared and the impacts to health and well-being. She talked about the first documentary she viewed, *Supersize Me*. She said:

> It just amazed me. We all knew how bad it was. We all know how bad McDonald’s is – it’s just disgusting. But to see how bad his health deteriorated in a year and what extra food was being put into salty foods – sugar was being added to it. What? Why? Why is that? Those are some questions you start asking yourself. What’s in the food that you put, you take off of the shelf? What’s in that?

These documentaries helped Amy critically reflect and eventually she changes the way she eats and shops. Critical reflection is the questioning of the integrity of assumptions and beliefs based on experience, including systematic, organizational, moral-ethical, therapeutic, and self (Mezirow, 1991). This type of reflection led Amy to self-examine her socio-cultural or epistemic assumptions on food and weight. She often uses the Internet to search for healthy recipes, often using sites like Muscle Fitness Hers, Runners.com, or Self Magazine and to learn about preservatives in foods. She now cooks clean for her family. She said:

> You just start to feel so much better when you realize you’re not having all the preservatives and whatever else is put into boxes of food. Those 100 calorie
snacks that people eat all the time, you feel so much better if you just grab an apple.

The documentaries and self-directed learning led her to join a CSA (community sustainable agriculture). This helps her feed her family healthy foods, but it is also an avenue to educate her daughter. She said:

I just think it’s important that we need to teach our kids. I don’t want to scare her but I want her to be aware of it…we actually went to the farm and saw how they grow things and each week in the summer we can get a box of their fresh vegetables. Kids see that, they know where it comes from.

However, when asked about negative impacts of media she said, “I don’t know if [media impacted me], because to me that’s always been somewhat unrealistic.” However, clothing shopping did have an impact. She said, “…you want clothes to fit the way, the way they would on models. The self-image in the way [media] portrays… I don’t know if I get too caught up onto that.”

However, she did acknowledge that she learned to critique messages since she often researches what she hears and sees on the news regarding health and fitness. She then quickly talked about the television show The Biggest Loser. She said:

I do like Jillian Michaels [trainer]. I love her in your face approach. I hate when people are like “Oh she’s too hard” I’m like “No she’s not” [laughter]. She needs to get in their face. I do read about her as well and I do listen to her Podcast sometimes. She has a lot of information about chemicals and everything as well, so if you haven’t listened to her Podcast she has some pretty good information too.
This in-your-face approach was adopted by Amy as well. When asked about if individuals commented on her weight loss. She said:

I can’t say I was disappointed at all [with comments from other people]. I do get a lot of people who tell you what to do. Like they all know what to do. Even though they might be like 3 sizes larger than you, at home smoking a cigarette, drinking a beer, and having pizza – they tell you what you need to do [laughing]…That’s what frustrating is what everyone wants to tell you what to do. Maybe I’m judgmental on my part too, but if they aren’t doing anything good for their bodies at the time that they’re telling me, then I really don’t want to hear it. I have to do what’s right for me.

**Getting back to Amy.** Amy always identified with being an active, athletic person. Before she lost the weight she talked about not feeling like herself. She was often without energy and frustrated with not being able to do the things she has done in the past. Through her weight loss she started to set exercise goals. She recently completed a 5K and 10K road race and competed in a half marathon. She stated:

I’m just starting to check some things off of my life list that I feel like I have a second chance at life and I’m able to do stuff with my daughter now that I don’t know if I would’ve been able to do.

Amy’s weight loss had profound influence or her physically and cognitively. The documentaries that she watched changed the way sees food, a transformative experience.
Nancy

Nancy is a 61-year-old woman. She is married with two grown children and is currently employed. Nancy has always remembered struggling with her weight and she talked about a lifelong effort to maintain weight loss. I interviewed Nancy in person.

Nancy’s Story

My weight has yo-yoed for 20 years…up and down, up and down. But I never was able to keep it off. This time is when I hit 60 years old. It was a year ago in the fall, and I was very depressed because of it. I was about 80 pounds overweight and not feeling very good about myself, especially turning 60 years old. I realized if I don’t get healthy… it wasn’t about weight loss, it was about getting healthier. What kind of a life is the rest of my life going to be? It was kind of a scary thing. My self-esteem was in the toilet. I’d wanted to lose weight and I said to myself that I need to. I just couldn’t get started.

My family, the kids especially, have tried to get my husband and I to eat healthier. My husband has several health issues including diabetes, high blood pressure and high cholesterol, and he doesn’t take real great care of himself. He doesn’t eat properly and we don’t eat real healthy at home. We eat out a lot so that makes it also hard. I wanted to [lose weight] but I couldn’t get my brain to cooperate. So that’s why I came to [hospital] to the obesity clinic and that’s another thing that hit me prior to that. The one time I was here for knee surgery and on my chart it said ‘obese’ – and it just struck me. I knew I was overweight, but that word ‘obese’…that word was a real stigma to me and it really bothered me that day. Being overweight is more acceptable than being obese. People look down on you; they think less of people because like they can’t control
themselves or what they eat. But anyway, the kids were trying to get us to be healthier. It didn’t really help. The youngest grandkids are 6 and 8 years old and their parents are concerned that we wouldn’t live to see them grow up. So I came to [hospital] and I went to their obesity clinic and I went to counseling. I think the counseling was what I needed to help get my head screwed on straight. The counseling would help me handle things when they arose, or when people would try to sabotage my efforts. That has happened in the past, including my husband. He doesn’t knowingly sabotage my efforts. It’s just his lifestyle and our lifestyle together is not always the same. He doesn’t choose to be healthier. He could eat a lot healthier and be more physically active. I also found through all of this, and in the past times I’ve lost weight, the best way to lose is not just watching your diet, it is a combination of diet and exercise - calories in, calories out kind of thing. So you have to learn that balance. If you want to eat that piece of pie then you better go for an extra half hour walk today. The balance is there to help you lose the weight.

I came to [hospital] and I met with a counselor and he helped me work through some issues trying make the proper responses when I didn’t get the support that I needed from people. That helped a lot and helped me get my head on straight. Then I started meeting with a nutritionist every six weeks. That was an accountability kind of thing, which really helped. It was structured and I began to write everything I ate down. Getting the counseling for me was the trigger to get it started, to get on the right track, to start to lose weight. I thought the program here was really, really good. And I kept coming and kept coming, I didn’t lose just the 10 percent, I think I lost more than 20 % of my weight. Now I wasn’t able to keep all of that off. I gained a little bit of that back. I
kept 40 pounds off of the 47 pounds I had lost. But I’m continuing to exercise and I think learning to make better choices all the time. It’s an ongoing process. I always allowed myself indulgences because I have a heck of a sweet tooth. If I didn’t allow myself the occasional splurge, I know what would happen…I’d sit down and eat a whole package of Oreos or something stupid – or just go on a binge. I know that’s how I tend to be, so I allow myself small indulgences, occasionally. But I counted it in my calorie allowance. I had done Weight Watchers several years ago so I knew a lot of the right things to do. I had learned then to read labels. That’s important because foods that seem healthy aren’t necessarily. Even now I occasionally really goof up. Eating out is a hard thing to do and my husband and I do eat out quite a bit, mostly on the weekend for breakfast and dinner. Learning to make better choices eating out and Calorie King Website is like my Godsend. It’s on my ‘favorites’ and I carried my journal with me everywhere I went. If we were going to fast food I had printed out from the Internet all of the menus from different fast food, luckily we don’t go to a lot. I think it is harder to eat healthy going to fast food. You have to learn what’s healthier. Sometimes a plain hamburger is better than a salad with all the crap on it. Just learning what’s healthy and trying to make better choices most of the time I think has been the reason for a lot of my success.

I Walk To the Beat of the Music

Walking, that’s my exercise of choice. I would get winded going up one set of stairs, now I can go up two or three running practically and not be out of breath. It’s such a good feeling. I mean when I first started walking I walked a 30 minute mile. Now I can do one-mile in fifteen minutes. I’m huffing and puffing but I can do it. I usually
walk 30 minutes. If I’m walking on the treadmill I know exactly how far I walked and can time it better. But when I walk outside I put more into it and tend to walk longer. I do enjoy walking and my son gave me a little iPod shuffle. I like to walk to the beat of the music. So I found some songs that are 130-135 beats per minute. Since then I’ve walked a couple times and it’s like “Oh yeah I love this new music” because it really does help get you motivated. When it’s hard, I walk on a treadmill in the winter because I don’t go outside. We have one at work in a small little fitness room. So I walk on the treadmill at lunchtime usually. If it’s really nice I’ve been out like this spring 2 or 3 times when it was a nicer day when the sun was shining and it wasn’t windy. When you walk outside you’re enjoying the smells of everything and the scenery and trying not to get run over by the tractor trailers coming down the road and stuff [laughter] but I can’t get my husband to walk. On the weekends I slack off. I pack my healthy lunch for work, so it allows me a little more freedom on the weekend to be a little more lax. But I still try to make the better choices. Just learning how things should be prepared and learning the healthier choices are a big help. At the grocery store my husband gets impatient sometimes, and says “Will you hurry up?” when I’m taking too long reading a label or trying to figure out “Do I want this one or this one.”

I Have More Confidence

My basic personality hasn’t changed; I feel like I’m the same person. But I feel a little bit confident. I do have so much more energy. I feel like I have more control over my life. Well, sometimes in my life I don’t always feel like I have control. I think in the past I let food be a crutch because I had control over that. With my job the way it is and I try to please my husband…my family. I didn’t try as hard to please me. I feel so much
better about myself now knowing that I’ve come this far, I’m not quite there yet but I’m more than half way there. I feel like I can continue and finish it. So I’m the same person. I have more confidence but I have more energy. I feel better about myself. I don’t have to wear plus size clothes anymore. I’m not a style conscious person especially. I was wearing a size 20 or 2x. Now I’m in a size 16 or 18. I had a whole wardrobe of 16 and 18 clothes that I had kept that I got back down into. Some of them are even too big now. I’ve gotten rid of all of the bigger clothes now. I’m not going to go back again. In the past I’ve always kept 2 or 3 different sizes of clothes for my thinner days – my fat days, whatever. I’ve gotten rid of all the bigger stuff now. If I can’t wear it, I get rid of it. I’ve bought some new stuff just because I’ve deserved it. I didn’t have money to buy a whole new wardrobe. Having the counseling is what helped me get over not feeling like I deserve to give me what I need, rather than just giving to the family. I’m sure a lot of mothers feel that way. My kids are now grown. The youngest is 37 years old. So it took me awhile to figure it out. Before when I lost weight I wasn’t happy with myself and I’d gain all of it back plus some. So this yo-yo range up and down kept getting higher, and higher, and higher. The lows didn’t get quite down to where they did before. I would gain 20 pounds then I’d lose 15, and then I’d gain 25, then I’d lose 20, then I’d gain 30, etc.

I’ve Made Changes That I Can Live With

It’s forever [weight loss]. I’ve made changes that I can live with forever. That’s a very important thing. I have given up most alcohol. I was never a heavy drinker before. We would go out to dinner and have one or I’d have a wine cooler. Then I found out wine coolers had 240 calories…so then I would drink a wine spritzer with diet 7-Up,
or just a little bit of wine. Even a whole glass of wine is less than 240 calories. Now I only drink on special occasions. Well I’ve just made the changes that I know I can live with forever. It’s not a diet – it’s a change in your whole way of thinking about food. It’s just what happened to me. Food is to be enjoyed of course, so I try not to eat anything that is a mediocre quality. I haven’t quite got to the point that it’s only fuel for the body. That’s a hard place to be, to stay there because I never was an athlete. I walk so that I can stay healthier and not gain weight back. But you have to make choices that you can live with or else you’re going to go back to the old eating habits. You’ll end up feeling deprived somehow. You have to learn to make substitutions for what is a treat for you. You change what the treats are; you make the healthier choice treat.

**She Has Such a Pretty Face**

I don’t like it when they portray heavier people in a bad light just because they’re heavy. There’s this one actress – Melissa McCarthy, she’s really funny. I’ve seen her in a couple of things and she’s pretty and when somebody’s heavy they say “Oh she’s got such a pretty face… if she’d only lose 100 pounds.” Sometimes heavier people have a bubbly personality to compensate for inadequacies they feel, or something. But I never really felt that with me. I didn’t feel like that influenced me on how I felt. There was a model that starved herself to be a regular model. She finally came true to herself and became a plus size model. She’s 6 foot and 140 pounds and she’s a plus-size model. What is wrong with this picture? There was some magazine that was showing all these plus-sized models that were nude but covered in weird positions so you didn’t see anything. I thought they looked beautiful – they’re not obese by any stretch. They’re probably even a little underweight for their weight. But they’re plus-size models. That
just gets me. That kind of stuff just bugs me when you see these skinny rail models with the hollow out cheeks and the hollow look in their eyes because they eat two celery sticks a day to keep their weight down or whatever. That’s not healthy. I’m trying to be healthy and continuing the healthy momentum.

Generally, I don’t think people act differently towards me. People that I haven’t seen in a while will comment and say, “You look great.” We saw some friends recently that we haven’t seen in a while so I had lost some weight since I had seen them and they were very happy for me and said how good I looked and everything. That made me feel good because I know I look better and I feel better. We were talking with them and they both do yoga. I was going to take a yoga class but I really didn’t have the extra money. They have this video that they use – “Biggest Loser Weight Loss Yoga.” So they showed my friend and he showed me some of the poses. He said “And with this video, they show the people that are beginning doing a modified position till you get strong enough that you can do the normal position.” We had gone shopping a couple days later and I looked for that video to buy it. I couldn’t find it anywhere so I ordered it online for $9.00 and it should be here any day now.

My son is a jock, mainly a runner and his wife is as well. They’re raising their kids healthy and they come to visit and we have all this junk in our house. Most of it’s what my husband buys. My daughter-in-law makes these snide comments “Well you should just throw that out.” Well my husband doesn’t waste food. He would never do that. There are always six or eight bags of chips, waiting in the wings. We buy our groceries separate. He buys his food. We always did. We packed our own lunches so he bought the stuff for his lunch – I bought the stuff for my lunch. I buy the fruits and
vegetables and the healthy stuff—foods that only I will eat. He buys more junk and pretzels. He snacks on pretzels. I don’t like pretzels especially. And I’m not a big chips person. I’m a sweets person. He likes the sweets too but he’ll snack on pretzels.

**I Want to Continue To Feel Good**

I feel good now. I want to continue to feel good. Early on into this whole process, my blood pressure was creeping up. My doctor was thinking about putting me on blood pressure medicine. I said, “Let me try to get it down without the medicine.” So I started cutting out sodium and watching the prepared food and canned goods. I try to buy frozen vegetables and stuff. So that helped me to think healthier in that regard—watch my sodium, getting more exercise, trying to increase my potassium to help offset the sodium that’s in foods. I got my blood pressure down to 120/70. I didn’t have to go on blood pressure medicine. My doctor was happy and I am happy. Now I’ve been on cholesterol medicine for three or four years and there’s a family history of heart disease. I was due to see my doctor in a few weeks so and I decided to “I’m going to cut my pills in half.” When I got tested my cholesterol was okay, and I’d cut my dose in half. I confessed to him what I did cut my prescription down and he said I could cut them in half. So I was taking a quarter of what I originally was. He tested me in six weeks and it was up just a tiny bit. He said it’s insignificant. He asked if I would like to go off and said “If you’d like to go off because of side effects (Charley Horse and memory issues) then get retested. If its back up too much we’ll want you go back on.” If you can keep it under control in this time period you can stay off of them. So that’s two big motivations right there. That has been a benefit of losing the weight.

Because I didn’t even have to go on the blood pressure medicine and my pressure
was 120 over 70 most of the time. I’ve learned that I don’t need to salt everything. I don’t salt hardly anything when I cook. My husband salts but he peppers more. I said, “I told you I just put a tiny bit in or I use sea salt because it has more flavor with less sodium.” I did know this from experience because when you have a lot to [weight to lose], the more you have to lose, the more you have to lose before anybody notices. I knew it would take a while and I didn’t say anything to some people for a while just to see how long it took for anyone to notice - it was a good twenty pounds. But when you only have 20 pounds to lose you might notice five pounds. A girl I work with is tiny, but she was like 8 pounds overweight. Well she lost that and it was very obvious. But when you’ve got a lot to lose, it takes a lot more to lose to notice – it really does. That can be a hindrance to somebody who’s looking for the feedback from friends.

**I Try To Be Less Judgmental**

Now, I am sympathetic with people who are heavy and who are trying. I try to be less critical of people who are heavy because you don’t know what got them to that point because I was there once. I try to be less judgmental of others because I know that it’s hard to get it off and to keep it off. It’s a daily thing you have to work at. I read a lot of different things about different ways, different diets, and reasons for overeating. I don’t really think that I’ve changed but I try to be sympathetic of people and not be judgmental because I’m thinner. It doesn’t make them less of a person because they either choose to be that way or happy to be that way or can’t control being that way, or have a medical issue that that’s why they’re that way, because you don’t know their story.

Maintaining weight loss is the hardest part. That is the hardest part. I’ve lost a lot of weight in my lifetime, maybe a couple hundreds of pounds. Keeping it off is the
hardest part, so you have to make the changes that you can live with, that you can put into your lifestyle and make better choices that you can keep it up. Sometimes you need a kick in the butt. Or maybe if you’re struggling to go back and get more help. But it’s…generally the more help you have, the more successful you’ll be. It’s harder when you don’t have your family in on the same page as you are. I mean my husband is not critical of me. He’s happy for me. But he doesn’t choose to be healthy for himself. He never, ever, ever said bad stuff to me when I was heavier. He never criticized my weight, criticized me for anything. Even though he’s not supportive in the effort, I have to do it on my own. I know that.

