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Experiences With Weight Loss Triggers in Women Prescribed to Lose Weight by Their Physician

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Abstract

Background: With the global rise of individuals classified as overweight and obese, weight-related screenings have been promoted to combat their high prevalence and associated health problems. Hopefully, such screenings can act as a 'trigger' for health behavior change, however little is known about the experience of weight loss triggers.

Objectives: The aim of this study was to elaborate on the experiences and meanings of weight-control triggers in a sample of overweight women prescribed by their physician to lose weight.

Patients and Methods: We conducted exploratory qualitative interviews, grounded in phenomenological practices, to elaborate on the experience and meaning of weight loss 'triggers' in a sample of overweight, female patients prescribed to lose weight by their physician.

Results: Weight-related screenings can act as a 'trigger' for health behavior change. Overall, we discovered five novel themes that embodied patients' complex experiences with triggers: (1) trigger realization, (2) trigger meaning, (3) knowing what to do, (4) perceptions of self, and (5) the good, the bad, the monitoring.

Conclusions: We believe our findings advance the novel understanding of experiences with triggers. Specifically, our work sheds light on why triggers occur, and can guide how to create and manage both realized and meaningful triggers for healthy behavior change. The present results suggest that trigger realization can come from several different sources (e.g. medical, emotional, clothing, social), yet women are capable of deflecting any potential trigger experience. In addition, our findings suggest multiple facets of self-monitoring experiences can actually be counterproductive in weight control. The results provide insight for primary care, weight control counseling, and future interventions for triggered patients.

Keywords: Body Weight, Weight Loss, Screening, Body Image

1. Background

Overweight and obesity rates continue to increase around the world (1), highlighting the argument that obesity is now a global epidemic, whose comorbid disease burdens span the economic spectrum, and call for urgent global action (1, 2). In response, screening for overweight and obesity has been promoted to combat its high prevalence and associated health problems (3). Such screenings are a common component of primary care, public health, and fitness settings, hopefully providing awareness and motivation for change in weight control behaviors. According to the feedback-processing model of self-regulation, a desire to change is initiated with a perceived discrepancy about oneself in relation to a standard or goal (4). The perceived discrepancy can then act as a 'trigger' for subsequent efforts to reduce the discrepancy and/or any affective response.

Common weight and body composition testing can produce such discrepancies and negative affective re-

sponses (5). In addition, triggering events have been cited as important sparks for weight loss and control behaviors in women, especially those related to diagnosis of risk and health concerns (i.e., medical trigger), improving appearance, and emotional or on-going discontent (6-9). However, women can cope in numerous ways to weight- and fat-related discrepancies (10), including avoidance behaviors, including the avoidance of health care (11).

Health care settings, including international settings, could be designed to capitalize on the motivation created by such triggers, but a better understanding of triggers is warranted. Previous researchers have explored the dynamic and often complex experiences associated with weight control (12-16). However, little is known about how the individual experiences triggers, especially as they relate to lived experiences with exercise and healthy eating behaviors.

2. Objectives

Thus, the aim of this study was to discover the experiences and meanings of weight-control triggers in a sample of overweight women prescribed by their physician to lose weight.

3. Patients and Methods

The study procedures conform to the ethical guidelines of the 1975 Declaration of Helsinki. As such, the Institution Review Board reviewed and approved the research procedures, and all participants signed an informed consent before participation. This research was conducted as part of a grant from Stephen F. Austin State University Research Enhancement Program.

3.1. Participants

A qualitative approach, informed by phenomenological practices, was chosen to elucidate these experiences (N = 7; Table 1). All patients presenting for a routine check up to the healthcare facility had their weight screened. Those with a body mass index (BMI) of 25 kg/m² or greater were referred to the study. Once the physician had prescribed weight loss, the patient was provided information on the present study, and asked to contact the researchers to schedule an appointment. Within the two-month recruitment period, nine participants contacted the research team interested in being a part of the study. Two participants never responded to follow-up calls, resulting in the final sample size. All participants volunteered, and were not compensated for their participation. To maintain anonymity, participants were given pseudonyms.

3.2. Method

Qualitative research has been regarded as a broad, umbrella term for research methodologies that seek to understand human experiences from a first person perspective, or simply as methods that do not involve the use of statistical procedures to explain some phenomenon (17). Phenomenology is not generally considered a method to follow, rather a creative approach or attitude consisting

of openness and willingness to allow the essential structures of phenomena to emerge from beyond the bounds of extant theory or presuppositions.

