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Abstract

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Keywords

Obesity, Women, Postmenopausal, Weight Management, and Grounded Theory

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"*Taking Charge of One's Life*": A Model for Weight Management Success

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Obesity is a serious, prevalent, and refractory disorder that increases with age particularly in women who enroll in formal weight loss treatments. This study examined the processes used by obese postmenopausal women as they participated in a formal weight loss program. Using grounded theory, interviews were conducted with 14 women engaged in a formal weight loss study examining success with specific, targeted weight loss treatments based on one's weight control self-efficacy typology. "Taking Charge of One's Life" emerged as a model for weight management success, comprised of three phases: engaging, internalizing, and keeping one's commitment. This study supports the unique, complex, and individualized nature of making a decision to lose weight and then maintaining one's commitment to weight loss. Key Words: Obesity, Women, Postmenopausal, Weight Management, and Grounded Theory

Introduction

Being overweight or obese is a serious health problem that affects over 66% of American adults (Centers for Disease Control and Prevention, 2006). The prevalence of obesity-related medical conditions continues to rise. Several medical conditions associated with obesity include hypertension, diabetes mellitus, dyslipidemia, certain forms of cancer, sleep apnea, and osteoarthritis (The Obesity Society, 2008). Nationally, related health costs may exceed $78 billion annually (Finkelstein, Fiebelkorn, & Wang, 2003). Research on obesity is extensive, and two major focal areas have been identification of correlates of weight loss and refinement/comparison of treatments. However, findings have been contradictory, and no single approach has been effective in maintaining long-term weight control. To better understand weight loss from the perspective of those actually trying to lose weight, a grounded theory approach was used to examine the process women experienced during their participation in a formal weight loss study.

The larger study examined success with specific, targeted weight loss treatments based on one's weight control self-efficacy (WCSE) type; *assured* or *disbeliever*. Women with *assured* WCSE were confident they could control their body weight, and women with *disbeliever* WCSE had a wavering faith in their ability to successfully accomplish this. All women received 10 weeks of heart healthy classes, followed by 24 weeks of active weight loss treatment aimed at their specific WCSE type, totaling 34 weeks of intervention. The goal of *assured* treatment was to support and further strengthen the confident efficacy beliefs of women with *assured* WCSE. The goal of *disbeliever* treatment was to build and instill confidence in women with *disbeliever* WCSE that they

could successfully accomplish the behaviors needed for weight control (Dennis et al., 2001). Women from the larger study were interviewed for the present grounded theory study following the 34 weeks of interventions, which offered them a wealth of experience that enhanced the potential value of the interview data.

Background

Obesity is a serious, prevalent, and refractory disorder that increases with age in African-American women, and increases through age 59 in Caucasian women (National Center for Health Statistics, 2007). Although obesity is easily diagnosed and its treatment could not seem more straightforward (eat less and exercise more), behavioral modification approaches to weight loss treatment have had little impact on long-term weight loss success (Wadden, Brownell, & Foster, 2002). The inadequacy of behavioral modification approaches for long-term weight control has led to an exponential increase in research on obesity treatments in recent decades. One focal area of obesity treatment research has been the identification of factors that are correlated with weight loss. Factors that have been examined include exercise, self-efficacy, weight management processes, stress, binge eating, social support, and client treatment matching (Allan, 1991; Dennis et al., 2001; Fabricatore & Wadden, 2003; Teixeira et al., 2006; Walcott-McQuigg et al., 2002). While self-efficacy, social support, and client treatment matching facilitated successful weight management, stress and binge eating appeared to impede it.

The treatment of obesity is divided into three major categories: diet, physical activity, and behavior therapy; pharmacotherapy; and surgery (National Institutes of Health, National Heart Lung and Blood Institute, NHLBI Obesity Education Initiative, & North American Association for the Study of Obesity, 2000). The first category has been the target of much research and relates to an individual's personal characteristics, behaviors, and habits. These factors may, however, be the most difficult to assess due to their individual variability.

Dennis and Goldberg (1996) identified two distinct types of weight control self-efficacy (WCSE). This factor refers to an individual's belief regarding his/her ability to carry out the behaviors necessary for successful weight management. Two major self-efficacy categories emerged: *assureds* and *disbelievers*. *Assureds* were goal directed, independent, and persistent individuals who manifested feelings of self-confidence about weight control. *Disbelievers* had a wavering faith in their ability to control their body weight, and a constant need for motivation and reinforcement to be successful in weight control. These self-efficacy categories were linked to weight loss outcomes in a standard, nutritional/behavioral weight loss program with *assureds* losing significantly more weight than *disbelievers*. Although self-efficacy beliefs and client treatment matching have been shown to facilitate successful weight management, the outcome variance accounted for by these variables has been limited. Thus, other factors are likely to be playing a role as women strive to achieve long-term weight control.