Analysis

Nancy has struggled weight her entire life. However, Nancy’s struggle was different then the other narratives. The key to Nancy’s success was talking with a counselor and helping her to learn that she is worth it. She said, “I think the counseling was what I needed to help get my head screwed on straight. The counseling would help me handle things when they arose, or when people would try to sabotage my efforts.” Nancy’s story although successful did not provide support of transformative learning. In fact, when asked if she changed, she said, “My basic personality hasn’t changed; I feel like I’m the same person. But I feel a little bit confident. I do have so much more energy.” The change although physical was an outcome of Nancy’s increased self-efficacy.

Nancy’s 60th birthday symbolized a need to change. She was not feeling good about herself, depressed, low self-esteem and she realized that she needed to get healthy. Losing weight wasn’t about appearance for Nancy; rather it was about healthy living.
She said to herself, “What kind of a life is the rest of my life going to be?” But Nancy needed help getting started. She speaks openly about her will to lose weight but realized she need help because her “brain would not cooperate.” That’s when she decided to go to the weight management clinic. While counseling helped her with her self-esteem she also learned new skills that were adapted into her lifestyle at the clinic. Nancy’s weight loss has led her to be more confident, more in control of her life and choices and she has more energy.

Throughout Nancy’s story several components were commonly discussed and related to her success. These include: weight terminology, interpersonal relationships, counseling, and media.

**Weight terminology.** In addition to her 60th birthday, another trigger that led to her wanting to lose weight was the time that she went for knee surgery. She saw her medical chart and noticed that it said ‘obese’. She went on to say:

Just struck me. I knew I was overweight, but that word ‘obese’…that word was a real stigma to me and it really bothered me that day. Being overweight is more acceptable than being obese. People look down on you; they think less of people because like they can’t control themselves or what they eat.

**Impact of interpersonal relationships.** Nancy openly stated that “…generally the more help you have, the more successful you’ll be” at losing and maintaining weight loss. However, Nancy’s story mainly concentrates on the constant divide of her closest family members; the support and encouragement of her children and the unhealthy behaviors of her husband. Although she wanted me to know that her husband never criticized her weight, she realized that he wasn’t supportive in the effort. Her weight loss
journey was individual and that she would “… have to do it on my own. I know that.”

She said:

My husband has several health issues including diabetes, high blood pressure and high cholesterol, and he doesn’t take real great care of himself. He doesn’t eat properly and we don’t eat real healthy at home. We eat out a lot so that makes it also hard.

A particular barrier is grocery shopping. Nancy and her husband buy their groceries separately. She said:

Well my husband doesn’t waste food. He would never do that. There are always six or eight bags of chips, just waiting in the wings. We buy our groceries separate. He buys his food. We always did. We packed our own lunches so he bought the stuff for his lunch; I bought the stuff for my lunch. I buy the fruits and vegetables and the healthy stuff. Foods that only I will eat. He buys more junk and pretzels.

However, Nancy’s children are very supportive of her efforts. Nancy’s exercise of choice is walking to music; the music that she gets from her son. She noted:

I do enjoy walking and my son gave me a little iPod shuffle. I like to walk to the beat of the music. So I found some songs that are 130-135 beats per minute. Since then I’ve walked a couple times and it’s like “Oh yeah I love this new music” because it really does help get you motivated.

Counseling. A lack of knowledge was never Nancy’s weight loss problem. She reflected back on her time with Weight Watchers several years ago where she learned “the right things to do.” She learned to read labels, for example. Nancy’s main issue
was her lack of self-worth. She noted that she often felt a lack of control and a tug of war between wanting to make her family happy, her work happy, and the needs of herself. Food was her crutch. While she was at the weight management clinic she met with a counselor. She stated:

The counseling would help me handle things when they arose or when people would try to sabotage my efforts. I came to [hospital] and I met with a counselor and he helped me work through some issues trying make the proper responses when I didn’t get the support that I needed from people. That helped a lot and helped me get my head on straight.

**Media and self-esteem.** When asked about the impact of media on her self-esteem she talked about how she didn’t like it when they portray heavier people in a bad light just because they’re heavy. She referred to a very popular actress:

There’s this one actress – Melissa McCarthy, she’s really funny. I’ve seen her in a couple of things and she’s pretty and when somebody’s heavy they say “Oh she’s got such a pretty face… if she’d only lose 100 pounds.” Sometimes heavier people have a bubbly personality to compensate for inadequacies they feel or something. But I never really felt that with me.

She also talked about how skinny is associated with health in America. She noticed the very skinny models that are often on magazines and runway shows, but she did not elaborate on how this impacts her views or behaviors.

That just gets me. That kind of stuff just bugs me when you see these skinny rail models with the hollow out cheeks and the hollow look in their eyes because they eat two
celery sticks a day to keep their weight down or whatever. That’s not healthy. I’m trying to be healthy and continuing the healthy momentum.

Chapter Summary

The purpose of this chapter was to provide six narratives in their entirety. The narratives provide insight into the individual journey of weight, identity and meaning. Following each narrative a brief analysis of each story was presented. The various important aspects of each story were highlighted.

In summary, the narratives reflected individual journeys of successful weight loss. The narratives revealed unique experiences that allowed each individual to navigate their weight loss journey in ways that could be adapted into their lifestyles. Each narrative although unique, shared common characteristics that offer insight into Mezirow’s (1991) TLT and critical media literacy and the learning processes associated with weight loss and obesity treatment in healthcare.

The majority of the narratives presented began with a trigger. These events or triggers, both gradual and sudden provided a platform for each participant to reflect. However, it was rare that this reflection was presented as critical. Rather, the majority of the reflection that was noted in the narratives was content and process driven.

Nevertheless, media, in Amy’s narrative, provided the stage to question assumptions, including hegemonic assumptions. Additionally, Mike’s new found physical change in weight led to the development of an afterhours exercise program. Amy and Mike’s narratives were the only stories that presented fundamental questioning that helped to reorder how they thought and acted.

Secondly, the primary learning processes occurred in the weight management clinic, and were largely the instrumental learning processes that allowed each individual
to learn the technical and scientific skills needed. The narratives did not produce language that could be viewed as communicative or emancipatory knowledge. Generally, the narratives provided a sense that there seemed to be an uncritical awareness of the impact of media messages on behaviors. It seemed as though the narratives indicated that the participants believed media messages surrounding weight were often seen as having an impact on others’ behaviors and feelings – but not their own. However, there were instances that there was a need for structural and social changes to solve the obesity epidemic.

The results of the study demonstrate the need for the integration of adult education theories and principals in medical weight management. Chapter 5 aims to provide an in-depth look at the collective analysis of all nine stories. Through ongoing discussion and revision with the thesis advisor, consensus on the underlying meaning of the codes was reached and the categories were more fully developed into five themes, which are presented in detail.
CHAPTER 5
COLLECTIVE ANALYSIS

Six narratives were presented in Chapter Four. In addition, each individual analysis was constructed through my interpretation of the interviews by using the participant’s words from my perspective in relationship to cognition, behaviors, and their meaning-making process that was guided by the study’s research questions. Chapter 5 aims to provide an in-depth look at the collective analysis of all nine stories.

The purpose of this study was to explore how learning manifested in successful weight maintenance and improved self-identity despite cultural stressors. There are connections among all of these stories that provide insight into the meaning-making and learning processes. Five key themes emerged from the qualitative phase and are summarized in Table 4. Two categories of themes surfaced, the first related to learning and the second related to identity, hegemony and resistance. In this chapter, I will discuss these categories in detail.

Table 5
Data Display of Qualitative Themes and Subthemes

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<thead>
<tr>
<th>Category</th>
<th>Theme</th>
<th>Subthemes</th>
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<tr>
<td>Learning</td>
<td>Triggers</td>
<td>Life events</td>
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<td>Health</td>
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<td>Individual initiation</td>
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<td>Learning process</td>
<td>Acquiring and adopting skills</td>
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<td>Motivation for weight loss maintenance</td>
<td>Development of self-worth and self-efficacy</td>
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<td>Helping relationships</td>
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<td>Identity, Hegemony, and Resistance</td>
<td>Cultural stressors</td>
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<td>Early identity to weight</td>
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<td>Entertainment media</td>
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<td>Weight stigma and the fashion industry</td>
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<td>Obesity discourse</td>
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<td>Response to weight of others</td>
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### Adult Learning

The first category of three themes centers around learning. These themes are grouped together to describe the triggers, learning processes, and motivations that initiated the weight loss process and helped maintain weight loss for the participants. The first theme focuses on triggers that propelled individuals to modify their behaviors and environments in order to overcome issues surrounding weight. The second theme, learning processes, centers on how the participants learned the skills that facilitated changes in behaviors. The third theme focuses on the motivational factors that keep the participants from weight cycling. Detailed findings from each theme are presented below.
Triggers

Participants were asked to describe their experiences of weight loss. And all participants spoke of life events, health status, or a combination of both as triggers that initiated this change. These events leading to these triggers varied, some were sudden and others were subtle, less profound changes. Regardless, the triggers began a cognitive process for the participants that led them to change. These events or triggers offer insights into Mezirow’s (1991) TLT and the learning processes in the context of weight loss and obesity treatment in healthcare. Mezirow’s theory, which is based on the individual, states that the disorienting dilemma sparks a process that forces an individual to begin self-examination of assumption and beliefs. Clark (1993) argues that integrating circumstances, although more lengthy, can also invite individuals into personal exploration. Integrating circumstances are described as missing contextual factors that allow for a person’s life issue to be resolved (Clark, 1993). These circumstances do not appear suddenly, instead “they are more subtle and less profound, providing an opportunity for exploration and clarification of past experiences” (Taylor, 2000, p. 299). Similar to other research, this study verifies the notion that the participants experienced a catalytic experience(s) that served as a platform to re-examine their health, body, or habits of mind (Liberman et al., 2009; Lopez, 1997; Phillipi, 2010). Both life events and health status are described in detail below.

Life events. Both positive and negative life events were seen as triggers for the majority of the participants. These life events ranged from the birth of a daughter, divorce, a milestone birthday, preparation for a wedding, among others. At the root of these life events were deep emotions; anxiety of social stigma or disappointment, fear of
being alone, or fear of a premature death or illness. For example, John spoke about the impact the birth of his daughter had on his weight:

> Just going through the whole process of being overweight my whole life, I look at it and sometimes it’s just, it’s overwhelming. I’ve had times in my life where, and this is probably only within the last two years, I just felt really bad and I just sat down and I had tears in my eyes because I just want to make sure that I’m there for my daughter. That’s the number one thing, I want to control my health and be there for my daughter. My daughter was the biggest factor in trying to lose the weight and keeping it off.

The birth of his daughter was life changing and the disorienting dilemma that evoked emotions in John that made him want to change his health. It made him realize that he wanted to be a healthy role model for her and to become healthier himself to live longer with her, to see her grown up. John’s health problems including high blood pressure and diabetes scared him. He said, “I wanted to be able to live my life with her…to focus on her and have the energy that I was going to need to be able to do things with her and I didn’t want my life to be cut short because of my stupid decisions.” His daughter is a constant reminder of the why he decided to lose weight and she continues to be a motivator to keep the weight off. Similarly to John, Pam also had health problems that she knew she had to worry about, but the main life event was not related to health. Her integrating circumstance, the event that led to increased stress and anxiety was the upcoming wedding of her son. She said:

> This is bad, my blood pressure is going up, everyone in my family dies of heart attacks, my legs hurt, and I have to do something. Those are all of the reasons
why I thought I ought to lose weight but I have to say probably the biggest reason was my son was getting married and I did not want to go to a wedding in a size 22 petite dress. I mean have you seen the clothes for size 22 petite? I don’t know if I would have if it wasn’t for that wedding.

Pam’s fear ignited the preliminary need to change her appearance. She also spoke about seeing photographs of herself as a motivator to change. She said, “I’d look in the mirror and I’d think I looked good, you know? I would not even notice how big I was until I saw photographs.” As she was telling her story, she cognitively understood that her ongoing health issues related to her weight were becoming an issue, especially because of her family history of stroke and heart disease. She was diagnosed with Graves’ disease; she had aches in her legs and she had high blood pressure. But it did not seem that health provided a process of self-examination for Pam; rather a combination of a social event and accompanied health risks.

Another example of a life event, or integrating circumstance was when Nancy spoke about her 60th birthday. This milestone birthday symbolized the intense need to become healthier and provided her with the platform to self-examine her life. She said:

When I hit 60 years old. It was a year ago in the fall and I was very depressed because of it. You know, my weight, I was like 80 pounds overweight and not feeling very good about myself, especially for turning 60.

It wasn’t about appearance for Nancy, rather her 60th birthday was a point of reflection. She asked herself, “What kind of life is the rest of my life going to be? It was kind of a scary thing.”
A few of the women also spoke about the impact that divorce had on their weight. Jane stated, “I got divorced about 10 years ago. My husband came to me and said that he loves me but wasn’t in love with me anymore. That’s when, I just…I just knew that I had to do something.” Gail’s story is similar. She spoke about how her insecurity was magnified through her divorce and how that event made her want to lose weight. She spoke about her lack of confidence, “the insecurity I had that nobody would ever want me if I was heavy.” Furthermore, Jane talked about how other past family influences prior to her divorce did not have long-term impact on her health or body weight. Instead, her divorce ignited her readiness to change. She said:

Before it was to please everybody else. I think that when it came to the divorce and to me, and to knowing that my husband wasn’t going to be around…I needed to do something for me. I think that made the whole difference.

The stories of divorce were among the most dramatic examples of disorienting dilemmas. Assumingly, this type of disorienting dilemma could have resulted differently in different people, depending on their personality and coping mechanisms, for example. However, Jane and Gail’s stories, both full of emotion, resulted in adult learning and had an outcome of weight loss.

Health. In addition to life events, participants reflected on their physical health or a medical trigger that led to a change in individual assumptions that may have had an influence on lasting behavioral changes (Mezirow, 2000). These health concerns helped participants to question the integrity and validity of assumptions and beliefs they had based on past experiences (Mezirow, 1991). Although the health triggers are incremental changes in physiology, and they did not occur over night, it may be that the
communication of these health issues combined with other life circumstances were enough to shift readiness to change. Participants spoke about health triggers that were commonly associated with increased body weight such as high blood pressure, sleep apnea, arthritic joint pain, and heart disease.

The impact that health outcomes have on the participants varied. For example, Betty explained that her weight loss began when “they wanted to put me on a c-pap machine.” John, the gentleman whose father was in the hospital for heart problems during the time of the interview spoke about his health issues. John stated:

I was afraid because I became a diabetic, my blood pressure’s been high, and it just really worried me because I had a lot of family problems….he [my father] had valve replacement and he had heart problems ever since.

John was both worried about his own health issues and his father’s chronic health issues. John’s father may have symbolized his own future if he didn’t change some of aspects of his lifestyle.

Interestingly, a few participants spoke about an outpatient medical encounter that triggered the need to change. Both of these experiences were related to a visual display of weight or physician generated weight terminology that was displayed in the participant’s medical record, or physician communication. Mike was one of the two males that participated in the study. He spoke about the genuine care of his physician and his rapport with his physician. He said, “I think it was my physician just sort of….I mean he was genuinely concerned about me. I think that’s really what it was.” Through his story he explained:
He just basically sat me down in front of the screen, showed me my weight, got his piece of paper out and on the graph and tipped he paper to show me…”This is what your weight has been doing for the last two or three years. Every time you visit me it is going up”. At that point I was like I’ve really got to do something about this.

What is not known is if the need to change was generated through physician communication regarding weight, or if it was weight trend graph that supplied a visual image of weight changes.

Nancy also had a similar experience in the exam room during an encounter. She stated, “The one time I was here [doctor’s office] for knee surgery and on my chart it wrote ‘obese’ and that just struck me. I mean I knew I was overweight, but that word ‘obese’…” This is important in a modern healthcare setting. This notion provides supporting evidence that the healthcare team can take small steps to include a more patient-centered approach to the prevention, identification, and treatment of this disease.

Many of the participants spoke about one or multiple independent events that sparked the need for change. The change process for Nicole was not based on one event or her health, unlike the other participants. She states, “…I was getting tired of wearing plus size clothing. I wanted to change my appearance. It was a gradual change.”

In summary, unique triggers such as life events/transitions and physical health status were characterized as events that created cognitive reflection and eventual behavioral changes. These triggers were not all described as disorienting dilemmas, as some examples were less dramatic and seemed to be the last event that sparked change. The triggers were described as both sudden or gradual, more subtle events over time.
Regardless, the triggers provided an avenue for personal exploration that led to their individual, initial need to change their health, appearance or lifestyle.

**Learning Processes**

As described above, the majority of the participants spoke about trigger(s) that created the need to change. However, in order for weight loss to occur behavior changes ultimately have to be incorporated into one’s life. Though, how individuals acquire this knowledge is less understood. The majority of the participants without prompting spoke about their learning processes that revolved around activities, skills, and tools acquired. From their stories it was evident that the majority of all learning occurred in either the weight management clinic or was through individual initiative.

**Individual initiation.** Individual initiation in many ways began when the majority of the participants self-referred themselves to the weight management clinic. This could be seen as an aspect of self-directed learning. Both the action of self-referrals and seeking out information using technology are examples of self-directed learning. Self-directed learning is defined by Knowles (1975) as "...a process in which individuals take the initiative without the help of others in diagnosing their learning needs, formulating goals, identifying human and material resources, and evaluating learning outcomes" (p.18).

The self-referrals were a deliberate effort to change and formulate a goal that involves a great deal of intrinsic motivation to change. The weight management clinic was an inclusion criteria to be eligible for the study, but the method of enrollment was not. The weight management clinic was an opportunity that was in each of their local environments. The weight management center was the setting for the learning, but the
process of getting to the clinic was often a result of a trigger. The self-referral aspect of learning is important to the Transtheoretical Model of Change (TTM). This acknowledges the TTM preparation stage, or the intention of changing. And the TTM’s process of change, consciousness raising as defined as an effort to seek new information and to gain understanding and feedback about the problem behavior (Prochaska & Velicer, 1997).