Thus, phenomenology is a process for the acquisition of knowledge through the interpretation of in-depth descriptions of human experiences. Much can be learned from such experiences, and provides an ideal foundation for future research of medical triggers. Accordingly, our sample size was more than adequate for the present research design and question (18), especially as we initiate exploration of the little understood phenomenon of triggering events.

A major premise within phenomenological research is that truth can be discovered within lived experience (19). To ascertain this knowledge, phenomenology explores detailed in-depth descriptions of specific experiences provided by the participants of the study. We were particularly interested in the specific experiences associated with body weight-related triggers, which involves one's body, views of self, the environment, and behavioral choices. Merleau-Ponty expresses that the body, itself, is a concrete agent of all of our perceptual acts, revealing that we understand ourselves as being, rather than simply having bodies (20). Thus, the body is able to play a fundamental, constitutive role in the experiences of weight-related triggers, since the body, self, and world are intertwined. Lastly, because phenomenology is a flexible approach, there have been numerous variations to the techniques used to acquire and analyze interview data. This broad range of styles has led to what some call 'method slurring', which is when researchers use techniques that are incongruent with the stated philosophical influences of their methods. For example, the use of apriori theoretical models or the testing of hypotheses as the bases of a phenomenological inquiry is strongly discouraged. Researchers who use phenomenology are not interested in generating abstractions or testing theoretically based hypotheses (21, 22). A phenomenological attitude consists of openness and a willingness to allow the essential structures of phenomena to emerge from beyond the bounds of extant theory or presuppositions.

Table 1. Participant Characteristics

Participant	BMI, kg/m ²	Age, y	Race	Marital Status	Household Income (per year)	Job Status	Weight Loss Difficulty ^a
Monica	25.70	21	White	Single	< \$15,000	Part-Time	6
Tina	34.80	20	Black	Single	> \$100,000	None	6
Alice	29.50	32	White	Divorced	\$15,000 - 24,000	Full-Time	5
Vicky	25.00	25	Black	Single	\$35,000 - 49,000	Full-Time	3
Hannah	32.70	20	White	Single	\$75,000 - 99,000	Part-Time	4
Becky	25.40	20	White	Single	< \$15,000	Part-Time	6
Veronica	39.70	26	White	Married	\$15,000 - 24,000	None	7
Values ^b	30.40 ± 5.60	23.42 ± 4.54	-	-	-	-	5.28 ± 1.38

^a7-Point Likert scale (1 : extremely easy; 7 : extremely hard).

^bData are presented as mean ± SD.

It is, however, pragmatic for qualitative researchers whose methods are informed by phenomenology to make explicit the philosophical assumptions that undergird their methodological procedures. This act of transparency adds to the trustworthiness of the study. The philosophical principles guiding this study were informed by interpretive and existential phenomenological practices influenced by the teachings of Heidegger (23, 24). Researchers who take a more Heideggerian approach are said to be using Hermeneutic or interpretive phenomenology. Hermeneutics, which is a science of interpreting texts, is an approach that emphasizes the interaction between pre-understanding and interpretation. This process called the 'hermeneutic circle' includes moving between parts of the text and the whole. This process is comprised of a decontextualization of the text as it is interpreted and organized into smaller more manageable segments to a recontextualization as the segments are interpreted related to the whole or the context of the text (see next section).

3.3. Data Collection

A semi-structured approach was used for the present interviews, and a simple interview guide was used to provide a list of the general topics that were to be covered in the interview. More specifically, each participant was asked to share her experiences with being triggered to lose weight, alongside weight control, exercise, and healthy eating. The participants were asked to share specific examples, and to talk about any thoughts or feelings before, during, and after their experiences. Probing questions were used to clarify the participant's descriptions.

Interviews were digitally recorded, and reviewed as an initial step in the analysis of the data (i.e. developing general interpretation of the interview as a whole) before the interviews were transcribed verbatim. The data analysis consisted of an interpretive analysis informed by Hermeneutic procedures (25). These procedures were an iterative process, which includes decontextualizing and recontextualizing the data. During decontextualization, individual units of meaning were removed from each transcript, and then organized into similar groups to condense the data into a more manageable form of interpretation. The data were then recontextualized using nomothetic analysis to express convergence amongst the meaning categories for all the participants (26). The convergence of the categories of meaning units constituted the structure or 'essences' that were the essential components revealing the experience and meaning of the phenomena, as described by the participants. To this end, we held that qualitative interpretations must reflect the meanings and experiences of the participants.