One factor that may be important as women attempt to manage their weight is the processes that they use to accomplish this task. In an ethnographic study of Caucasian women between the ages of 19-52 (mean age 30 years), who were seeking to control their weight outside of formal treatment, "changing one's whole life" emerged as the overarching process used by obese women who became successful weight managers

(Allan, 1988, 1989, 1991). Because obesity is more prevalent in older African American and Caucasian women, and more refractory in women who participate in formal weight loss programs, examining the processes that are used by these particular women as they participate in formal weight loss treatments may be important.

Studies that have examined the processes women use as they participate in formal weight loss programs have been limited. Most weight loss studies examine the effectiveness of the program instead of experiential participation. One study focused on the decision-making processes women used in seeking treatment for obesity (White, 1984). Using grounded theory, White identified two stages women experienced in making a decision to pursue weight loss; they were perceiving a loss, which related to personal awareness and defining oneself as needing to lose weight; and isolating oneself, which related to avoiding uncomfortable situations related to one's weight.

Another study examined the effectiveness and process of change in weight over time, but used the transtheoretical model of behavioral change as a conceptual guide (Prochaska, Norcross, Fowler, Follick, & Abrams, 1992). That study provided a framework for monitoring weight loss through the stages of change; individual experiences, however, were not examined. To capture the true complexity of the experiences women have as they participate in formal weight loss treatments, examining the processes that women use from their own perspectives is important.

In the present study the investigator used grounded theory to examine the subjective processes that obese, postmenopausal women used when they participated in weight loss treatments. The investigator was a normal weight female doctoral nursing student interested in women's health and risk reduction, with many years of experience working with patients in psychiatric settings. She was also certified as a clinical specialist in adult psychiatric and mental health nursing by the American Nurses Credentialing Center. Her advanced training and experience provided her with the knowledge and skills necessary to conduct interviews, establish rapport quickly, and elicit personal information necessary to derive grounded theory. The investigator's dissertation chairperson was the principal investigator for the parent study and invited her to conduct a qualitative study using the sample from the parent study, as there could be other factors involved in the weight loss process besides weight control self-efficacy that had not yet been identified. If other factors could be identified through a grounded theory approach, incorporation of those factors into weight loss treatments might improve the effectiveness of weight loss treatments.

Methods

Grounded theory (Glaser & Strauss, 1967) was the methodological approach used to examine the processes that obese postmenopausal women engaged in as they participated in a formal weight loss program. Although both Glaserian and Straussian approaches were incorporated, the data collection and analysis procedures followed more of a Straussian framework (Strauss, 1987; Strauss & Corbin, 1990). The grounded theory approach was fitting for the present study because it assumes that people sharing common circumstances experience shared meanings, behaviors, and a specific social psychological problem that is not necessarily articulated. The goal is to generate theory

that accounts for a pattern of behavior which is relevant and problematic for those involved (Glaser, 1978).

Because grounded theory research requires interpersonal interaction, the researcher is inevitably part of his or her ongoing observations and must become aware of personal preconceptions, values, and beliefs. Only through self-awareness can he or she begin to search out and understand another's world. Such understanding is vital to grounded theory research, as Berger and Kellner (1981) remind us.

> If such bracketing (of values) is not done, the scientific enterprise collapses, and what the [researcher] then believes to perceive is nothing but a mirror image of his own hopes and fears, wishes, resentments or other psychic needs; what he will then not perceive is anything that can reasonably be called social reality. (p. 52)

Personal assumptions of the investigator for the present study were delineated and managed by acknowledging her assumptions, bracketing them, and discussing them with a peer debriefer to examine any influence from the assumptions to the data analysis, interpretation, and findings. The author's personal assumptions were: (a) obese women suffer from obesity in large part because of their inherited physiological genetic make-up and (b) obese women cannot change their inherited physiological constitution, but they can change their eating and exercise patterns. These recognized assumptions were managed in three ways. First, they were managed by reviewing the audio-tapes, verbatim transcripts, and emerging coding schema for initial interviews with experts in obesity and qualitative methodology. Second, they were managed by discussing the research analysis, findings, and interpretations on a regular basis with these same individuals. Third, they were managed by following strict data collection and analysis procedures appropriate for grounded theory research