Secondly, all participants have tried to lose weight in the past and have recognized weight cycling and multiple failed attempts. When the trigger was dramatic enough to initiate the need and will to change, they recognized that they could not do it alone. As John said, “…I wanted to lose weight, but I was having a hard time doing it on my own.” Taking the initiative to identity resources to participate fully and freely regardless of the reason was self-directed. For example, Jane stated, “I didn’t get referred. I wanted to go, I wanted to do it. I was tired of being heavy and I saw other people go.” Similarly, John and Pam both said, “I approached them…” and “I want to lose weight, can you refer me?” Amy spoke of her experience, “I was trying different things. I was trying to be active and I was trying to watch what I was eating. I went to my doctor and I had asked for help.” Nicole gave details on her actions to look for additional medical help. She explained:

I just wanted to do something. I talked with my family doctor and I told her I wanted to lose and then she could tell me who to go to and then she recommended me to [weight management clinic]. That’s how I got here.

Many of the participants were surgery candidates at the weight management clinic. A few of the participants actually had intentions of having the surgery. John said,
“I have seen the success of that gastric bypass surgery from other people.” With John’s successful natural weight loss he reflected back on thinking why he initially elected to have the surgery, “I might have been looking for a quick fix.” This is not a unique feeling. Jane also felt similarly after losing weight naturally. She said:

I went through the whole program and I was within two weeks of getting scheduled to go to surgery and I backed out. By that time I had been walking 10 miles a day and had lost 92 pounds. I don’t have to go under the knife, I can do this.

Many of the participants also talked about self-imposed goal setting. Goal-setting revolved around individual experiences and life situations. For example Mike and Amy talked about their goals:

Mike: In the summer I direct camp for 4th, 5th and 6th graders. The year before here is a big hill across the road that they hike and I wasn’t able to do that. I physically wasn’t able to do it. I just could not get up there. I missed a couple of things with the kids that I couldn’t do and it was my decision that this time next year I was not going to miss any activities with the kids. I have to get in shape so I can continue to do this because it’s something that I enjoy doing in the summers.

Amy: I started to run and I started to set goals and I did a 5K and a 10K. This month I did a half-marathon. I’m just starting to check some things off of my life list now that I feel like I have a second chance at life.

Another example of individual initiative is through the use of technology and media. This learning often led to taking more interest in certain topics and continuing to
explore other areas of health and fitness. Nancy talked about a website called, Calorie King. She uses this site to, “Learn to make choices eating out. The Calorie King website is like a God-send. It is on my ‘favorites’ because it tells you the calories of things.” Amy also uses popular magazine websites for information. She was used popular websites like Muscle and Fitness Hers, Self Magazine and runners.com to find information on cooking and exercise tips. She says, “It is so easy to just Google something. I just Google something and of course, like I said the recipes come up and all the information is right there. I just think we all need to be aware.” Amy also used movies to learn about food preparation, “I started to see movies and documentaries about how food was prepared.”

The learnings from these movies led her to look into further information. She said, “Anything that just interests me it snowballs.” Technology and media has made Amy aware of her choices when she food shops. Technology and media provided information that otherwise many individuals would not have access to. For example Nancy said, “I read stuff all the time because a different perspective of different tips even helps you with recipes.” Participants also talked about the use of email and electronic newsletters as a way to gain knowledge on health and fitness.

**Acquiring and adopting skills.** In the study’s context the educational environment occurred for all of the participants in the form of a medical weight management program, or a non-formal adult learning environment. This is the environment where the participants with the help of a facilitator learned many of the tools and skills. This is an example of technical knowledge. Acquiring the knowledge and skills is the seventh step in Mezirow’s (2000) Transformative Learning Theory. But
without the opportunity to participate in discourse and critical reflection the skills and knowledge acquired at the weight management clinic, from a theoretical perspective may not have provided an avenue for transformative learning.

The medical weight management clinic provided the participants with a nutritionist. This individual was the educator or facilitator. In some cases the nutritionist and the participant worked together to create an individual understanding of the problem behaviors and created a plan that would fit into their lifestyle. Without this opportunity many of the participants would have never had the chance to learn the skills that laid the foundation for success. Mike said:

I think it was the things they [weight management clinic personnel] taught us. I don’t want to oversimplify it but it was some type of exercise dedicated activity. I don’t even want to say exercise. A dedicated activity program and portion control.

All individuals spoke about the key concepts that they acquired including, goal setting, stimulus control, and self-monitoring. Portion control, increased water consumption, weighing food, food journaling, and learning to read food labels were among the skills most talked about. The majority of these components of operate conditioning were seen as positive reinforcers. Once the behaviors were identified as providing results they were adapted into a lifestyle practices and not seen as dieting or punishment. For example, John said:

I think it was the things that they [weight management clinic] taught me. They were teaching you how to prepare healthy foods, portion control, chewing a certain amount of time just to slow down the process…only fill the center of the
plate, you know the smaller the plate because then it looks like more food, a lot of it is all in your because if you chew more and took your time while you were eating then you would fill up faster than if you woofed your food down really quick because your body doesn’t register.

Nicole uses a calorie guide that was given to her by the weight management clinic. She said, “I was given by my doctor a weight guide, it gives me all the calories of all the food there is and I go by that guide. The guide had all the foods in there, how many calories each one had, and how much you should eat.” This guide helped her eat properly. She remembered, “Before I was always hungry. I wanted to eat snacks and big portions of everything. I was always hungry so I ate almost all the time.”

Other important skills including proper portion sizes, reading food labels, and other healthy eating practices were taught at the weight management clinic. Nicole said, “I also look at the calories each thing has on the labels. I get a lot of fruits because I was told to eat snacks between meals. I also get diet stuff, like diet drinks.” Pam’s healthy eating practice is to “…get a salad dressing, I put it in a little bowl next to it, and dip into it so I feel like I don’t get as much.” When Pam goes out to a restaurant she also takes half her meal home. She said, “…we’ll get a big serving of meat and we’ll get a box and take it home…I [also] found out to my shock how big a tablespoon really is.” And Mike continues to track what he eats by using a food journal and has a steady exercise plan. The nutritionist helped Amy problem solve a common problem that she was having after exercising. She said:

Of course the one problem I would have would be after I’d exercise on a Saturday, which would be a longer period of time. I might go shopping
afterwards then all of a sudden I’d be famished and then I’d eat too much. She [nutritionist] would say, “Why don’t you pack a bar...this would be a good bar...like a Cliff bar or you can buy ones that do not have so much preservatives.” She worked with me and made a plan that worked for me, to know I don’t have to fit into a mold.

Personal, individualized plans that were facilitated in what was presented to be a non-didactic manner were adapted into the participant’s lifestyles and viewed as important aspect to success. Amy said, “I learned to adapt this into my lifestyle. Not a lifestyle that can generally fit into anyone else’s, but it is for my lifestyle.” Amy also talked about how she had to block other people’s nutrition advice. She said, “…what’s frustrating is what everyone wants to tell you to do. You can really get side-tracked by people saying, “I did this and this, and you should do this and that.” She talks about filtering this information and sticking to what she knows works for her. Pam said, “You get this image that there’s a magic fix. There isn’t a magic fix, but the actual fix is easier than people think.” Nancy spoke about finding the right ingredients that would work for her, she said, “It is forever. I’ve made changes that I can live with forever.”

Another example of individualized plans is that fact that the participants either had a philosophy of an ‘all-or-nothing approach’ while others gave themselves permission for guilt-free indulgences. Pam compared the approach to quitting drinking. She said, “…you just don’t have it around. You just don’t have the stuff in the house that you shouldn’t have.” Amy has similar views, “I have to eat a clean diet to lose weight. I have to have nothing extra.” However, Nancy allows an occasional indulgence. She
said, “…I always allowed myself indulgences because I have a heck of a sweet tooth. If I
didn’t allow myself an occasional splurge I know I would what would happen…”

In summary, many of the participants learned basic eating and physical activity
skills that were adopted as behaviors at the weight management clinic. The results
indicate that regardless of obesity prevention efforts including policy and the built
environment, education should be a top priority. As Pam reflects, “I think a lot of people
really do not know. My husband was shocked to find out how many calories were in a
glass of Coke.” Mike echoed this by stating, “…that’s the struggle with those of us that
have an obesity problem; what do we do, what tool do we have to help us, to help us
through the process?”

All of the learning, regardless of where and how mostly led to the participants’
understanding that they could lose the weight, finding what was right for them, and then
adapting these behaviors and new ways of thinking into their lifestyles. All of the
participants incorporated the knowledge that they learned in the weight management
clinic into their new, healthier roles/lifestyles. This learning had a positive impact on all
of the participants and helped each of them to successfully lose weight. In turn, each
participant gradually built his or her self-confidence and self-efficacy. The newfound
self-confidence and self-efficacy were key motivators for weight loss maintenance.

Motivation for Weight Loss Maintenance

All participants in this study were weight loss maintainers. The participants did
not have a weight loss surgery and there were no participants who spoke about
pharmacotherapy as having an influential role in their successful weight loss. Stories of
weight loss maintenance from these individuals provide great insight into weight related
issues and solutions. Learning processes that helped the participants lose and keep the
weight off were described in the prior section. However, with the cultural stressors and
food saturated environment that we live in, it is important to uncover the motivational
factors that keep them from weight cycling. When asked about the motivation several
subthemes emerged including self-worth and self-concept identity and helping
relationships. These themes are discussed in detail below.

**Self-worth and self-concept identity.** Undoubtedly, participant’s self-worth and
a positive self-concept developed after weight loss. When the majority of the participants
spoke about their experiences prior to losing weight, there were overtones of self-doubt,
low self-esteem and low self-worth. The dominant discourse of obesity which includes
overtones of individual responsibility and often includes words like, “choices”, “shame”
and “embarrassment” were seen among the study participants prior to weight loss
success. Amy explains, “I just always had something that I put before myself. I just
didn’t feel good about myself physically.” Many would participant in negative self-talk
and describe themselves by using words such as; “sloppy big”, “lazy”, “on medications”,
“miserable”, “cranky”, and “chubby”. They felt tired, unenergetic, and sluggish. Gail
remembers looking in the mirror and saying, “Wow, I’m ugly.” And Nancy said her
“self-esteem was in the toilet.”

The new feelings of a healthy body image was seen a motivator to continue
healthy behaviors. Post weight loss John and Mike feel more comfortable with
socializing. Mike talked about his past feelings of being social and how he feels today.
He said:
Again, it sort of gets back to the stereotypical thing. I sort of viewed myself like they’re going to think about me like “he’s a big fat guy”. And you know, now that I lost the weight I don’t think I’m any different but I sort of, it’s almost like I have confidence in the fact that they’re not going to be judging me along those lines.

In addition, John also believed in his ability to navigate eating environments without sabotaging his progress. He talks about holidays and family parties and how they are centered on food. John said:

Everything is centered around food, so I just have to really watch because I’m at the point now where they expect me to know and watch on my own, I don’t get people saying, “Hey, do you really want to gain all that weight back”. So, now that kind of stopped and it’s up to me to do it on my own.

Jane simply said that through her success she “Learned to love herself. I feel better about myself, I feel good.” Her self-confidence led her to get her teeth capped (she was always self-conscious about her smile) and to begin the “healing process”. She talks about this experience, “I’ll tell you what, it is the neatest thing I’ve ever done because not only am I healing, my feet are healing, and my mouth is healing.” Pam talked about her positive self-image as well. She said, “To be honest now I think I’m smaller than I really am.” This is very different than her past reflections of when she was gaining weight. She remembers that her husband told her that when she would gain weight it was like “…you’re putting on body armor.”

Almost all of the participants talked about yo-yo dieting and weight cycling as a previous constant battle. The physical changes were positively embraced by others,
which led to participants speaking about the positive comments others made to them. In many ways this was linked to increased self-concept identity which continued to be a motivator of weight loss maintenance.

John said, “If you look nicer, you’re going to feel nicer.” He said, “…everyone was more supportive, they said:

Wow look at you, you lost a lot of weight, how did you do it?” and I basically just told them, I just drank a lot of water and I was going for walks. I never went in any great detail, but it was just nice to see people notice.

Betty also talks about how she would receive compliments from her hairdresser, who was her walking partner in the past. As did Jane, “I’m very excited about everyone noticing me smaller.” Pam also talks about self-concept identity as a motivator. She spoke about the comments her relatives make when she visits, “Oh, you look better than you have in your whole life”. Mike said spoke about this as a motivator as well, “…it is a little of vanity I think because of the comments that people make to me.” He continues to talk about a recent experience. He said:

Even just today before I came over here I saw one of the staff, she works at [location] and she was on-site. Her dad was having a procedure and she walked by and saw me and said “Oh Mike good to see you. I just can’t believe how good you look.” She said, “Every time I see you I have to take a double take because I wasn’t sure.” I’ve seen her now for the last couple years and it’s, I think some of it’s that um but like I said I sort of hate to say that. It’s vanity.

A part of this new found self-concept for Mike is the ability to shop in regular store. He says, “That was a huge thing. That was big. I don’t have to buy the ‘big man’ stuff”
anymore.” For many of the participants there were implicit associations with *beauty as thinness* and *thinness as beauty*, which are dominant values in our culture. These messages of beauty and fashion were learned, often absorbed by advertising and media outlets. Amy also talked about the positive reactions that she got from friends. She said:

> They do tell me that they see a difference. But a lot of people see me gradually, but yeah, I was just with a group of people from college not too long ago and we were pulling the pictures from the last time we were together and they were like “Oh my gosh look at you from back then and look at you now.” So they can definitely tell a difference. It feels great.

This new found self-worth has led to increased self-efficacy, which is described as a person's perceived ability to perform on a task as a mediator of performance on future tasks and self-liberation, which helped many of the participants believe they could make the change and they were also committed to maintaining these behaviors (Bandura, 1977; Prochaska & Velicer, 1997). A change in the level of self-efficacy can predict a lasting change in behavior if there are adequate incentives and skills (Bandura, 1977).

With the increased self-image and self-efficacy the healthy eating and physical activity patterns continued, which had many medical and physical health outcomes. Pam talks about how she couldn’t climb the stairs in her office. Now she said, “I can run the stairs, three flights of stairs. I’m not really out of breath. I would have been puffing to the point where I would scare people and now I’m not. That is one of the biggest changes.” Many participants talked about lowering their blood pressure, getting off of medications, and no longer needing the c-pap machine. Pam remembers when her doctor told her, “You don’t have high blood pressure anymore. You just flat out don’t.”
Helping relationships. In addition to improved self-esteem and self-efficacy, participants also linked social support or helping relationships as a motivator for weight loss maintenance. In Taylor’s (2007) critical review of transformative learning research, transformative relationships were an essential factor in transformative experiences. From this theoretical perspective, this study provided preliminary evidence that interpersonal relationships, mainly relationships that offered trust, support, and friendship, were seen as key to sustaining motivation of a long-term behavior.

In this study, the relationships were of family members who offered acceptance, trust and encouragement throughout their weight struggles and more importantly after successful weight loss. There was only one participant, Nancy, who spoke about her unaccommodating husband, but she explicitly stated that he has never criticized her about her weight and he still encourages her. But he is not an active participant in the healthier behaviors of the family. She said, “He encourages me and he always says that the more I can lose the better my knee will feel. This is true.”

Unlike Nancy, Pam and Mike talk about how their partners are active participants in the behaviors. Pam talks about her diet partner being the motivation to keep her going. He partner is her husband who adapted the same eating behaviors as her. She talks about the importance of her husband’s support by saying, “that has been the most powerful motivator available. He didn’t do this because he wanted to lose weight. He did this to save me.” She continued to say:

My husband who also was really overweight said, “If you will do this, I will do it with you.” And so there’s only two if us and rather than us having to cook a diet meal for me and a regular meal for him, we ate the same meals. Both of us lost
a huge amount of weight. He lost about 200 pounds. And I would have never ever have been able to do it without my diet partner. This was a huge deal. The two of us keep each other honest.

Similarly, Mike spoke about how the help of his partner motivates him. He said, “We walk together, we have partner thing. I exercise with my wife.” He talks about how his wife and pet dogs help him stay motivated. He explains:

It’s getting into that habit of the old me…come home from work, sit down and relax. You know, have a snack, have a beer, and just sort of relax and then you know it’s like, “Oh my goodness it’s too late to go walking now. [Now] I go home, I change my clothes and go for a walk. That’s really it. It may sound stupid but the dogs are another thing. The dogs have that routine now, so if I don’t walk for the night, I mean they’re like nuts in the house.

Mike has embraced the success of the buddy system so much that it has led him to develop a walking program at his workplace. He said:

We are going to start scheduling a day that anyone who wants to come and walk, we’ll get a group and start walking…Getting back to the buddy system where if you have someone to do it with, you know, people are more apt to do it.

Nancy, Mary and Amy also had family members and friends that encouraged their healthy lifestyles. Nancy said, “My family, especially my kids, have tried to get my husband and I to eat healthier. They’re very support and encouraging of my efforts.”

Mary talks about her self-worth had helped her with finding a new relationship that motivates her. She said, “It wasn’t because of the success [weight loss] it was because I found someone that cares about me.” And Amy talks about participating in a CSA. She
said, “My boyfriend and I we took his kids and we took my daughter to the farm and we explained to them that we wanted fresh foods and we wanted to have things that didn’t have chemicals in it. Eat healthy – so let’s go see where our food is going to come from.”

This study found that helping relationships are an important aspect to weight loss maintenance. These relationships can provide the supporting foundation to continue healthy behaviors. However, although it wasn’t the majority, there were participants that spoke about family ‘pressure’ for losing weight. A few individuals recalled family members saying, “You need to lose weight”, or a father saying “For every pound you lose I’ll pay you $5.00.” Family pressure or even support without the readiness to change could backfire and have negative outcomes such as decreased self-esteem or feelings of being singled out.