3.4. Data Saturation

To help ensure data saturation (i.e. no new relevant information emerges), interviews were analyzed in this

manner throughout the entirety of the study. In phenomenology, data saturation can be achieved with sample sizes of 5-6 (18, 27). The present sample size ($n = 7$) provided further support that data saturation was achieved. One author, EE, completed all interviews, while all authors completed comparative interpretive analysis of the data. There were no prior existing relationships between the researchers and the participants.

4. Results

Analysis revealed five major themes depicting experiences with weight triggers.

4.1. Trigger Realization

All participants discussed experiences that led them to this point, alongside their realizations of common triggers in their lives (i.e., moments of salient, perceived discrepancies). Four major sources of trigger realization emerged: medical, emotional, clothing, and social.

4.1.1. Medical

The physician provided a unique opportunity to put weight status, something they were already aware of, into a new, heightened level of awareness and consciousness.

"I know, actually him saying that was like, oh, it's official, someone actually put it into words. Someone actually told me that I have gained it" (Vicky).

"When I got off the scale at the doctor's office, I was about to fall over, cause I was like, I can't believe I got over 200 pounds!" (Alice).

4.1.2. Emotional

Many trigger experiences were emotional, thus stimulating realization. Monica cried when she found out she needed to lose weight. Others exhibited an array of negative emotions related to their trigger experience, such as guilt, sadness, discouragement, or defeat.

"The target weight of someone my height is about 60 pounds less than I am. So, that was pretty shocking." (Hannah).

"Hearing him say, '80 pounds', is just defeating. I guess, because that's like a whole - that's a small child!" (Veronica).

Interestingly, the triggering experience did not guarantee an emotional response or realization. Participants were able to deflect any potential emotional response, protecting their perceived self. For example, Vicky deflected away from herself, to her clothing. "I noticed, like, sometimes my jeans. I have to go up a size. It's just the way they make the jeans. It's not me".

4.1.3. Clothing

Wearing and purchasing clothing provided an often-cited source for weight-related trigger realization. Experiences were generally focused on how the body fits inside the clothing, or how the body looks while wearing the

clothing. However, many women depended on their poor fitting of clothing to act as a cue for change, and hope for future success.

“My pant size. When I buy clothes, is one of the things that’s like, when it’s time to workout” (Alice).

“I have boxes of clothes that are too small that I’m keeping in my closet, because I’m gonna fit in those again” (Vicky).

4.1.4. Social

Participants expressed social contexts as sources of trigger realization, even though nothing was directly said or done to initiate thoughts of weight loss. For example, Becky relayed that just hanging out with friends, or others she did not even know, would bring on insecurity about her weight. Social contexts (e.g. family and friends) provided an important area of comparison. Subsequently, participants maintained a heightened awareness of the complex interaction of oneself, the social surroundings, and the perceived consequences.

4.2. Trigger Meaning

Closely linked to the triggers realized within the first theme, participants openly shared how a trigger transcended into a deeper meaning or reason the triggers were specifically meaningful to them. In other words, trigger meaning is simply the reason(s) why the trigger experience is important to that specific individual, thus becoming realized. Underlying beliefs or attitudes towards being overweight were related to the emotional response, subsequently heightening saliency. In general, all experiences revolved around perceived attractiveness, being healthy, and avoiding future health-related concerns (i.e., morbidity and/or mortality). The most common reason shared was appearance-based, from generally wanting to “look good”, and/or avoidance of looking bad, fat, or horrible. For example, Monica shared, “I don’t wanna get fat and look horrible.” Tina stated, “I continue to pack on the weight, and it’s not just weight, for me, it’s fat. It’s actual fat!”

Coming from their physician, participants also highlighted their desire to maintain and improve their health. Several responses were generic in nature, such as “I wanna be healthy”, “...just to be healthier,” or “...have all my levels right.” Several had remembered and relayed what their physician had told them.

“I know I need to lose weight, cause it will be less work for my heart.” (Veronica).

If I didn’t start doing something, I would get Type 2 diabetes. I am not obsessed about it, but enough that it’s important. That’s why I try to healthier than not” (Alice).

The majority of the health concerns were existentially related to their future, such as living a long time, fear of not being in the future, or avoiding massive medical bills. For example,

“Do I want \$40,000 worth of medical bills later, or do I

want to pay \$2.50 for an apple instead of a bag of chips?” (Alice).