Sampling

All participants were enrolled in a formal weight loss research program; women were identified by their self-efficacy scores as either *assureds* or *disbelievers*, and prescribed formal and traditional weight loss strategies according to their self-efficacy identification (Dennis et al., 2001). In order to gain the greatest variability of information in the current qualitative study, purposive sampling was used and 50% of the sample was *assureds* and 50% were *disbelievers.* The setting for this study was a major metropolitan medical center located on the east coast of the United States of America. This sample of 14 (7 *assureds* and 7 *disbelievers*) women was drawn from a larger weight loss study (Dennis et al.) of 35 obese postmenopausal women. In terms of demographics, 36% of the participants were African-American and 64% were Caucasian, ranging in age range from 50-68 years (mean 59, s.d. 9), and a body mass index of 27 to 40 kg/m^2.

Data Collection

After obtaining Institutional Review Board approval to conduct the present study from both the university where the PI was enrolled in doctoral studies and the medical

center where the research was implemented, the study was introduced to the women at their final weight loss group meeting. Women were told they would be contacted by phone to set up an interview as soon as their post-testing schedules that were part of the parent study were available. It was made clear to the women that participation in the parent study did not require them to participate in the present study. Women were scheduled for post-testing procedures by the coordinator for the parent study. After post-testing schedules were obtained, women were contacted by phone and invited to participate in the present study. All women who were contacted agreed to meet for an interview. When they arrived for the interview, the study was explained to them in greater detail; a pseudonym was assigned; and informed written consent was obtained. Interviews were conducted before or after post-testing procedures in a private room where interruptions were likely to be minimal. This strategy incorporated the most convenient time and place for the women to participate in 1 to 2 hour interviews.

Data were collected using formal, semi-structured interviews. Following written informed consent, each participant was asked to respond to questions that reflected basic issues surrounding weight loss. Since discovery is the aim of grounded theory (Strauss & Corbin, 1990), additional questions were included that allowed the interview to flow and comments to emerge naturally. Although, an interview guide (see Appendix A) was developed to include questions that reflected the basic issues surrounding weight loss, it was not adhered to rigidly, and questions were allowed to emerge naturally. For instance, one woman stated that she had problems with "control." Probing then focused on eliciting a more detailed explanation, to gain a better understanding of what she meant by "control". Interview questions moved from the general to the particular. For example, a beginning research question was: "Tell me about your experiences in this weight loss program." A specific question later in the interview was: "What helped you to stick with your new eating and exercise behaviors during the holidays?" Ultimately the research questions elicited information fundamental to grounded theory studies, such as causes, conditions, strategies, phases, and consequences (Glaser, 1978) related to weight loss and treatments. Interviews lasted 45-90 minutes. All interviews were audio-taped and transcribed verbatim, since the immediate recording of data is vital to the success of grounded theory generation (Hutchinson, 1993). Pseudonyms were used in the transcripts to protect confidentiality.

Data Analysis

The constant comparative method of data analysis was used (Glaser & Strauss, 1967). Early interpretations and findings were continually questioned and validated in subsequent interviews. Although, both Glaserian and Straussian approaches were incorporated, the data collection and analysis procedures for the present study followed more of a Straussian (Strauss, 1987; Strauss & Corbin, 1990) framework. Specifically, data were collected and analyzed using a coding paradigm (family of codes) that focused on causes, conditions, strategies, and consequences. Three assumptions guided this process. The first assumption was that people sharing common circumstances share a specific social psychological problem that is not necessarily articulated, and this fundamental problem is resolved by means of social psychological processes. The second assumption was that the discovery of a core or basic social psychological process (BSP)

is an essential requirement of a quality grounded theory and illustrates social processes as they continue over time. The third assumption was that processes illustrate progressive movement, reflected in phases or stages, or non-progressive movement, that is, purposeful alterations or changes in action/interaction in response to changes in conditions. In this study the BSP was viewed as progressive movement, reflected in phases, and the sub-processes were seen as non-progressive movement.

Using the constant comparative method of data analysis, initially the data were fractured into as many small pieces as possible (Level I coding) using words that described the action in the setting (in vivo or substantive codes) to ensure full theoretical coverage. Examples of early substantive coding were, "exercising indoors due to safety concerns," "exercising in the morning because my knees hurt more in the evening," "avoiding weighing after overeating," and "setting a realistic weight goal to avoid failure."

As Level I codes were accumulating, questions were asked of the data such as, "What does this incident indicate?" Each incident was then compared with other incidents, and similar incidents such as exercising indoors, exercising in the morning, avoiding weighing, and setting a realistic goal were clustered. Then the following question was answered: "What category would include these similar incidents? Protecting oneself emerged as the category that would include these particular similar incidents. Level II codes, or categories, elevated the data to more abstract levels.