**Summary**

The first three themes were related to the adult learning practices of the participants that were associated with the triggers that initiated successful weight change, the learning processes that were adopted into their lifestyles, and the motivating factors that continue to have influence on weight loss maintenance. Often the triggers that initiated change were not the same as the motivating factors to continue long-term behaviors. As Reyes (2012) suggests, these findings assume that with the correct skills and specific motivators there is hope that individuals can reverse the weight gain cycle and learn to cope and navigate through an obesogenic environment.

The next category of themes will explore how socio-cultural and political factors impact participant beliefs, perceptions, and attitudes of obesity. This section will
continue to examine how the adult learning themes may have manifested to larger undertones of culture, power, and identity.

**Identity, Hegemony, and Resistance**

The second category and following themes are related to the predominant influences and identity stressors that impacted the participants. The dominant system of obesity discourse creates and shifts culture that can influence eating and physical activity beliefs, values, and eventual behavior. The implicit messages that are channeled through reality television, comedians, sitcoms, and news coverage are how individuals read the world and create assumptions and beliefs on gender, race, beauty, and culture. This research was guided by a fundamental question wanting to investigate how individuals can succeed at weight loss and keep that weight off despite a deeply woven, saturated culture that communicates free choice yet discriminates against weight status.

Themes arose that captured broader concepts of media messages, the obesogenic environment, and identity. The first theme is cultural stressors. This theme is centered on media messages, stigma, and participant’s early identity to weight that had consequences on the participants worldviews that surround obesity and weight status. The second and final theme is related to obesity discourse. This theme is centered on the participant’s communication about their beliefs, values, perceptions and explanations of obesity post weight loss success.

**Cultural Stressors**

The theme of cultural stressors involved several subthemes: early identity to weight, entertainment media as pedagogy, and weight stigma and the fashion industry.

The development of a self-identity to weight at an early age impacted the participants’
self-worth. Secondly, the participants were asked to speak about the effects that media has had on their weight loss journey. The dominant media messages had interesting influences on participants’ decisions, values, and attitudes related to weight and obesity. Lastly, all participants have had past struggles with weight. Many spoke of early stigma and the need to be socially accepted. Clothing, dominant beauty, and fashion were seen as a symbol of success and social acceptability. All three subthemes are discussed below in detail.

**Early identity to weight.** The participants were asked to tell their stories and experiences about weight loss. Each participant began their story at different points in their lives, but many started in childhood. These childhood memories were still a very emotional story for the participants to tell. The experiences included discrimination, family pressure, and an internal identity to their external appearance.

Jane emotionally reflected on her earliest experience with weight. Her story started in 4th grade. This was the time when remembered hating being ‘heavy’. She spoke about a specific incident in her 4th grade nurse’s office. She said:

The teacher set aside time to weigh every student. We would go stand in a line outside the nurses’ station at the school and each child would go into the nurse’s office get weighed and, somebody would say their weight out loud and somebody would record it. My teacher was a wonderful teacher. He kept noticing that I would move from one child to behind another. I kept moving back to the end of the line so I wouldn’t have to get up there, get up there to go get weighed. Finally he noticed that and he came over to me and said, “Jane what’s, what’s wrong?” And I started to cry. He said “What’s wrong, why do you keep moving back in
the line?” and I said, “Because I don’t want anyone to hear my weight” because I was so upset about.

Jane remembered being bullied for her weight around the same time. She remembered the other students were very mean to her and they would say nasty things. In particular she remembered students calling her “gumby pants”. This was because she would have to wear her mother’s clothes to school. She said, “A lot of times she [mother] had to make me my clothes because back then…back in the 1970’s or so they didn’t have the nice clothes that they have today for full-figured girls.” Her weight steadily increased throughout high school.

John had similar experiences when he was a young child. He didn’t speak of school, but he did talk about a particular instance with his mother. He said:

When I was five I had my tonsils out and my mother told me that] after that. She kind of made a joke about it and said, “Your tonsils always blocked your food from going down.” But once I had my tonsils out everything just flowed freely. It was kind of funny. But from the time I was in grade school, all the way through middle school and high school I would gain weight.

Although there was no evidence of malice behind John’s mother’s words, most likely this was a playful banter between mother and son, but the impact was all the same. And Pam also spoke about a childhood memory that impacted her into adulthood. She stated:

I went through puberty early for someone in my generation. I was 11 years old. By the time I was 13 I had roughly the same build that I have now, only I was 13 and I weighed about 115 pounds. I was big for a 13 year old girl. I was bigger
than all the boys in the class. I thought of myself as a big person. I thought of myself as a tall person, even though I’m 5 feet tall.

Pam identified early with weight. She transformed these negative feelings into feelings of strength. It wasn’t until adulthood where she began to gain weight again. In fact, all throughout college her friends would call her “Little Pam”. Although society would most likely consider this a compliment, she never liked this nickname. She said, “I don’t think I liked that. I really don’t think I liked that at all.” It seemed that she hid behind her weight; her weight helped her from feeling vulnerable and exposed.

These stories negatively impacted the participants’ self-worth as a child. Individuals who are victims of this type of stigma often cope with unhealthy behaviors. Feelings of “being chunky” growing up, or being an outcast, or picked on does not have positive effects on the personal battle of weight loss that all of the participants eventually endured into adulthood.

**Entertainment media as pedagogy.** Media has a conscious and unconscious effect on “what” we think and “how” we thing about both social and personal issues (Tisdell, 2008). Media largely constructs obesity as one of these social issues (Saguy & Almeling, 2008). Media acts as public pedagogy, which refers to “the education provided by popular culture; popular culture teaches audiences and participants through the ways it represents people and issues and the kinds of discourses it creates and disseminates” (Sandlin, 2007, p. 76). The mass media is an example of the social acceptability of weight stigma (Heuer, et al., 2011).

During the interviews, each participant was asked to describe how television, movies, magazines or other types of media may have impacted their self-esteem or self-
image. The responses that emerged from this question resulted in three categories: a) Individuals could identify and reflect on examples of this type of popular culture and the impact that the messages may have had, b) Individuals understood that people could be impacted by the types of messages, but these messages had no impact on them, and c) Individuals were not impacted. All three examples will be discussed.

The first category provides examples of the types of media that may have left a lasting impression and the influence of this type of media exposure. For example, John talked about his feelings regarding the quest for a ‘perfect body’. He said, “I sometimes used to think, “Would more women like me?” or whatever, but it just is what it is and I can’t change what’s on TV, that’s just the way they’re portraying it.” However, he said that he never thought about the impact media may have had prior to weight loss. Most of his reflection occurred post weight loss success. He said, “I personally never really looked at it [media] too much, in that respect, but I think that since I lost the weight I noticed more.”

Jane also talks about how media portrays the perfect size of a woman. She said, “I was just talking to my mom about that [media]. Yeah it upsets me because there’s no, I don’t think… I think society sets the standard and says the perfect size woman is like a size 8. What’s a size 8?” She then talked about how a recent example of a television show, The Bachelor, where a man is searching for a wife. She said:

There are never, ever any heavy-set people on there, ever. You never see somebody that’s heavier set or maybe doesn’t have the best look or whatever, but they’re always blonde and long-legged, or dark hair and dark eyes, and there’s just beautiful. I’ve never ever once seen a heavy-set woman on any of those
shows. It makes me angry, because it isn’t real. And hello, I mean heavier people are married [laughter]. It drives me nuts.

Mike explained the impact that media messages regarding weight have influenced him, specifically about how overweight individuals are stereotyped into certain personality types or characters. He said:

In media the overweight person is kind of as the goof or the person that’s, kind of the fun goofy guy or girl….or the one that’s sort of the outcast. Nobody likes the overweight person or their sort of the outcast or they’re sort of the ugly one. This representation made him think about how he treats people based on a physical appearance. He said, “I think that that’s impacted me because I didn’t, I’ve never thought that way. I don’t treat people that way just because you’re thin and slender, nice-looking what I treat you any different than I treat anybody else.”

Interestingly, John thought that if America wants individuals to be healthy, then “they should focus on more healthy stuff if they’re going to put it on TV…they should promote healthy eating more than all this stuff they’re trying to promote now.” Pam spoke about The Dove Campaign for Real Beauty, a campaign created to encourage discussion around the need for a wider definition of beauty (Dove, 2013). She said, “There is a level of ‘skinny propaganda’, so to speak. Those Dove ads were really quite helpful, that showed women of all different sizes. I think those were like, well those actually made you feel better.”

Secondly, a few participants talked about how they recognize that popular culture has created an overweight actors persona, but this had little impact on their values or behaviors. Jane talks about a very famous actress, Melissa McCarthy, famous in the
movie *Bridesmaids*. She said, “There’s this one actress – Melissa McCarthy, she’s really funny. I’ve seen her in a couple of things and she’s pretty and when somebody’s heavy they say “Oh she’s got such a pretty face… if she’d only lose 100 pounds.” She went on to talk about how often an overweight person will overcompensate for inadequacies by having a bubble personality. However, she said that she never really felt that she did this. She doesn’t feel like this type of popular culture influenced her feelings. Similarly, Pam felt the same way; negative messages of beauty on television but little impact on her in adulthood. She said:

I’m sure [media had an impact on me] when I was younger, but if you’re talking about during that loss, it really didn’t. Because we just don’t want, we just didn’t watch television where that was an issue. If you’re watching *Law and Order* it’s not really an issue.

However, she does go on to say that she believes that these messages teach behaviors. She said, “I think it teaches people you have to be a size two.” She also comprehends that these types of unrealistic expectations may result in overeating. She said, “I think that it teaches us to disrespect our bodies. There is this, “I will never look like this. I’m going to go have more ice cream because it doesn’t matter anyway. There’s no way I can win.” She just didn’t think that these types of messages had an impact on her in adulthood.

Interestingly, Amy’s entire story had a theme of media literacy. She started to see movies and documentaries about how foods were prepared and the impacts on health and well-being. Movies and documentaries changed the way she thinks, feels, eats and shops for food – her value system changed. She talked about the impact the documentary *Super Size Me* had on her:
It just amazed me. We all knew how bad it was. We all know how bad McDonald’s is – it’s just disgusting. But to see how bad his health deteriorated in a year and what extra food was being put into salty foods – sugar was being added to it. What? Why? Why is that? Those are some questions you start asking yourself. What’s in the food that you put, you take off of the shelf? What’s in that?

Since then, she has seen a variety of other food-related documentaries and books. She acknowledges how much she learned from these films and how she now has the ability to critique and reflect on messages that she receives regarding food sources. This media exposure has directly influenced how and why she shops and cooks for herself and was a form of transformative learning.

Lastly, other individuals simply could not connect with popular culture as a means of education. For example, Betty said, “I never really thought about it that way [how media can have an impact of me].” Nancy said the same, “I don’t watch TV and those shows. It really has no impact on me at all.” Media messages in these cases were not reflected upon.

In summary, it is important to not only recognize but to also engage with the social and political influence of media in everyday life, especially for those in a marginalized group (Hoeschsmann & Poyntz, 2012). The majority of the participants talked about the unrealistic and unhealthy messages on health and wellness that are dominant on popular reality television shows, movies, and advertising. Many recognized the types of stigma through this type of medium, which often took the form of ridicule and unrealistic body images. However, no one spoke about the larger forces that create
and disseminate these messages, or why? The structural and social factors were not
commonly seen as having an immediate impact on the participants’, but they did not
argue that the messages may have impact on others. Yet, many of the participants’ spoke
about the unrealistic messages and images that are commonplace on television. They
viewed these messages as unrealistic and not attainable.

**Weight stigma and impact of the fashion industry.** Weight stigma is defined by
Puhl and Latner (2007) as “negative weight-related attitudes and beliefs that are
manifested by stereotypes, bias, rejection, and prejudice toward children and adults
because they are overweight or obese” (p. 558). Obese individuals commonly face
discrimination in employment, education, in the media, by family members, interpersonal
relationships and by their healthcare providers (Puhl, et al., 2005; Schwartz, Chambliss,
Brownell, Blair & Billington, 2003).

During the interview participants were asked to describe how people are acting
differently to them since they have lost weight. Surprisingly, there were not many of the
participants who spoke about unfair treatment or discriminatory events in the past, nor
did they speak about people treating them differently since they lost the weight.
However, as discussed above, many experienced weight stigma early in life as a child.
We know that weight discrimination occurs often and could it be the lack of awareness or
acknowledgment of stigma is a form of coping, or denial or self-preservation (Puhl, et al.,
2005; Schwartz, et al., 2003)?

Mike said that he never really felt judged about his weight but he did know of
others who experienced such discrimination. He said:
I don’t think… no not really. I mean I don’t think that to my face, I really don’t.

I think I’ve sort of been fortunate in that because I know some others that have or have heard anecdotal comments about how some people are treated. I think I’ve been fortunate and I don’t know what that is, but I don’t think that I’ve felt that.

However, he recognized that since he lost weight people talk with him more. He said, “It’s almost like, not that they excluded me, but it just seems like, they’ll initiate or come up to me, seems like more than what they did in the past.” He attributes this to his new self-confidence.

Other participants did not have experiences of others treating them differently. However, Betty did talk about how she thought employers wouldn’t want to hire someone who was obese. She said:

I know if an employer would see me, would probably not like me because I’m heavier than most people. Well I just think if you’re lighter they’re not as likely in some cases to hire somebody that’s overweight because it’s going to be a drain on their perspective of the person that’s in there. Most employers as I can see it like it if you’re not really heavy and they don’t need to worry about paying for insurance or whatever for your health.

This story speaks of the implicit associations that individual make with obesity, even for those that were once labeled as obese. And lastly, Gail talked about how she never really knew what heaviness was until adulthood and that she used to laugh at other people who struggled with weight.
Although experiences of stigma and discrimination were not expressed as an issue for many of the participants, a common theme among participants was clothing. The participants not only talked about clothing as a physical marker of dropping weight, they talked about clothing as normalizing into society. As they dropped weight, many were able to shop in the “normal” section of the stores. This was often described as a “huge”, “big” moment and a symbol of success. The participants talked about the larger size clothing not being stylish and a struggle to accommodate their shape. Mike talked about shopping in regular stores is a “huge thing”. He said:

I can shop for clothes in regular stores. I don’t have to go to the, I don’t have to shop at the JCPenny’s big man’s catalog anymore. I can go into almost any store and buy clothes. To me that was a huge thing. That was a big thing. I don’t have to buy the big man stuff anymore.

John also talked about stylish name brands and the better selection of clothing now that he lost weight. He said:

I’m able to buy nicer clothes because it’s harder to buy the really stylish name brands that I wanted to buy when I was bigger without spending $100 on a pair of jeans because they were specially made or something. Now I can buy jeans and shirts, whatever I want!

Pam talked about how she felt when walking through the misses section to shop for clothing. She said:

I tell my husband, this first time I walked out of the woman’s section of clothing in a store and over to the misses, I said, I wanted there to be music in the air like there would be in a movie, which just went “ahh” [laughter] because this is just a
miracle to me. I’m over here now and I haven’t looked at clothes this size in 15 or so years, and all of a sudden I’m going and saying, “Oh, well that’s too big.” [Before] I would go to JCPenney and buy plain black polyester pants and then 2, 3 months later I’d go get another pair just like it.

Lastly, Amy talked about how clothing is about how not only the fit, but the feel.

I guess shopping, when I shop [laughter]. That would be something – you want clothes to fit the way, the way they would on models. The self-image in the way [media] portrays… I don’t know if I get too caught up in that. Clothes are a big thing. You want your clothes to not only fit right; you want them to feel right on you.

These messages of beauty and fashion were learned, often absorbed by advertising and media outlets. Perhaps the clothing industry for “plus-size” individuals could be viewed as a discriminating source, even the label “plus size” holds implicit meaning. The event of shopping for clothing outside of the “plus size” section was a symbol of size acceptance and normalization. Nevertheless, there was a lack of discriminatory experiences based on weight and size, as opposed to what has been reported in the literature (Puhl, et al., 2005).

**Obesity Discourse**

The socially constructed fear of fat helps to drive values of thinness and often creates confusion, miseducation and continued controversy from a sociocultural perspective on how to approach the treatment and prevention of obesity. This social underpinning creates a personal responsibility positionality, which often comes with overtones of bad habits, laziness, and gluttony. Obesity discourse, in many cases led by
the media, often takes this position. The news media often dramatizes science by adding “fat in the fire” to shift blame to the individual and shaping obesity into a social problem (Saguy & Almeling, p. 53). Each participant was asked to describe what they thought was causing the overweight and obesity epidemic in the country. From a critical perspective, the purpose of this question was to explore the meaning making process and incidental learning that challenged belief systems and assumptions post weight loss.

**Belief system.** Changes in the socio-cultural landscape were seen as the main reason for increased weight gain among the population. The participants’ habits of mind were reported to be dominantly sociolinguistic, moral-ethical and aesthetically based. These changes were regarding family based practices, changes in the food laden landscape, technology, sedentary lifestyles, and the social acceptability of “bigger is better” messages. Only one individual spoke of laziness, signifying individual level causes of weight gain.

Participants reported that portion sizes and the arrival of “bigger is better” by restaurants were among changes in the cultural landscape that causes obesity as. As John said, “…the extra large everything. When you go to McDonald’s, they say, “Do you want to super-size that?”’, or whatever. It’s not even just McDonald’s – it is all fast food restaurants.” Similarly, Mike stated:

I see it all the time that ‘bigger is better’. The ‘double-stuff” this and the ‘super-size’ that. Not to pick on McDonald’s, but what I’m saying…everything’s ‘the bigger the better’. I remember even when I was younger the advent of buffets and the sort of – you can eat everything that you want. I think that has a lot to do with it.
The glorification of these types of foods through commercials was also seen having an impact. John said, “…they make everything look so good that you want to go out and buy it, you know?” Food quality, added preservatives and sugar in the foods were also talked about. Pam said:

Soda [is causing the obesity epidemic]. I think its soda, I think its sugar. I have to think that a major way you put on the pounds is through drinking them, pardon the word cola. You’re having another 150-300 calories with the meal. You don’t notice you’re doing it. So I think that’s a big deal.