“My whole thing is the future, and the fear of not being in the future” (Tina).

4.3. Knowing What to Do

Participants openly stated that they knew what they should be doing; however, many were not enacting strategies in their daily lives to put this knowledge into practice.

“I mean, I know that I need to lose weight” (Hannah).

“I’m very aware that I’m not doing what I should be doing to lose weight” (Veronica).

In addition, participants were commonly able to formulate why they were not being successful, at times, getting to the root of their weight issues.

“I’ll be honest, I’m not eating healthy. I don’t eat healthy. I love fried foods. I eat that a lot. I am not a big breakfast eater. I don’t eat breakfast at all. So, when I eat lunch and dinner, I’m starving” (Vicky).

“Even though I know better - I won’t eat what I’m supposed to, then I’ll eat three times that!” (Veronica).

Lack of physical activity and/or increased sedentary time was also a common area of improvement expressed to aid in weight control. Interestingly, many expressed commonly promoted behavioral tactics that could help them be successful, such as making plans, prioritizing, using free time, avoiding quick fixes, and progressing toward goals.

“Plan a time, everyday, to go work out and make sure it’s, like, free time, and I don’t put anything else in that place” (Hannah).

“Everybody wants a quick fix. That quick, those pills, whatever you can do quickly, but it’s more of a life long thing, like I said, in the future, it’s something to progress up to” (Tina).

However, not all knowledge was accurate (especially from popular media sources), and subsequently impacted beliefs and efforts following a trigger.

“I’ve really been trying to walk - just something simple, just to get moving, but that’s not going to help burn anything” (Tina).

“I’m going to do a couple of sit-ups, I’d run, eat salads, drink some water. So, I’ll do that for about a week, I should at least lose a pound, and I haven’t” (Vicky).

Similarly, bias emerged in many participants, especially toward what the experts and media have said on a subject. However, participants were quick to relay what experts say on a subject, but did not fully understand what it meant. For example, Tina admitted, “My thing is portion size. I don’t know what portion size I should eat.” She appeared to know that her issue was with portion size, yet did not know much about portion size. Participants appeared to have accessed these issues (e.g. portion-control) from media or other sources, such as health food stores, and had a somewhat automatic bias, so they now believe their problems are rooted in these areas. These

findings expressed the susceptibility to the media influence in behavioral choices to control weight, especially when self-control or efficacy beliefs were low. Tina also shared, "I've tried to look things up, like how to burn fat. I even tried supplements. It was like a fat burner thing I got at the whole foods market. That didn't work."

4.4. Perceptions of Self

All women had specific perceptions of self, including labels, which impacted current and future behavior. There was a clear connection between the perceived label, and the attributional bias that resulted. For instance, Veronica labeled herself as a "food addict" and "head case". Accordingly, she expressed difficulty in controlling food intake and eating too much, even though she knew that it was in her best interest to do so.

Others expressed similar perceptions of self, which affected their level of effort to control their weight. For example, Veronica shared about the lack of confidence in weight control from years of failure, "I start believing I can't." These perceptions of self were also able to help some women deflect the potential motivating essence of the trigger realization. As a result, triggers were never realized, and they remained consistent in their unhealthy, habitual lifestyles.

4.5. The Good, the Bad, the Monitoring

All participants spoke to some aspect of their own self-monitoring, but presented mixed bag of perceptions of its use and effectiveness. Hunger, cravings, body weight, appearance, and clothing were the most common areas these women monitored. Clearly, self-monitoring was an emotional journey for many, and it did not always result in positive, approach-oriented triggers and behaviors. Some women were constant self-monitors of their body weight, however it did not necessarily translate into behavior change.

"I used to think about it [weight] a lot. I first realized that I had gained a lot of weight. It was on my mind all the time" (Monica).

"I think about my weight all day. Like, once a day, at least" (Veronica).

Similarly, self-monitoring became habitual and automatic from repetition over time, losing its impact. Subsequently, the experience and power of the trigger realization process was lost. As a great example, Vicky expressed, "So, when over years of time, you constantly check your weight, you're like, it's the same thing you think. You think, 'I don't have to worry about this. I used to be 110', but you know I, well, I'm getting older, you know? It was probably extra, but once again, it wasn't too big, it was enough I didn't notice anymore, so I didn't have to think about it."