Level III codes, or theoretical codes such as causes, conditions, strategies, consequences, were used to conceptualize how the substantive codes related to each other as hypotheses to be integrated into theory. For example, protecting oneself was conceptualized as a strategy for keeping one's commitment to weight management success. Keeping one's commitment was an important subcomponent of the basic social psychological process (BSP), taking charge of one's life. Since generation of grounded theory occurs around a BSP, this essential element was continuously searched for throughout data analysis. Eventually, through constant reference to the data combined with rigorous thinking, the BSP emerged. From that point forward, the data were selectively coded around the BSP until saturation was achieved.

Memoing and sorting were used to facilitate selective coding. Memos are written records of analysis related to the formulation of theory and are essential, for without them the researcher would have no written record of his or her analysis. By reading and rereading them, then by sorting them, the researcher can begin to discover how codes come together to form categories, and how the categories come together around a core category (Strauss & Corbin, 1990). Handwritten memos were begun at the inception of the research project and continued until the final writing. As memos accumulated, they were sorted by code to delineate the relationships among the individual codes, and their collective relationship to the BSP. For example, the following memo helped to delineate the relationships among the individual codes that were categorized as protecting oneself, and their collective relationship to the BSP, taking charge of one's life.

Memo

Protecting Oneself

> I ask myself, what is going on here? These women all seem to be concerned with preventing various sorts of physical injury during exercise. For some, this concern centers around bad weather; for others, the focus of concern is personal safety. It's like they are protecting themselves from some form of physical injury. But, when I think about it, not only do they protect themselves from physical injury, they also protect themselves in other ways. For instance, some avoid weighing themselves after overeating, while others strive to achieve a goal weight that is higher than the biomedical weight standard. It's like they are trying to avoid failure. Are these strategies for protecting themselves from psychological injury? When I really think about it, these women are trying to protect themselves both psychologically and physically. But what is the purpose of protecting themselves? How does protecting oneself relate to taking charge of one's life? What theoretical code applies to protecting oneself? Is protecting oneself a strategy? If so, a strategy for what? Maybe, it's a strategy for keeping one's commitment to weight management success. But how could not weighing oneself after overeating be a strategy for keeping one's commitment? I don't see how this could help the women keep their commitment. But wait a minute. If they weighed themselves after overeating and saw that they gained weight this might lead them to perceive themselves as having failed. If they fail they might become frustrated and give up. So, not weighing after overeating may help them to keep their commitment by preventing them from giving up. I must conclude then, that protecting oneself physically and psychologically, is a strategy for keeping one's commitment to weight management success. Keeping one's commitment to weight management success is the third phase of the overarching process, taking charge of one's life.

Once these relationships were delineated, and no new conceptual information was available to indicate new codes or expansion of existing ones (saturation), closure was reached and writing the conceptualization of the substantive theory, with the BSP as its central focus, began. The phases of the BSP were used as subheadings for the elaboration of categories. Memos and reconceptualization of the theory continued during and after the initial writing. Eventually, through constant dialogue with the data, the substantive theory emerged, complete with causes, conditions, strategies, and consequences.