Amy talked about the added preservatives in everyday foods. She said:

My daughter came home with these crackers the one time…I looked on the back and I didn’t know any of the ingredients and I Googled it and it was the same thing that was in, a chemical that was in lighters was in her food!

John even said, “I think they are brain washing people.” He never elaborated on who ‘they’ were, but I believe he thinks there is a relationship between the “…way everything is portrayed on TV”, the media outlets, and invasive marketing.

Secondly, the advances in technology were viewed as a cause of the obesity epidemic. Technology such television, smart phones, hand held video games, and computers were among the technology that was mentioned. It was believed that these advanced methods of technology encouraged a sedentary lifestyle and thus, weight gain. Jane said, “Children nowadays are all sedentary, they don’t go outside to play. We went outside to ride our bikes and played baseball and now kids come home, they look for their iPads, their phones, and their computers.” Nancy said, “Kids don’t play outside. They don’t know how to play unless they’ve got an electronic thing in their hand.” That
technology also impacted adults. She said, “I mean adults are occupied with electronic stuff like TV’s, but I think jobs are more demanding too and people are always trying to do better.” Betty said, “They eat and they go do whatever they’re going to do. It’s usually sitting in front of a television and not moving.” Television has also impacted family eating practices. Mike said, “I think some of it is our traditional mealtime is gone away. I think that to me was a big thing. If I go back even as a family with my wife and kids, we sat in front of the TV and watched it, we ate in front of the TV at times.”

Responses to body weight. In addition to the causes of obesity, participants were asked about how their reactions and how views of obesity changed through the process of successful weight loss maintenance. Responses revealed empathy and various levels of in-group support. Reflection of past perspectives of having gone through this struggle was evident. However, there were still undertones of personal responsibility and blame as supporting language behind many stories, supporting that claim that obesity is voluntary and linked to personal behaviors. The participants’ attitudes and perceptions will be discussed.

Pam, John, Mike and Nancy expressed empathy and less judgment of people who struggle with obesity. They reflected on their feelings and their past struggles with weight loss and weight cycling. They also recognized the multiple reasons why individuals become overweight and obese. The reasons, excuses, and suggestions for the cause of obesity will be discussed below.

Pam expressed empathy for obese persons struggling to lose weight. She expressed that she knows exactly how they feel. She said:

I look at people now [post weight loss], and I think we both do this, and think
“Oh, God bless your heart.” It means you don’t have to be this way. It isn’t hopeless. You can do something about this. Your feet hurt and your back hurts. You can’t find clothes. We know exactly how you feel – it’s just a feeling of, for me at least, of intense sympathy and knowing that these people think “There is no way I could ever lose this.” Because like me they’ve gained weight and lose weight and gained weight and lost weight…

Nancy also expressed sympathy for individuals with weight struggles due to the many factors that impact weight gain. She said:

Now, I am sympathetic with people who are heavy and who are trying [to lose weight]. I try to be less critical of people who are heavy because you don’t know what got them to that point because I was there once. I try to be less judgmental of others because I know that it’s hard to get it off and to keep it off. It’s a daily thing you have to work at. I read a lot of different things about different ways, different diets, and reasons for overeating. I don’t really think that I’ve changed but I try to be sympathetic of people and not be judgmental because I’m thinner. It doesn’t make them less of a person because they either choose to be that way or happy to be that way or can’t control being that way, or have a medical issue that that’s why they’re that way, because you don’t know their story.

Mike believes that individuals who are not socially labeled as obese do not truly understand the struggle. He said:

I view [obesity] more as the struggle that people have. I don’t think that unless you’ve been in it, you don’t know the struggle that those of us that are in it have. I work with a lot of great people and to see somebody that “I need to lose 10
pounds” and it’s like “Well, not really.” People struggling with, I feel overweight; I’m 2 or 3 pounds overweight. They don’t know what it’s like. They don’t know the struggle of being 100 pounds over, 50 pounds overweight.

Lastly, John spoke about the overwhelming feeling that he gets when he looks back at his life being obese. He said:

[Since I lost weight my view on obesity] I think it’s gotten worse. I don’t think it changed for the better. I think it’s upsetting for me because I know firsthand what it’s like. Just going through the whole process being overweight my whole life, I look at it and sometimes it’s just, it’s overwhelming.

Other examples of participant rhetoric have undertones of individual responsibility. For example, when John spoke about his life being overweight and the time that he wanted to spend with his daughter he said, “I didn’t want my life to be cut short because of my stupid decisions”. Jane also talked about how it was her individual responsibility to take control of her health. She said, “…if you don’t take care of your body, no one else will.” Participants, like Jane and Amy were mildly less sympathetic when describing their attitudes and perceptions on those that struggle with weight. Amy and Jane still discussed multiple causes for increased weight and reflected on their personal struggles. But their views also implicitly held increased individual blame; based on either physical appearance or bad habits and excuses. For example, Jane notices more people who are obese and how they look post her successful weight loss. She said:

I think that since I’ve lost weight I’ve noticed more people in society and how they look. And I think, “Oh my God how could that person let themselves go and be that big?” I don’t mean that meanly or like I was never that size, not at all.
I’m just saying that really you just need to stop and take a look in the mirror at yourself.

And it seemed that Amy struggled with the multiple factors that cause weight gain. She believes that drive and personality of a person contribute to weight loss success. She said:

I don’t know. Some people I do feel are obese and really try and other people, you just see bad habits and excuses. I think personality has a lot more than when you visually look at somebody.

There seems to be a balance of rhetoric that includes both intense sympathy, changes in society, and individual responsibility. Sympathy emerged when the participants reflected on their own personal struggles of weight loss. This suggests in-group connections. On the other hand, each participant personally made the voluntary healthy lifestyles decisions that impacted their weight. The argument for controllable choice was also evident.

**Summary**

In summary, this chapter provided the collective thematic analysis of the narratives from nine successful weight loss maintainers who were once seen in a medical management program. The stories that the participants have chosen to share were worth exploring. The thematic analysis was framed by the theoretical frameworks that grounded this study; Transformative Learning Theory, Transtheoretical Model of Change, Critical Public Pedagogy and Critical Media Literacy. There were two categories that emerged from the study; adult learning and identity, hegemony and resistance. Each category was broken down into themes.

The first category included three themes that were associated with the triggers that initiated successful weight change, the learning processes that were adopted into their
lifestyles, and the motivating factors that continue to have influence on weight loss maintenance. Participants described life events/transitions or health outcomes as the triggers that initiated the readiness to change. The triggers were both sudden and subtle changes in meaning schemes.

The examples of triggers from this study are consistent with the literature that acknowledges disorienting dilemmas or integrating circumstances as learning processes that facilitate action (Liberman et al., 2009; Lopez, 1997). This study found that both positive and negatively oriented circumstances were seen as triggers for the majority of the participants. This study supports the notion that the participants experienced a catalytic experience(s) that served as a platform to re-examine their health, body, or habits of mind, although not critically. The narratives that mentioned divorce and John’s birth of his daughter were the disorienting dilemmas that were most dramatic. Changes in health status could be seen as integrating circumstances that lead to adult learning and a need for adjustment in behaviors, this is not a unique finding (Phillipi, 2010). In Mezirow’s TLT, a disorienting dilemma could lead to the self-examination of feelings, and then a critical assessment of assumption. The participants did speak of intense emotions associated with a trigger. However, the majority of participants in this study did not seem to practice critical reflection or acknowledge critical reflection, nor did the participants talk about the opportunity to participate in rational discourse during their process of weight loss. These are key aspects to Mezirow’s (1991) Transformative Learning Theory that are prerequisite for transformative learning to occur.

The second theme focused on adult learning processes including where, and how the participants gained knowledge. From the participants’ stories it was evident that the
The majority of all learning occurred in either a non-formal educational setting or was self-directed. Self-directed learning is defined by Knowles (1975) as "...a process in which individuals take the initiative without the help of others in diagnosing their learning needs, formulating goals, identifying human and material resources, and evaluating learning outcomes" (p.18). In the non-formal setting primarily instrumental learning occurred. Technical knowledge, or instrumental learning, is learning that enables one to discover new skills (Cranton, 2006). The common learning processes revolved around the development of new activities, skills, and tools that enabled the participants to modify their behaviors or environments. Goal setting, stimulus control, and self-monitoring were among the key concepts. Portion control, increased water consumption, weighing food, food journaling, and learning to read food labels were among the skills most talked about. The majority of these components of operant conditioning were seen as positive reinforcers.

Motivation to continue long-term behaviors emerged as the third theme in the first category. The most common motivators were self-worth, helping relationships, and self-concept identity. The role of relationships in transformative learning is emphasized in the literature; although, the context of such literature is often in the form of group discussions and rational discourse (Taylor & Cranton, 2012). However, in Taylor’s (2007) critical review of transformative learning research, transformative relationships were an essential factor in transformative experiences. This study provided evidence that interpersonal relationships, mainly love relationships, which offered trust, support, and friendship, were seen as key to sustaining motivation of a long-term behavior. It should be noted
that the triggers that initiated readiness to change were not the same as the motivating factors to continue long-term behaviors.

In many cases, with few exceptions, motivation of long-term behavior was not a result of new found perspective. Mezirow (1978) defines a perspective transformation as “A structural reorganization in the way that a person looks at himself and his relationships” (p. 162). According to Clark (1991) there are three dimensions of a perspective transformation: psychological (changes in understanding of the self), convictional (revision of belief systems), and behavioral (changes in lifestyle). Behavioral changes were identified in all participants; however, there narratives provided less verification of changes in belief systems, or changes in understanding themselves.

The second category explored how socio-cultural and political factors impacted the participants’ beliefs, perceptions, and attitudes of obesity post weight loss. This section examined how the adult learning themes may have manifested to larger undertones of culture, power, and identity. The dominant discourse of obesity creates and shifts culture that can influence eating and physical activity beliefs, values, and eventual behavior. The implicit messages that are channeled through reality television and news coverage, among others, are how individuals read the world and create assumptions and beliefs on gender, race, beauty, and culture.

Cultural stressors were identified as the first theme in this category. This theme involved several subthemes: early identity to weight, entertainment media as pedagogy, and weight stigma and the fashion industry. Many participants spoke about childhood memories of weight that included experiences of discrimination, family pressure, and an internal identity to their external appearance. These stories negatively impacted the
participants’ self-worth. Secondly, entertainment media was identified as a means of developing attitudes and perceptions of weight and obesity. The participants either noted specific examples of the media that impacted their view; or they understood that these types of messages could impact people, but these messages had no impact on them; or thirdly, there was no reflection on media by a few participants. Several participants talked about the unrealistic and unhealthy messages on health and wellness that are dominant on popular reality television shows, movies, and advertising. Many recognized the types of stigma through this type of medium, which often took the form of mockery and unrealistic body images. Some spoke about how these messages as unrealistic and not attainable. Overall, the participants seemed to share a lack of awareness, opportunity and lack of knowledge around the bigger picture regarding the obesity epidemic, with few exceptions. There seemed to be an uncritical awareness of larger structures that impact the discourse of obesity and weight certainly widens the gap between those that struggle with weight and those that treat it.

Thirdly, there was little talk about discriminatory experiences in adulthood based on weight from the participants. This is not consistent with the research that indicates weight stigma is pervasive in many forums (Puhl, et al., 2005). However, the event of shopping for clothing outside of the “plus size” section was a symbol of size acceptance and normalization.

The last theme was obesity discourse. This included changes in meaning structures and responses to body weight by the participants post weight loss. Changes in the socio-cultural landscape were seen as the main reason for increased weight gain among the population. The participants’ habits of mind were reported to be dominantly
sociolinguistic, moral-ethical, and aesthetically based. These changes were regarding family based practices, changes in the food laden landscape, advanced technology, sedentary lifestyles, social acceptability of ‘bigger is better’ and other messages of the industry. Sympathy and in-group support was most commonly associated with responses to obese individuals. This was due to reflection of the participants’ past feelings of having gone through weight struggles. However, there were also undertones of personal responsibility and blame from supporting language behind many stories. This type of rhetoric supports the claim that regardless of the landscape, obesity is often viewed as voluntary and linked to personal behavior, even by those who were once obese.

The finds of the collective thematic analysis will help to provide implications for theory and practice. These will be discussed in the final chapter.
CHAPTER 6

CONCLUSION

The purpose of this narrative inquiry was two-fold: a) to explore the experience and meaning-making processes of individuals in a medically supervised weight management program who have lost weight and maintained that weight loss and, b) to explore how this learning manifested in successful weight maintenance and improved self-identity despite cultural stressors. This study employed conversational and unstructured interviews to elicit stories from 9 adult participants who successfully maintained a weight loss of 10-20% for at least one year and who were once enrolled in a medical weight management program.

Chapter Four presented the narrative stories from the interviews and each individual analysis. Chapter Five provided the collective thematic analysis which resulted in two categories and five themes. The first category centered on adult learning. The first theme was related to triggers that were grounded by health and life events. Secondly, learning processes were evident in the narratives and were either self-directed, largely instrumental knowledge and occurred in a non-formal environment. Thirdly, weight loss was seen primarily as a physical transformation motivated by increased self-concept and helping relationships. The second category centered on hegemony and resistance. The fourth theme focused on cultural stressors including the fashion and entertainment industries. The fifth theme focused on changes in obesity discourse post weight loss. The study ends with a consideration of the findings in light of the theory for adult learning and practical implications for strengthening subsequent intervention design.
The purpose of this final chapter is to assess major findings of the research, presented in Chapter 5, within the context of intersecting theoretical frameworks relating to adult education: Transtheoretical Model of Behavior Change (TTM) (Prochaska & Verlicier, 1997), Transformational Learning Theory (TLT) (Mezirow, 1991), and Critical Media Literacy as informed by Critical Public Pedagogy (Giroux, 2001, 2004; Heuer et al., 2011; Hoeschsmann & Poyntz, 2012). This is followed by an examination of the implications for practices within the field of adult education, and obesity treatment in healthcare. The chapter will conclude with recommendations for future research in adult education, obesity prevention, as well as other disciplines.

**Theoretical Implications**

The study revealed several key themes relevant to the participants’ experiences of weight loss and weight loss maintenance. These themes will be examined within the context of the theories that grounded the research, particularly TLT.

**Weight Loss Maintenance and the Exploration of Adult Learning**

All individuals have unique experiences. There is a need to understand these experiences as a human being. Transformative learning is the process by which these previously uncritically assimilated assumptions, beliefs, values, and perspectives are questioned and thereby become more open, permeable, and better validated (Mezirow, 2000). The rational and analytical process of Mezirow’s TLT occurs when individuals change their frames of reference by critically reflecting on their assumptions and beliefs and consciously making and implementing plans that bring about new ways of defining their worlds (Mezirow, 1991). Critically examining previous assumptions and beliefs
that result in new meaning can occur through a process of personal perspective transformative.

Anecdotal evidence from this study offer insights into Mezirow’s TLT and the learning processes in the context of weight loss and obesity treatment in healthcare. This section will discuss implications for TLT as related to weight loss maintenance and the study’s findings including; disorienting dilemmas/integrating circumstances, critical reflection, and rational discourse. All three of these concepts are important to the transformative learning process.

**Disorienting dilemma/integrating circumstances.** A *disorienting dilemma* is the initial phase of transformative learning (Mezirow, 2000). Mezirow’s (1991) theory, which is based on the individual, states that the disorienting dilemma sparks a process that forces an individual to begin self-examination of assumption and beliefs. A disorienting dilemma could be triggered by an internal or external life crisis or major life transition, although it may also result from an accumulation of transformations in meaning schemes over a period of time. These changes in meaning schemes over time are also called other triggers, or *integrating circumstances*, all of which may promote transformative learning experiences (Clark, 1993). Clark (1993) argues that integrating circumstances can also invite individuals into personal exploration. Integrating circumstances are described as missing contextual factors that allow for a person’s life issue to be resolved (Clark, 1993). These circumstances do not appear suddenly, instead “they are more subtle and less profound, providing an opportunity for exploration and clarification of past experiences” (Taylor, 2000, p. 299).
This study found that both positive and negatively oriented circumstances were seen as triggers for the majority of the participants. These types of triggers can engender deep emotions including; fear, stress, anxiety, and happiness. This study confirms the notion that the participants experienced a catalytic experience(s) that served as a platform to re-examine their health, body, or habits of mind. Study participant triggers were sudden or gradual and ranged from the birth of a daughter, divorce, a milestone birthday, or preparation for a wedding, high blood pressure, joint pain, among others. The narratives that mentioned divorce and John’s birth of his daughter were the disorienting dilemmas that were most dramatic. Changes in health status could be seen as integrating circumstances that lead to adult learning and a need for adjustment in behaviors, this is not a unique finding (Phillipi, 2010). In a healthcare setting an integrating circumstance could often be seen in the form of a diagnosis. These triggers such as life events/transitions and physical health status were characterized as events that created content reflection and a platform for eventual behavioral changes. Surprisingly, many participants described these triggers as transformative and life changing, yet when asked if they saw themselves differently post weight loss, the majority related the change to being only physical. Although it was evident that the triggers described by the participants led to action, the long-term impact of behavior still calls for further investigation. The triggers did result in almost immediate action; the long-term impact will vary depending on the additional individual learning experiences.

The examples of triggers from this study are consistent with the literature that acknowledges disorienting dilemmas or integrating circumstances as learning processes that facilitate action (Liberman et al., 2009; Lopez, 1997). Many of the integrating
circumstances described in this study provided an avenue for personal exploration that led to their individual need to change their health or appearance. The changes ranged from epochal to incremental (Mezirow, 1978). Although the health triggers are incremental changes in physiology and they did not occur over night, it may be that the communication of these health issues combined with other life circumstances were enough to shift readiness to change.