5. Discussion

Based on the present results, we highlight the potential benefit of triggering experiences in behavior change, es-

pecially when the trigger is realized (i.e., fully aware, understood clearly), and holds specific, important meaning to the individual's perceived self or identity. Trigger realizations commonly revolved around medical (e.g., physician), emotional, clothing, and/or social sources, however women were capable of deflecting any potential trigger experience. Appearance and existential views of health provided the most common sources of meaning (i.e., why trigger was important) behind the trigger experience. In this study, we were the first to shed light on why triggers occur, and can guide how to create and manage both realized and meaningful triggers for healthy behavior change. For example, practitioners might consider placing attention on guiding patients to more positive experiences that connect to who patients are and/or desire to be, and encourage belief that the benefits of weight control are worth the effort (28). Future research is encouraged to more aptly explore trigger realization experiences.

Within the triggering experiences, women knew what to do, but this knowledge did not translate to the enacting and/or maintaining of those behaviors. Participants were especially vulnerable to faulty perceptions of self, bias toward media and other sources (whether correct or not), alongside self-serving bias that hindered realization of triggers and/or translation into behavior change. Previous research has shown that if these beliefs and thought processes become too rigid, difficulty with weight maintenance can result (29). To aid, self-monitoring provided a potential, key facilitator of change and maintenance, helping interrupt normalcy and cultural routines for eating and exercise (i.e., trigger) (30). However, as a novel extension of current understanding, our findings suggest multiple facets of self-monitoring experiences can be counterproductive.

First, active monitors pay attention to body weight, cravings, appearance, and clothing, but all can result in emotional responses that might deter future monitoring or behavior. As a result, feeling states might then be regulated with comfort foods and/or avoidance. In addition, we found that self-monitoring can become automatic, or habitual, resulting in an act of "going through the motions" and ineffective. Similarly, a lack of vigilance is a common characteristic of weight regainers, but not maintainers (29). Practitioners can introduce how to properly cope with the emotional experience (10), and maintain awareness of meaningful self-monitoring to prevent automaticity. In addition, practitioners can utilize previous understanding of behavioral and cognitive factors that discriminate those successful and unsuccessful with weight control in conjunction with triggering events (7, 9, 12).

Despite having an adequate sample for the present research design and question, the present sample was small, and might not be representative of patients generally. However, as previously stated, our intent with the present study was not to generalize the results, rather initiate exploration of the little understood phenom-

enon of triggering events. A qualitative approach, informed by phenomenological practices, provided an ideal starting point. In addition, the women in this study were representative of individuals in a rural area within a developed country, which highlights a perspective of food availability and environmental characteristics that might not be representative of weight control within less developed countries. Obesity continues to expand in its global impact, including lower socioeconomic areas, thus trigger experiences within other areas of the world are very important to advancing our understanding of successful self-regulation of weight control behavior. We interviewed patients who initiated contact with the research team to provide their experience with the weight loss trigger from their physician. In total, the physician triggered at least 15 women. However, only 9 women initiated contact with the research team. Thus, it is feasible that the women who did not initiate contact with the research team could provide additional experiences with weight loss triggers that were not captured within the present data. Future researchers should seek novel methodologies to capture the experiences of these women, especially as data supports women can use such triggers as a reason to avoid health care. We encourage researchers to further develop our findings.

Using qualitative interviews grounded in interpretive and existential phenomenological practices, we successfully explored the experiences and meaning of weight loss 'triggers' in a sample of overweight, female patients prescribed to lose weight by their physician. In conclusion, our findings were the first to explore why triggers occur, and express that trigger experiences are complex. Practitioners and researchers should consider the complexity of trigger experiences in future research and interventions; especially how triggers might be leveraged to guide healthy behavior change and maintenance in overweight and obese patients.

Footnotes

Authors' Contribution: Study concept and design: Mark D. Faries; Acquisition of data: Elizabeth Espie, Kyle P. McMorries, Mark D. Faries; Analysis and interpretation of data: Mark D. Faries, Erik Gnagy; Drafting of the manuscript: Mark D. Faries; Critical revision of the manuscript for important intellectual content: Elizabeth Espie, Erik Gnagy; Statistical analysis: Erik Gnagy, Mark D. Faries; Administrative, technical, and material support: Mark D. Faries, Kyle P. McMorries; Study supervision: Mark D. Faries.

Conflict of interest: The authors confirm no conflict of interest.

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