Findings from this study shed light on the particularly important triggers that occurred in the company of a physician. These triggers demonstrate the incredible impact the health care team can have in advancing or recognizing the readiness to change in a patient. For example, diagnoses, or narrative used by a physician within an encounter, or a visual of a weight plot are often the end of the transformational role in medicine. Often, little discussion between patient and physician, usually due to lack of time, does not permit the physician to elaborate on instruction or share information. Therefore, it is up to the patient to be developmentally capably of pursuing change outside of the hospital or clinic setting. Physician communication, motivational interviewing techniques and trusting relationships with the healthcare team may assist individuals in the weight loss struggle and serve as possible platforms to facilitate transformational learning.

Critical reflection and rational discourse. Two key concepts of Mezirow’s framework are critical reflection and rational discourse. Mezirow (1991) believes that critical reflection is a prerequisite for transformative learning to occur. Brookfield (2000) also agreed that critical reflection is fundamental to transformative learning. He said, “An act of learning can be transformative only if it involves a fundamental questioning
and reordering of how one thinks or acts” (Brookfield, 2000, cited in Merriam, 2004, p. 62). This questioning also involves hegemonic assumptions, which are important to the topic of obesity.

There are three types of reflection; content reflection, process reflection, and premise reflection (Mezirow, 1991). Though only premise reflection, or critical reflection can lead to transformative learning (Mezirow, 1991). Experience is essential to a perspective transformation taking place. This “experience” is socially constructed and it is the subject matter for transformative learning. Experience is what is critically reflected on (Mezirow, 1991). Critical reflection is the questioning of the integrity of assumptions and beliefs based on experience, including systematic, organizational, moral-ethical, therapeutic, and self (Mezirow, 1991).

Reflection is important after two phases of Meizrow’s (2000) ten-phase transformational learning; disorienting dilemma and self-examination. A disorienting dilemma is an experience that contradicts our previous thoughts, assumptions, and beliefs. And self-examination is a critical assessment of our socio-cultural, structural forces, or epistemic assumptions. However, as Taylor (2007) noted in his critical review of transformative learning literature, addition emphasis is needed in identifying and articulating participant’s critical reflection retrospectively.

Critical reflection can lead to dialogue with others, or rational discourse. Rational discourse is the essential medium through which transformation is promoted and developed. During this process, an individual will explore his or her newly discovered dilemma with others, either in a one-on-one or in a supportive group environment. It often involves those that have had similar situations of discontent and questioning and
where an environment is created to share how others have encountered the process of transformation (Mezirow, 1991). Mezirow’s (2003) definition of discourse is defined as “dialogue involving the assessment of beliefs, feelings, and values” (cited in Phillipi, 2010, p. 45). This type of opportunity can serve as a venue for non-threatening dialogue that can lead to a reframing of assumptions, critique and support new ideas, and behaviors (Mezirow, 1994).

Critical reflection or opportunities for rational discourse were not dominant themes in the study. However, there were individual cases where content and process reflection was evident. For example, Nancy reflected on her 60th birthday. She asked herself, “What kind of life is the rest of my life going to be?” Additionally, when asked about current reactions of obesity, post weight loss, reflection on many of the participant’s past experiences of being obese were clear. Increased sympathy, empathy, and in-group support were most commonly associated with present responses to obese individuals. However, when reflection was evident, it was often not in the form of premise reflection. One exception was Amy. Amy developed a process of critical reflection through watching movies and documentaries. She questioned where her food came from, what was in it, and why. This type of critical reflection shaped her behaviors, assumptions, and beliefs of the food system.

Furthermore, it was evident that the learning that took place within the weight management clinic was largely instrumental; comprised of banking knowledge that was disseminated by a dietician or physician. Although this type of knowledge is extremely important in weight management, there is a limitation if this is the only type of knowledge or learning available, because critical reflection cannot develop. From a
psychological theoretical perspective, many of the participants participated in learning that resulted in first order change; a change of existing activities that align with values and norms, without changing any aspects of the underlying paradigm of weight gain or weight loss (Frohm & Beehler, 2010; Waters, Marzano, & McNulty, 2003). However, transformational change requires a paradigm shift in how the problem is conceptualized. This is called a second order change and requires individuals to learn new approaches that are often in conflict with current values and norms (Frohm & Beehler, 2010; Waters, Marzano, & McNulty, 2003).

From the perspective of obesity treatment, Phillipi (2010) stated that if “adults cannot critically reflect they are dependent on others to create change. In these instances, health becomes a commodity provided by a practitioner or drug” (p. 44). Transformative learning should result in learners being able to assess the validity of knowledge or ideas of others, and not just to accept or act on ideas uncritically (Mezirow, 1997). This study offers additional anecdotal data that the weight management clinic has the opportunity to provide an environment for critical reflection and rational discourse. A healthcare setting can often be rushed and frequently providing information in a didactic manner. Mezirow (2003) suggests that adults must have learning capabilities in order to properly reflect and to understand the meaning of experiences – which means, adults must establish or development a capacity to be critically self-reflective and to exercise reflective judgment. Time for in-depth discussion and dialogue within a group or with a practitioner could help motivate critical reflection. Activities like journaling or support group settings within a weight management clinic can foster critical reflection and rational discourse. Furthermore, healthcare professionals and family members can aid individuals who
struggle with weight by helping to create their own form of narrative around important
events and make meaning of their experiences.

**Self-efficacy.** TLT was helpful in providing a framework for the cognitive
processes and meaning making. However, not specifically discussed as a part of the TLT
is the concept of self-efficacy. It is the TTM that includes this concept into its
framework. Self-efficacy research conducted by Bandura (1977) showed that the
perception a person has about his or her own ability to act out a specific behavior is
important in determining behavior change. Self-efficacy is an important concept in
weight loss, as research as demonstrated that weight gain has psychological and social
implications that can lead to lowered self-concept (Puhl & Latner, 2007).

This study demonstrates that a learning outcome of successful weight loss was a
new-found sense of self-efficacy, self-confidence, and positive self-image. When the
majority of the participants spoke about their experiences prior to losing weight, there
were overtones of self-doubt, low self-esteem and low self-worth. These new feelings
were seen as a motivator to continue healthy behaviors. These are not novel findings, as
Bandura (1977) and Prochaska and Velicer (1997) also found that new found self-worth
has led to increased self-efficacy and increased ability to perform on a task, and also a
commitment to maintaining behaviors.

**Weight Loss Maintenance and the Learning Process**

Two of the major themes that resulted from this study focused on adult learning
processes including *where*, and *how* the participants learned. The disoriented
dilemmas/integrating circumstances were often the vehicle that initiated the plan to
change, but the majority of the participants without prompting spoke about their learning
processes that revolved around activities, skills, and tools acquired. From their stories it was evident that the majority of all learning occurred in either the weight management clinic or was through individual initiation. For the purposes of this discussion the adult learning model and types of knowledge the participants spoke about will be discussed.

**Self-directed learning.** Self-directed learning is defined by Knowles (1975) as "...a process in which individuals take the initiative without the help of others in diagnosing their learning needs, formulating goals, identifying human and material resources, and evaluating learning outcomes" (p.18). The study’s narratives resulted in many of the participants seeking out information and resources around healthy eating and physical activity by means of technology and news outlets on their own. Many participants spoke about using the Internet to find healthy recipes, or reading popular magazines for exercise information. This learning often led to taking more interest in certain topics and continuing to research other areas of health and fitness. For example, Amy said that what she learned from magazines and movies changed the way she looked at food and shopped for food.

The other aspect of self-directed learning was seen when the majority of the participants self-referred themselves to the weight management clinic. This was a deliberate effort to change and formulate a goal that involves a great deal of intrinsic motivation to change. The weight management clinic was an inclusion criteria to be eligible for the study, but the method of enrollment was not. The weight management clinic was an opportunity that was in each of their local environments.

The self-referral aspect of learning is important to the TTM. First, the self-referral aspect acknowledges the TTM *preparation* stage, or the intention of changing.
And the TTM’s process of change, consciousness raising as defined as an effort to seek new information and to gain understanding and feedback about the problem behavior (Prochaska & Velicer, 1997). According to the TTM, consciousness-raising occurs during the precontemplation stage (Prochaska & Velicer, 1997).

**Non-formal education.** Non-formal education is described as learning that occurs in a formal environment not but formally recognized. The study’s findings resulted in all participants acquiring the skills to change behaviors in the weight management clinic. The clinic served as the non-formal educational setting that was one of the only aspects that was consistent for all study participants. The clinic helped the participants learn the basic health information and provided the opportunity for personalized plan of action. Portion control, increased water consumption, weighing food, food journaling, and learning to read food labels were among the skills most talked about. The participants described the key concepts that they acquired in the clinic including; goal setting, stimulus control, and self-monitoring. The majority of these learning processes was seen as a first order change and was components of operate conditioning and positive reinforcements (Frohm & Beehler, 2010).

The results indicate that regardless of obesity prevention efforts including policy and the built environment, education should be a top priority in obesity treatment and prevention. The learnings that provided the foundational evidence-based eating and physical activity information for the participants were a crucial aspect to their success. All the participants spoke about the benefits of these new-found skills and how they adopted these learnings into their lifestyles. However, the elements of learning in this environment were for the most part instrumental knowledge.
**Types of knowledge.** There are three types of knowledge suggested by Habermas (1971) including; technical knowledge, communicative knowledge, and emancipatory knowledge. The adult educator has specific roles that can foster the three types of knowledge. Because weight loss is multi-faceted, it is necessary for an individual to understand and be able to learn in all three domains. Technical knowledge, or instrumental learning, is learning that enables one to discover new skills (Cranton, 2006). This study confirmed that the participants’ spoke mainly about this type of knowledge that resulted in first order changes in the weight management clinic (Frohm & Beehler, 2010). This type of knowledge is common, because many weight loss treatment programs focus on behavior modification. Cranton (2006) uses the example of instrumental learning to become a skilled carpenter. The skills that one processes in order to be a successful carpenter can lead to a new way of seeing themselves and the world around them (Cranton, 2006). The simple equation of energy balance is comprised of skills that create energy expenditure or energy consumption; food shopping, preparing food, reading food labels, measuring portion sizes, proper exercise techniques, etc.

Secondly, communicative knowledge is learning about themselves, others, and social norms (Cranton, 2006). Relevant to a communicative learning domain, a transformative learning approach to weight loss can include aspects of critical reflection of assumptions, discourse, and reflective action resulting from a transformation of meaning structures (Mezriow, 1994). From a theoretical perspective, the study’s findings reveal that these aspects are missing in the participant’s stories. The goal in this context is for individuals to address change in a healthy way and in the way they learn, essentially to become an active participant in choices moving forward. Learners will let
go of old ways of thinking, coping, reacting, and their old sense of self and move toward a healthier version of self (Dirkz, 1998). From a psychological theoretical perspective, this would occur in second order change (Frohm & Beehler, 2010). By learning to use prior interpretations and experiences to create new revised interpretations, this can lead to a new perspective that may impact weight. Individuals should not just accept the information that has been presented, but participate in critical reflection. Lastly, communicative learning environment goes hand in hand with the third learning domain, emancipatory learning.

An emancipatory learning environment is established when the learners critically reflect on their old habits and become open to other viewpoints (Cranton, 2006). The educator’s role is that of a reformist (Cranton, 2006). A co-learning environment can be established, meaning the educator works with each student to find out about their lives and experiences (Cranton, 2006). The educator’s role goes well-beyond teaching learners how to select healthier food choices and learning about new exercises, but to provide an opportunity for reflection through critical questioning, and consciousness-raising activities that could include journal writing, role playing, integrating other ways of knowing through the use of the arts or dance (Cranton, 1998). From a theoretical perspective, the narratives uncovered that this type of learning was not overwhelmingly evident in the weight management clinic. However not exclusively, as one participant did reflect on old habits and changed frames of references by reading and watching food documentaries – but this was largely self-directed. By helping learners understand how their experiences have impacted harmful decisions with health, the learner may be able to
develop and realize their ability to participate in a fuller understanding of those experiences, which could lead to a healthier, permanent course of action.

All three of these learning domains could be embedded as core components of a weight management program. Most often instrumental learning is the primary outcome of a weight loss, or health education program. This research advocates for continued instrumental learning – providing the basic nutrition and physical activity skills that provide a foundation.

**Summary.** The findings from the stories demonstrate the need for the integration of adult education theories and principals in medical weight management, specifically those that facilitate transformative learning. Participant stories also show that weight loss and weight loss maintenance is fundamentally an individual progression. In the same way, the U.S system of healthcare reflects “American values of individualism and autonomy but may be poorly designed to address the patients’ larger health and development needs” (Phillipi, 2010, p. 40). However, the issue of obesity expands past the individual and involves society. That is why there could be a place in clinical weight management for patient’s to reflect on larger structural, political, and environmental components that have influenced behavior that has impacted weight.

Although long-term behaviors were evident in all participants this behavior was not driven by the result of a perspective transformation. Mezirow (1978) defines a perspective transformation as “a structural reorganization in the way that a person looks at himself and his relationships” (p. 162). According to Clark (1991) there are three dimensions of a perspective transformation: psychological (changes in understanding of the self), convictional (revision of belief systems), and behavioral (changes in lifestyle).
Behavioral/lifestyle changes was a theme in all participants, however, there was little evidence in the narratives of changes in belief systems, or changes in understanding themselves with the exception of a few individual cases. The problems surrounding obesity and the solutions that our modern medical paradigm currently offers are contradictory. From an adult education standpoint, there may be a place for critical adult education in the weight management service line that fosters critical reflection and rational discourse.

Uncritical Adult Education and Obesity

We live in an 'obesogenic' environment, characterized by messages, products, schedules, and places that promote increased food intake, unhealthy foods, and physical inactivity. The obesity epidemic is a complex issue that should involve government, healthcare, industry, media, family and individual efforts for collaboration and change. The implicit messages that are channeled through reality television and news coverage are how individuals read the world and create assumptions and beliefs on gender, race, beauty, and culture. This research was guided by a fundamental question aiming to explore how individuals can succeed at weight loss and keep that weight off despite a deeply woven, saturated culture that communicates free choice yet discriminates against weight status. What has not been well studied to date is the lived experience of successful weight loss maintenance in the context of the multi-dimensional viewpoints of obesity. Simply put, do individuals learn to deconstruct the exploitation of the messages received by so many factors – or is it a matter of utter strength of will?
This section will discuss the learnings from this study, which include five subsections; dominant discourse, uncritical awareness, obesity talk, “fattertainment” (Heuer, 2013), and the impact of the fashion industry.

**Dominant discourse.** The dominant discourse of obesity which includes overtones of individual responsibility and often includes words like, “choices”, “shame” and “embarrassment” sheds light on the ethical and policy questions which for the most part revolve around media and consumerism. In this study, many of the participants developed an early identify with weight and eventually struggled with weight issues. By sciences’ definition the study’s participants meet the criteria to be labeled successful. However, from an adult learning perspective only a few were able to critically reflect on their learning and on a system that impacted this weight struggle, as discussed earlier. Interestingly, through their weight loss success many of the individuals changed the way they view obesity. Overwhelmingly, this change included increased sympathy, empathy and less judgment towards those who continue to struggle with weight. This is an important finding.

Regardless of the integrating circumstances or disorienting dilemmas that lead to success, or their new feelings associated with weight, all participants wanted to change their weight to lessen further harm to themselves. This was based on his or her individual benefit, which ranged from the social context (e.g. fitting in social situations or finding clothing) to health outcomes (e.g. lowering blood pressure and joint pain). From a theoretical standpoint, this may indicate that there is a place for critical adult education as it relates to weight, size, obesity and media.
Rich (2011) states that it is crucial to recognize that when “considering these media as forms of public pedagogy, they can be understood in terms of their political and educational character and how they align with broader social, racial, economic, class and institutional configurations” (Giroux, 2008, cited in Rich, 2011, p 5). This includes issues of lookism and fatism as they are structured for public consumption. Overall, the participants seemed to share a lack of awareness, opportunity and ignorance around the bigger picture regarding the obesity epidemic, with few exceptions. The uncritical education and awareness of larger structures that can impact obesity discourse widens the gap between those that struggle with weight and those that treat it. Therefore, there is a need to address what the “productive power of obesity talk” does to those who suffer from it (Guthman, 2009, p. 1116). As Kellner and Share (2007) state:

It requires a democratic pedagogy, which involves teachers sharing power with student as they join together in the process of unveiling myths, challenging hegemony, and searching for methods of producing their own alternative media.

(p. 64)

For that reason, the next sections aim to discuss the study findings regarding uncritical awareness, the impact of hegemony and media and the intersection of critical media literacy.

**Uncritical awareness.** Participants acknowledged that media messages surrounding weight were often seen as having an impact on others’ behaviors and feelings. There was only one participant who acknowledged the need for structural and social changes to solve the obesity epidemic. Although instrumental learning occurred at the weight management clinic, questions concerning the why’s and how’s were not
addressed. The participants did not reference consumer awareness of larger influences of weight as a topic that was addressed in the weight management clinic. From a theoretical perspective, because of this, one may assume that participants will continue to struggle with assimilate to dominate messages.

Secondly, the majority of the participants identified early to an identity to weight. The social pressure linked to weight early on has been shown to have consequences (Puhl & Latner, 2007). These consequences include psychosocial health consequences including feelings of loneliness, self-blame, a devalued social identity, and lowered emotional well-being of a child (Puhl & Latner, 2007). These findings hold true in this study. Interestingly, it was found that many of the participants did not consciously recognize the negative impact that media messages had on self-esteem and body image. However, many were aware of the impact these messages could have had on them as children. And more importantly, many recognized that media created unrealistic expectations that could impact others. These preliminary findings may shed light on a space for adult critical media literacy in weight management clinics. From the perspective of critical media literacy, becoming critical consumers of media is an important skill to develop and will help with interpreting, critiquing and navigating through health messages.

Health professionals have been increasing recognizing that media have a significant influence of young people (Bergsma & Carney, 2008). Recent research has demonstrated that media have a negative effect in a variety of categories including; violence, body image, dieting and obesity (Bergsma & Carney, 2008). However, the systematic review by Bergsma and Carney (2008) was focused on youth. Critical media
literacy can involve adult participants in examining messages that may influence values, attitudes and behaviors. From a theoretical perspective, this type of education embedded in weight management may help adult participants navigate our obesogenic environment. However, further research will be needed with an adult population in non-formal educational settings.

**Navigating obesity talk.** The socially constructed fear of fat helped by obesity discourse drives values of thinness and creates confusion, miseducation and continued controversy from a sociocultural perspective on how to approach the treatment of obesity. The news media often dramatizes science by adding “fat in the fire” to shift blame to the individual and shaping obesity into a social problem (Saguy & Almeling, p. 53). A recent study found that while news media often view themselves as balanced, the participants from the study associated the news media as focusing too much on the problems of obesity, rather than taking a solutions-based approach (Holland, Blood, Thomas, & Lewis, 2013). Participants in Holland’s et al. (2013) study suggested that news media take responsibility for the potential impact of its coverage of obesity. This suggested that individual expectations for the media were seen in a higher light as compared to what is reasonable. John also suggested this notion during the interview. He stated:

I think they’re brain-washing people. I think they should focus on more healthy stuff if they’re going to put it on TV and they want America to be healthy then they should promote healthy eating more than all this stuff they’re trying to promote now.

News reporting that is interconnected with illegitimate medical science and inaccurate
messaging reinforces obesity to be framed as a social problem and highlights individual blame for weight status (Saguy & Almeling, 2008). A belief about obesity in the absence of supporting scientific evidence poorly inform public policy, develops inaccurate public health recommendations and creates confusion for the public (Casazza, et al., 2013).

**Entertainment media as public pedagogy.** Media has a conscious and unconscious effect on “what” we think and “how” we think about both social and personal issues (Tisdell, 2008). Media largely constructs obesity as one of these social issues (Saguy & Almeling, 2008). Media acts as public pedagogy, which refers to “the education provided by popular culture; popular culture teaches audiences and participants through the ways it represents people and issues and the kinds of discourses it creates and disseminates” (Sandlin, 2007, p. 76). The mass media is a compelling example of the social acceptability of weight stigma (Heuer et al., 2011). A great example is the notorious quote from the pilot show of Showtime’s hit television series The Big C (IMBb, 2013):

> Fat people are jolly for a reason. Fat repels people. Jolly attracts them. I know everyone is laughing at you're joke, but no one's inviting you to the prom. So, you can either be fat and jolly or a skinny bitch.

Stigma through this medium is often seen in a multitude of forms, from the constant ridicule of persons with obesity in television and film, to the media’s portrayal of blaming individuals for their obesity in the majority of news coverage, magnifying the individual level causes of weight gain (Heuer et al., 2011).

Many of the participants spoke about TV programming that impacted them, both positively and negatively. There were several programs that are acknowledged as having
negative messaging regarding weight. Jane spoke about *The Bachelor* as well as the movie *Bridesmaids*. When she spoke about *The Bachelor*, she said, “There’s never, ever any heavyset people on there, ever…and hello, I mean heavier people are married [laughter]. It drives me nuts”. Similarly, Melissa McCarthy, a female comedian actress is socially viewed as obese starred in *Bridesmaids*. She is often criticized for her size. Jane said, “I’ve seen her in a couple of things and she’s pretty and when somebody’s heavy they say “Oh she’s got such a pretty face… if she’d only lose 100 pounds.”

Then again, several participants spoke about TV programming that had a positive impact. Pam spoke about the positive message of *The Dove Campaign for Real Beauty*, which is a campaign created to encourage discussion around the need for a wider definition of beauty (Dove, 2013). She said, “Those Dove ads were really quite helpful, that showed women of all different sizes. I think those were like, well those actually made you feel better.” Amy learned how to critique media messages and the larger food system by watching documentaries. She reflected on the first documentary she watched, called *Super Size Me*. She said, “What? Why? Why is that? Those are some questions you start asking yourself. What’s in the food that you put, you take off of the shelf?”

The negative portrayal of weight in the media supports the continuation of weight bias, which has been linked to increased food intake and sedentary lifestyles (MedScape, 2009). Nevertheless, this study also produces anecdotal evidence that media has the opportunity to promote positive messages of size and beauty.

**The impact of the fashion industry.** Weight stigma is defined by Puhl and Latner (2007) as “negative weight-related attitudes and beliefs that are manifested by stereotypes, bias, rejection, and prejudice toward children and adults because they are
overweight or obese” (p. 558). Obese individuals commonly face discrimination in employment, education, in the media, by family members, interpersonal relationships and by their healthcare providers (Brownell et al., 2005; Puhl et al., 2005; Schwartz et al., 2003). This unfair treatment reduces quality of life and jeopardizes emotional, psychological and medical health (MedScape, 2009). This stigma has negative implications for winning the individual weight loss battle. And there is a multi-billion dollar weight loss and dieting industry that markets directly to individuals who are the victims of such discrimination.

Experiences of stigma and discrimination were not expressed as an issue for many of the participants in this study. Further research could examine the association of not being a victim of weight stigma and long-term weight loss maintenance; or if this was denial of discriminatory experiences, a positive coping tactic of self-preservation.

However, a common theme among participants was clothing. The participants not only talked about clothing as a physical marker of dropping weight, they talked about clothing as normalizing into society. Reyes et al. (2012) also found that both weight regainers and maintainer reported that the way their clothing fit was a primary marker of weight status. Beauty as thinness and thinness as beauty are dominant values in our culture. These messages of beauty and fashion were learned, often absorbed by advertising and media outlets. From a public pedagogy perspective the clothing industry for “plus-size” individuals could be viewed as a discriminating source; even the label “plus size” holds implicit meaning. It was common that the process of shopping for clothing singled the participants out. As they dropped weight, many were able to shop in the “normal” section of the stores. This was often described as a “huge” [Mike], “I have made it”
[Jane] moment and a symbol of success. The participants talked about the larger size clothing not being stylish and a struggle to accommodate their shape.

**Summary.** Media does its share in contributing to the “cultural politics” and “visual culture” of obesity (Holland et al., 2013, p. 9). In agreement with Holland (2013) and colleagues, this study suggests that there is a need for both prevention efforts and fat acceptance – not to legitimate fat, but to diminish anti-obesity discourse, which is perpetuated by the media. The themes in this study also show that there are still divergent responses from the study participants that shed light on different values systems and ethic groundings of the participants (Holland, et al., 2013). From a theoretical perspective this may suggest that critical media literacy may have a place in weight management curriculum.

**The Intersection of the Theoretical Frameworks**

A multi-disciplinary approach may be crucial to better understanding the complexity of obesity. The findings of the research shed light on the idea that no single theoretical framework is likely to explain the complex web of weight loss or weight loss maintenance and each theory used in this research leaves certain questions unanswered. This section will discuss the intersection of theoretical frameworks relating to adult education: Transtheoretical Model of Behavior Change (TTM), Transformational Learning Theory (TLT) and Critical Media Literacy as informed by Critical Public Pedagogy.

Health behavior change theories, like the TTM are useful conceptual models that can help to inform the processes of health behavior changes. Grounded in a behaviorist philosophical orientation, and developed around “cognitive-behavioral indicators” (Moore, 2005, p. 296) the TTM does not offer much value in understanding
how individual’s change over time. Whereas, TLT can add depth to the learning processes of health behavior changes and focus on how individuals learn to change their pre-disposed assumptions and culturally constructed perceptions over time. By converging an adult learning perspective, specifically TLT to the TTM, the ability to interpret meaning-making behind life experiences can be deeply examined (Moore, 2005).

There is an organic need to converge these two theories. As Moore (2005) stated, “both theories offer schemes of learning, changing, and growing for people seeking to make meaningful, life-transforming changes” (p. 394). It may be that adding the TLT lens to TTM provides a more holistic approach to represent “what the individual experiences and how to cope as she or he proceeds through the journey of transformational change” (Moore, 2005, p. 409).

Additionally, TTM helps to predict if an individual is ready to change, whether to include in an intervention, and to assist in guiding a change. TTM is primarily cognitive based, rooted in psychology and does not draw attention to how the individual’s experience impacts meaning, or how environmental or social factors may impact change processes. However, Merizow’s (1991) TLT is centered on the individual.

This research separates itself from the literature because this study examined how individual learning took place in relation to their weight loss through means such as media and other social spectrums. Critical Media Literacy and Critical Public Pedagogy are critical lenses to study the obesity epidemic due to the multi-faceted issues that involve both rational, cognitive constructs as well as the examination of the multiple psychosocial factors that impact weight.
Although the theories that grounded this research worked together to provide a framework to study weight loss maintenance this combination is not perfect and still leaves many questions unanswered. Although the practical need to study weight loss maintenance through the viewpoints of Critical Media Literacy and Critical Public Pedagogy is needed, these theoretical perspectives offer a unique set of assumptions and specific implications to practice that to do not connect with all the particular aspects of weight loss maintenance. As mentioned above both the TLT and TTM are centered on the individual. For instance, the TTM is a model of intentional change that focuses on the decision-making abilities of the individual rather than the social and biological influences on behavior as other approaches tried (Velicer, et al., 1998).

Another concern is the attention to context in both of the major theories. Both the personal, individual as well as environmental and social implications are evident in the weight loss process. These contextual factors are significant in the transformative learning process as well (Taylor, 2007). As Taylor (2007) stated, there has been a number of studies beginning to provide greater clarity to the nature of context and the connection to a perspective transformation, but further research is needed.

Lastly, there is a complexity of behaviors and learning that is associated with weight loss and weight loss maintenance. The research associated with TTM and TLT is mostly connected with a single behavior and there is criticism with the validity using TTM with more complex behavior changes (Brug, Conner, Harré, Kremers, McKellar, & Whitelaw, 2005). The same holds true with TLT, as there are only two studies to date that used this framework to explore weight loss.
Implications for Practice in Obesity Treatment Efforts

This study was approached by using multiple theoretical frameworks and intended to result in practical implications for weight loss interventions within a modern medical paradigm, as well as for adult education and overall obesity prevention efforts. Many studies have noted that weight loss maintenance is the hardest aspect of weight control, and those that do lose the weight eventually regain the weight overtime (Jeffery et al., 2000; Sciamanna et al., 2011; Wadden et al., 2007). It is evident that the participant stories revealed that successful weight loss maintenance is largely an individual progressive of adopting behavior changes and learning processes overtime with many obstacles and failures along the way. In many ways there is truth behind Callahan’s (2013) words regarding changing the system including the narrative around obesity. Callahan (2013) noted, “We need to change almost everything about the way we live, more or less simultaneously” (p. 34). Callahan (2013) goes on by stating that the reversal of obesity or long-term behaviors to reduce weight “requires changing the patterns, woven deeply into our social fabric, of food and beverage commerce, personal eating habits, and sedentary lifestyles” (p. xx). I argue that the patterns of our social fabric are created throughout our everyday lives including our habits and assumptions. Establishing healthy eating and activity behaviors are essential, but maintaining these behaviors permanently is difficult. From a clinical standpoint, “The single most important challenge in the clinical management of obesity is improving long-term maintenance of weight loss” (Jeffery et al., 2004, p. 100) and the motivational factors that help individual continue to have success is an important aspect to investigate and adapt into practice.
There are two areas of practical recommendations that are offered to increase the likelihood of long-term weight loss maintenance and achieve better health outcomes from both a healthcare and intervention design perspective. The first section is addressing obesity in healthcare and the second section is dedicated to intervention design implications. Both topics will be discussed in detail.

**Addressing Obesity Treatment in Healthcare**

Everyone you encounter has an opinion of the cause and a suggested solution to the obesity epidemic. In many ways, this is part of the problem that you see with treatment approaches and the rhetoric that surrounds this issue. Guthman (2007) states that as a result “fatness appears as a choice to disregard the rules” (p. 1126). Often the narrative in the medical paradigm rests on individual practices and is the “inversion of a public health model” (Guthman, 2007, p. 1126). The question still remains around if body size and weight should be addressed in a medical environment in the absence of connected health outcomes (e.g. labs, pain, etc.)?

To this point, after the data collection period of this study was completed, the American Medical Association (AMA) (AMA, 2013) declared their position that obesity is a “disease” (Hensley, 2013). The AMA (2013) stated:

RESOLVED, That our American Medical Association recognize obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention. (cited from Hensley, 2013)

This declaration caused controversy and the Associated Press continues to engage in dialogue around the pros and cons of this endorsement. As Saguy and Riley (2005)
discussed, “In the case of body weight, medical frames compete with political rights frames” (cited in Felt et al., 2012, p. 4). There are obvious economic and political repercussions of the AMA’s decision; beginning with the likelihood that with such a label many healthcare organizations will have to cover (pay) for medical interventions, and it seems likely that pharmaceutical companies will benefit from the development of new weight loss drugs (Hensley, 2013). Moreover, it is yet to be seen how this endorsement will impact the national conversation around subsidies and the food environment.

Nonetheless, the declaration creates a national discussion and more public attention to the continued debate of obesity positionality; societal or a morally based, individual responsibility approach. This is an example of the constant dialogue that obesity endures in the national spotlight; mixed messages that are politically grounded. To this end, it is not my intent to agree or not agree with this position.

As addressed in a previous section, media and industry do their part in providing the American public with information on the causes and cures for this issue in mass, in often an “alarmist” fashion (Saguy & Almeling, p. 59). From a theoretical perspective, this may perpetuate the creation of discourse that leads to miseducation, adopting questionable practices that lead to yo-yo dieting and ultimately failure resulting in weight regain. In a healthcare setting, particularly in an outpatient environment, there could be an assumption that a physician may have more success with activated or engaged patients. If this isn’t the case the physician or clinical team seeks to activate or engage his/her patients. Individuals who seek out information in a self-directed manner, evidenced in this study, were once engaged and activated patients – or at least a degree of motivation. But with the percentage of the population that fail at weight loss, these once
motivated individuals will become more and more discouraged and fail at individual self-management behaviors.

The healthcare community has an important role in delivering value-based healthcare and keeping the patient at the center of this approach. One of the ways would be to develop processes (or innovations) that are implemented by a trained workforce; working together to communicate effectively that would lead to quality medical care strategies and a better quality of life. The healthcare community has an opportunity to reduce stigma, reengineer the clinic workflow, and partner with local communities to create multifaceted approaches for long-term weight loss maintenance behaviors.

**Reducing stigma.** Research demonstrates that there are “substandard health care experiences for obese individuals (Puhl & Heuer, 2010, p. 1023). Patients who feel stigmatized about their weight are more likely to avoid routine preventive care, have lower healthcare utilization, and when they do seek health services their care may be compromised (Puhl & Heuer, 2010). When patients feel stigmatized, they are vulnerable to depression and low self-esteem, they are less likely to feel motivated to adopt lifestyle changes, and they are more likely to turn to unhealthy eating patterns for comfort (MedScape, 2009). One study found that physicians build less rapport with obese patients as compared too nonobese (Gudzune, Beach, Roter, & Cooper, 2013). It is known that the healthcare setting is a significant source of bias and stigma (Puhl & Heuer, 2010).

To address weight stigma in healthcare, strategies led by the Yale Rudd Center for Food Policy & Obesity (2011) range from straightforward ideas to improve provider-patient communication, to physical environmental changes in the office environment like
increasing the size of blood-pressure cuffs and offering large gown sizes (Medscape, 2009; Wang et al., 2004). Additional gaps exist in the medical healthcare team’s training on motivational interviewing and patient-centered approaches to obesity prevention and treatment. The modern medical paradigm could do more in this topic in preventive screening and lacks expertise in discussing and prescribing obesity treatment.

Professional development training for the healthcare team should concentrate on critical-reflection practices to help identify personal biases associated with obesity. A trained workforce is a vital link in the healthcare team’s success. These strategies could make significant strides in the reduction of bias in clinical practice but there have been limited qualitative studies or effectiveness studies that have examined patient’s reactions to these practices.

**Clinical workflow.** Given the modern medical paradigm, the healthcare team can take small steps to include a more patient-centered approach to the prevention, identification, and treatment of this disease using health information technology (HIT). There has been a widespread adoption of digital electronic health records (EHRs), including the Geisinger Health System, which has transformed the landscape of medicine. HIT should be leveraged to improve quality of healthcare. HIT can expand the impact of innovation within the healthcare setting and be used to design, implement, evaluate, and disseminate the learnings that can potentially reduce costs and improve clinical outcomes. This type of innovation can be used in the outpatient setting and focus on obesity prevention and treatment.

However, there is a balance with the use of technology and a patient-centered approach that is needed to help combat weight. HIT should not replace patient
interaction, rather be used to more effectively enhance and streamline communication between physician and patient. As Brendel (2009) noted:

A picture of meaningful medical care must not only focus on improving diagnostic and technological capabilities but should also aim to invite a patient’s narrative into dialogue, in line with a medical practitioner’s objective expertise, not beneath it, to empower the patient to embrace a more robust understanding of illness. (p. 28)

The patient should play a critical role in this approach. The adoption of HIT should be approached thoughtfully and take into account the current relationship between physician and patient and influence language used to address this subject. One possible recommendation is the clinical reengineering of the clinic workflow is to capture behaviors and attitudes prior to the encounter using mobile handhelds, or other modalities. The waiting room time prior to the encounter, for example, can be the environment to capture such self-reported data. The data that is captured could generate into the EHR and the provider would have the results. The patient could prioritize his/her concerns or needs associated with weight, eating, physical activity, that could lead to a joined narrative and individualized counseling and education. For example, if portion sizes were the concern, the physician would know this in advance. Knowing this information would create a context and allow the physician to understand individual challenges that the patient is facing and more importantly, ready to talk about. Understanding that there is often a lack of time during an outpatient visit, this would alleviate this pressure by using the waiting room time to more efficiently capture patient reported data. This type of care may build rapport and trust within the doctor-patient
relationship and enable joint goal setting, both crucial aspects to improve awareness, education, and risk factors for co-morbidities associated with obesity.

**Link to community resources.** Lastly, assuming the patient learns the skills needed to participant in a healthier lifestyle, both the availability of resources, access and cost to healthier options remain a concern. Partnerships with the community to advance the availability of fresh and local fruits and vegetables and physical activity venues would be create a link between learning and behaviors. The participants in the study came from a predominantly working class background. Amy mentioned that her grocery bills are expensive because she doesn’t “buy the stuff that’s cheap”. Access to healthy options is an issue in rural Pennsylvania and the medical community could leverage community partnerships to promote and align with farmers and recreational centers.

Providing practical guidelines and strategies for healthcare providers is a step in the right direction to offer care that is culturally sensitive, proficient, and equitable for all people.

**Weight Management Intervention Design Implications**

Focusing on the successful elements of weight loss within the specific issues of the complex web of obesity causes is the next logical step given the failure of almost all existing prevention approaches that start with the assumption that humans will act rationally in their best interest to change their behavior (Robinson, 2010). The results of the study suggest that regardless of obesity prevention efforts including policy and the built environment, education should be a top priority. It is important for individuals in weight management programs, who are eager to learn and change, feel supported on many levels from their medical providers. Negative experiences with their healthcare
system raise concerns that patients will have less success and more importantly have the potential to seek information from unreliable sources. Although the implications to practice is healthcare can be seen as intervention design suggestions, this section will focus on the adult learning components that are missing in current weight loss programs.

This study recruited individuals who participated in a medical weight management center and who have successfully kept weight off. There was a rigorous methodology used to query the EHR and to identity participant selection. We created weight plots and individually examined them to determine the likelihood that the patient experienced >15% weight loss as a result of the visits with the weight management clinic and whether the weight loss was maintained for at least 12 months. However, this resulted in only 28 participants. This is evidence in and of itself. All participants spoke highly of the program component, physicians and dieticians, and related what they learned in the weight management clinic as the foundation to their success. Nevertheless, there are several recommendations from an adult learning perspective that could enhance the critical components needed to facilitate transformative learning experiences and ultimately long-term behavior changes in this environment.

From a theoretical perspective, critical transformative learning and critical media literacy and communicative knowledge could be facilitated and recognized as an important factor in adult weight management. Brendal (2009) stated that exploring transformative learning in weight loss can “accelerate the pace at which a medical culture in the United States shifts its expectation to create critically reflective patients” (p. 29). Using components of transformative learning theory in a weight-loss context may help
identify barriers to the change process and help clinicians and educators become facilitators of change in a medical setting (Dubouloz et al., 2010).

This section focuses on how weight management programs can facilitate transformative learning by focusing on critical reflection, rational discourse, and developing interventions that are grounded in humanism rather than just behaviorist approaches.

**Fostering critical reflection and self-knowledge.** Reyes (2012) concluded that weight loss maintainers reported having greater positive self-talk, self-efficacy, and problem-solving ability. Although this study did not compare regainers to maintainers, similar aspects of self-efficacy and a focus on individualized plan for success and problem solving were evident. Cranton (2006) noted that if the educator sets an environment to empower students, transformative learning can occur. Two key aspects of transformative learning and weight loss are critical reflection and self-knowledge. If a person is overweight and is in a program to lose weight, asking questions is a key to uncover assumptions and frames of references. Questions can be an effective tool to begin conversation or to open up areas of prior concern and bring new understanding and new ways of thinking (Cranton, 2006). Why are they engaging in this habit? What prior experiences lead to this happening? This was seen in Amy’s story and the power of asking questions. She said:

- What? Why? Why is that? Those are some questions you start asking yourself.
- What’s in the food that you put, you take off of the shelf? What’s in that?
- In the context of weight loss, premise questioning, which gets to the belief system in a sociolinguistic domain and is at the core of critical theory is important (Cranton,
These questions can help individuals recognize power within society. Premise reflection can help vulnerable populations realize the true value of self and help to identify power structures of government or media that help to create this blame. Secondly, consciousness-raising activities are also important when developing a weight loss treatment program. “Consciousness-raising is breaking free from one-dimensional thought, understanding and unmasking power structures, recognizing hegemony, and critiquing social ideologies (Brookfield, 2005, cited in Cranton, 2006, p. 143). This can occur when exposed to different perspectives.

Evidence from the narratives indicated that the majority of participants in this study did not practice critical reflection or acknowledge critical reflection, nor did the participants talk about the opportunity to participate in rational discourse during their process of weight loss. However, participants were asked about how their reactions and how views of obesity changed through the process of successful weight loss maintenance. Responses revealed empathy and various levels of in-group support. Some critical reflection of their past perspectives of having gone through this struggle was evident. But undertones of personal responsibility and blame were still supporting language behind many stories; supporting the claim that obesity is voluntary, the result of laziness, and linked to personal behaviors. Aspects such as critical reflection, critical questioning, and consciousness-raising activities could be embedded in weight loss program, which can help to foster transformative learning and uncover the assumptions, values, and beliefs that are associated with obesity discourse.

**Adopting a humanist approach.** In humanism, individuality is valued, and therefore a behavior cannot be predicted because of the unique differences of all people
A humanistic weight loss approach would promote one’s individuality by getting to know each person and pull out each person’s special talents and skills (Elias & Merriam, 2005). Personal, individualized plans that were adapted into the participant’s lifestyles were seen as important aspect to success and a key finding in the study. For example, Amy said, “I learned to adapt this into my lifestyle. Not a lifestyle that can generally fit into anyone else’s, but it is for my lifestyle.”

It is in a humanistic weight loss approach where reason is an important quality. Combined with compassion and empathy, humanism focuses on the whole person (Elias & Merriam, 2005). A behaviorist weight loss program would look exactly the same for each person. A humanistic approach would be tailored to fit the needs of contextual, historical, genetic, and spiritual aspects of an individual. For example, a 1,200 calorie diet from a packaged commercial weight loss program would not always meet the needs of a diabetic individual with a vegetarian background.

Additionally, self-concept and perception are important to address in weight loss treatment (Elias & Merriam, 2005). Self-concept is “a person’s subjective evaluation of who he or she is” (Elias & Merriam, 2005, p.121). Increasing and examine self-worth, especially in the context of the heavily stigmatized disease of obesity, should be a high priority in a treatment plan.

It would be beneficial to move beyond the one-dimension of the overweight individual, but also involve those that are close to that individual, family, and friends. In addition to improved self-esteem and self-efficacy, participants also linked social support or helping relationships as a motivator for weight loss maintenance. Mainly, the relationships were of family members who offered acceptance, trust, and encouragement
throughout their weight struggles and more importantly after successful weight loss. In fact, prior to bariatric surgery it is common to counsel the spouse of the individual to confirm that they are supportive of the decision (Kral, 2001).

Lastly, another key concept of humanism is perception. Humanists believe that perception can explain behavior (Elias & Merriam, 2005). A person’s perception is one’s attitudes, beliefs, feelings, and values (Elias & Merriam, 2005). A humanist understands that in order to change behavior, one must gain insight on their perception first. Finally, responsibility and humanity are the last assumption of humanism values (Elias & Merriam, 2005). Humanists understand that individuals are social by nature and that interaction with others can recognize “the common humanity of all people” (Elias & Merriam, 2005, p. 122). Group sessions, or support groups are a good example of how the last few assumptions of humanism can be achieved and expressed in a weight loss context. Support groups can influence the positive aspects of group dynamics and discussion. Mentoring relationships with the facilitator, reliable experts, and a trusting environment where individuals can be open to sharing, and analyze their experiences is seen as a supportive tool. Support groups or helping relationships can also build a bridge to new relationships and new actions, which build self-efficacy, competence, and responsibility to the greater good of society.

Creating a weight loss treatment plan that focuses on aspects of an individual’s perception, life experiences, responsibility, and self-concept can lift the spirit of an individual who has most likely not been heard in society. Involving both the affective domain as well as the cognitive domain could potentially increase an individual’s success in permanent weight loss.
Limitations and Suggestions for Future Research

There were several limitations to this study. The first limitation related to the research design. The quality within using qualitative methods is dependent on the skill level of the researcher and the biases he/she holds. Therefore, the validity of the findings is often related to the objectivity and credibility of the researcher. Secondly, qualitative research results are not usually generalizable to a larger group. This research project recruited a small scale of participants from the same weight management clinic in rural Pennsylvania. Due to this location and small number of participants, there is a lack of diversity and the results may represent views of the dominant culture. Thirdly, the semi-structured interviews did not capture key demographic information such as income, educational level, and race/ethnicity. Without the collection of these variables it is difficult to make associations of individual weight loss experience as it relates to social class, gender, and race. And so, the stories from the participants may not express the same experiences from other parts of the state or country.

Taking these limitations into account, the agenda for future research is vast. There are three main areas that were identified through this study that focus on future research: a) to continue to study transformative learning in weight loss maintenance using quantitative methods; b) to continue to study the typology of patients that have learned to navigate our environment and successfully lose weight; and c) to explore how critical media literacy can be used positively as an educational tool in obesity treatment.

To date, there has been considerable attention to the concept of transformative learning and the identification of transformative learning due to health status; the adult learning literature often refers to people being transformed, or changed by the experience
living with a chronic disease or a new health status. Although this study did not have overwhelming evidence to support the concept of transformative learning or generalize a perspective transformation in this population, the results still have significant contributions to the adult education and obesity prevention fields. The findings from this research provide a platform of qualitative data to continue to study the experience of weight loss maintenance through a critical transformational learning lens. Additional qualitative methods should be used to continue to study how those who have transformative experiences reflect on power structures in the social context those experiences. Furthermore, research is needed to explore if individuals who have successfully lost weight and kept it off reflect on hegemonic assumptions or other structural forces.

Moreover, many of the participants in this study seemed to learn the instrumental skills that were timed correctly with a trigger to personally navigate their obesogenic environment. However, individual responsibility and a moral compass were still undertones of why they were obese and more importantly a factor in their success. Internalized language of “my stupid decisions” was evident throughout the stories. There seems to be a balance of personal choice and the toxic environment we live in. Increased awareness and instrumental learning may not be enough to shift worldviews. Even though cultural stressors were seen a cause of the obesity epidemic, this knowledge was trivial.

There is also a need for more quantitative research methods in transformative learning. Studies should look at population-based weight loss success. The results of the study provide anecdotal evidence to support that weight loss and weight loss maintenance
is an individual progression. We still know little about the typology of individuals that have learned to navigate our environment and have maintained weight loss. Cross-sectional and comparison designed studies could be used to focus on the prevalence of weight loss maintenance and could more closely pin specific patient typologies or characteristics that could provide data to facilitate transformative learning in practice. Specifically, there is a need to focus on the role cognitive development and the ability to have transformative learning experiences (Merriam, 2004).

Thirdly, additional research is needed to determine how media education can be used as a form of adult education in weight management settings. Studies should focus on both health and behavioral outcomes. Research to date has indicated that participation in mass media health campaigns are of women from a higher socioeconomic group, which is commonly associated with already healthier health practices (Miles, Rapoprt, Wardle, Afuape, & Dunman, 2001, cited in Boyce, 2006, p. 202). This is important because the critical media literacy curriculum is generally in the pedagogical environment rather than having adults as the target audience and the participants from this study were mostly from an observed working class background.

Lastly, further research is needed to understand how gender, age, sex, and spirituality is associated with people who are and who are not identified as obese and how they view media and other entertainment venues. To what extent do media impact cultural perspectives of weight and body size? Implications for such research aims to provide evidence for the need to formally address media’s impacts on behaviors, attitudes, perceptions that impact adult weight and could potentially provide additional recommendations for media guidelines, standards for advertising and other mass
communications involving weight and size.

**Final Reflection**

“*Transformational learning ultimately shapes people; they are different afterward in ways both they and others can recognize*” (Clark, 1993, p. 47).

Indeed, this journey was a gradual transformation of my own assumptions, beliefs, and values as they relate to health and humanity. The beginning of this journey was driven by my own personal passions. Yet, the process was a test of stamina that eventually needed to be fueled by mental, physical, and emotional energy. I have learned a tremendous amount about my profession and myself; it was truly a transformative experience.

During the process of this research I had the pleasure of meeting the fascinating, deeply moving individuals who shared their stories of weight and how long term weight loss is possible. They have taught me more than they know. Each of these individuals, who have long standing history with weight struggles, eventually created a personalized, unique way to keep the weight off. It was rewarding to understand their learning and change processes. It is also important to acknowledge that the many of the participants believed in sharing their story in the hopes that it would help others. For that I am grateful.

I embarked on this research as a naïve student who had a picture of what successful weight loss maintenance looked like; completely transformative, full of vibrant healthy, active individuals who have learned a deep appreciation for exercise that impacted their worldviews completely. During the interviews, I was struck at how
emotional the stories and words of the participants were. Deep, poignant life experiences have shaped their identities and the ways they have learned as adults.

I found this study both rewarding and challenging. This study forced me to look at my own assumptions, beliefs and values as they relate to weight; to challenge my own implicit associations and biases as they relate to our visual culture. Because of this, I have deepened my own practice as a researcher and am constantly looking for innovative ways to approach obesity research in a healthcare setting. As an adult educator with a focus in public health, I have always deeply believed in social change and multidisciplinary approaches to establish depth within a practice. However, this study has reminded me once again that there are individuals behind the public health agenda; all unique, all with their own story. It is to that point that I will continue to urge media, science, and our medical field to work together in a solutions-oriented, ethical way of understanding that behind news or research articles there are individuals.

There is hope however, that with the right tools, facilitation, learning and mindset, there seems to be the recipe for successful weight loss maintenance. As adult educators who work in the research, medical, or the obesity prevention field, it is our responsibility to adopt adult education theories and practices as they relate to all health and wellness initiatives and participate in this facilitation.

At the center of value driven healthcare, there is enormous job in continuing to learn and deliver best practices to increase the ability to deliver high quality care and a positive patient/family experience. My hope is to continue to share my new knowledge with the integrated health system I work for, to foster public and private collaborations, and continue to involve patients and their families while acknowledging individual
preferences and values so that as a system we can continue to deliver the best care we can. Ultimately, my vision is to have patients and their families get the best healthcare possible so they can live happy, socially equitable, and healthy lives.
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Appendix A. Participant Recruitment Letter

Geisinger Center for Health Research
100 North Academy Avenue
Danville, PA 17822-4400

Date

Full Name
Address
City, State, Zip

Dear (Insert Name):

As a member of the Geisinger Center for Nutrition and Weight Management you are being invited to participate in a research study about successful weight loss maintenance. We are trying to learn more about how you lost weight and kept it off. The Center for Health Research is conducting the research as a part of a dissertation study (thesis or final project) that is in collaboration with Pennsylvania State University.

Participation will involve an interview that is recorded to learn more about your story of successful weight loss maintenance. Your story is important to help us understand how individuals lose weight and keep it off.

Your decision on whether to take part in this study is voluntary. Your care at Geisinger will not be affected by your decision to take part. We respect your privacy and will keep your responses confidential. No personal information about you has been or will be released to Pennsylvania State University. If you decide to participate you will receive a $20 gift card to thank you for your time and participation.

The Center for Health Research will contact you in 10 days to discuss the study and interview times. If you are not interested in participating, please opt-out by calling toll-free at 1-866-XXX-XXXX, Option X.

Sincerely,

Christopher Still, DO
Director, Center for Nutrition & Weight Management
Geisinger Health System

Rebecca A. Staznett, MPH
Sub-Investigator
Center for Health Research

If you have questions about your rights as a participant, please call the Geisinger Institutional Review Board (IRB) at (570) 271-8663 identifying study # 2012-0350

Version: 09/26/2012
Appendix B. Guiding Interview Questions (Un-structured Approach)

1. Tell me about your experience of weight loss.
   a. What made you want to lose weight?

2. Tell me about a typical day in your life when you were overweight?
   a. Please tell me about how you thought about or would describe yourself to others prior to your success?

3. How did you know you were ready for change?

4. Through this journey, how did you change?
   a. How do you feel about or describe yourself now?
   b. What changed the most?

5. How do you stay motivated to maintain your weight loss?

6. Describe how television, magazines, movies, etc. affected your self-image.
   a. Could you please give me at least one example of that?

7. Have you ever experienced weight bias/discrimination?
   a. Can you describe this experience?
   b. When you walk into the room of people who knew you at a larger size, how are people acting differently since you’ve lost weight?

8. What do you think is causing the overweight or obesity epidemic in this country?

9. Is there anything else you would like to share about your experience?
CURRICULUM VITAE

REBECCA A. STAMETZ

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EDUCATION

1999-2002   BS, (Exercise Science), Bloomsburg University, Pennsylvania, PA
2003-2004   MPH, (Community Health Education), East Stroudsburg University, East Stroudsburg, PA
2009-2013   DEd, (Adult Education), Pennsylvania State University, Harrisburg, PA

PROFESSIONAL EXPERIENCE

2004-2007   School and Community Program Coordinator, Pennsylvania Advocates for Nutrition and Activity, Penn State University Outreach, Harrisburg, PA
2007-2010   Campaign Coordinator, Penn State Hershey Center for Nutrition and Activity Promotion, Penn State College of Medicine, Hershey, PA
2010-2011   Project Manager I, Geisinger Center for Health Research, Geisinger Health System, Danville, PA
2011-2012   Project Manager II, Geisinger Center for Health Research, Geisinger Health System, Danville, PA
2012-2012   Research Associate, Geisinger Center for Health Research, Geisinger Health System, Danville, PA
2012- Current Operations Lead, Clinical Innovations Research & Evaluation, Geisinger Center for Health Research, Geisinger Health System, Danville, PA

SELECTED PUBLICATIONS & PRESENTATIONS


Stametz, R. A. (2013, November). Conversations with Adult Weight Loss Maintainers. Poster presented at Obesity Week, Atlanta, GA.


HONORS AND AWARDS

2002   Pennsylvania State Athletic Conference Champions, Bloomsburg University Women’s Soccer Captain
2004   President’s Certificate of Recognition, East Stroudsburg University