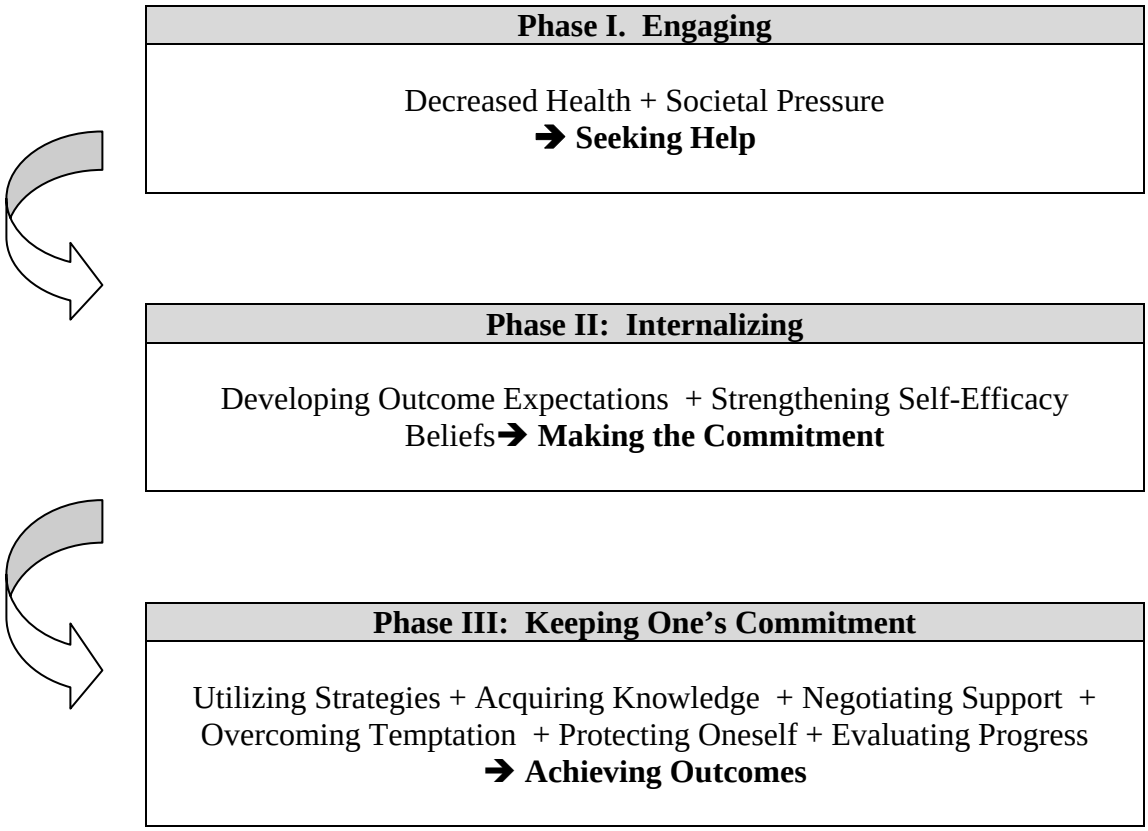
The criteria for evaluation of scientific rigor used in this study were: credibility, fittingness, auditability, and confirmability (Sandelowski, 1986). Credibility was selected as a criterion for evaluation of scientific rigor because it addresses truth value. In qualitative research truth value generally resides in the discovery of human phenomena or experiences as they are lived and perceived by subjects. Fittingness was selected because it addresses applicability or representativeness. In qualitative research, representativeness frequently refers to the data rather than to the subjects or settings per se. Specifically, the

researcher must establish the typicality or atypicality of observed events, behaviors, or responses in the lives of the subjects. Auditability was selected as a criterion for evaluation of rigor because it addresses consistency. A qualitative study can only be replicated when another researcher can clearly follow the "decision trail" used by the investigator in the study. In addition, confirmability was selected because it addresses neutrality. In qualitative research neutrality refers to the findings themselves, not to the subjective or objective stance of the researcher. Several strategies were used to achieve these criteria. Credibility and fittingness were achieved by using segments of actual data (i.e., quotes), and presenting such faithful descriptions and interpretations of the women's experiences that the researchers from the parent study were able to recognize the experiences after having only read about them in the findings chapter (Sandelowski, 1986). Several other strategies were used to address credibility and fittingness. These included asking questions during the interviews that were relevant to the research purpose such as, "How did your friend's support help you lose weight?"; not interviewing participants during post-testing procedures; using high quality audio-taping equipment to record interview data; having back-up recording equipment available in case of primary equipment failure; transcribing interview data immediately after collecting it to evoke memories of informants' nonverbal behaviors and interviewer's personal feelings and responses to monitor bias; keeping informants focused on their weight management experiences (Hutchinson & Wilson, 1992); writing down personal reactions to participants and information that was shared immediately after interviews and transcription sessions, and during data analysis (Hutchinson & Wilson; Rew, Bechtal, & Sapp, 1993); and remaining open and receptive to learning from participants throughout the research process by asking informants to share their experiences, and then listening as they revealed themselves (Rew et al.). Auditability was achieved by keeping a written record of the progression of events in the study (Sandelowski). To establish a comprehensive audit trail, four types of documentation were used: (a) contextual; (b) methodological; (c) analytical; and (d) personal response (Rodgers & Cowles, 1993). Contextual activities, behaviors and occurrences, and methodological decisions were recorded as field notes; analytical ideas as memos; and personal feelings, thoughts, and biases as personal journal entries. These forms of documentation made it easier for the researcher to describe, explain, and justify the specific purpose of the study, how participants came to be included in the study, and how they were approached. They also helped the researcher determine how to collect data, how long to continue the data collection process, the nature of the setting in which the data were collected, how the data were analyzed and interpreted, and the specific techniques used to determine the credibility and fittingness of the study and its findings.

Findings

The overall theory that emerged from the interview data was "*Taking Charge of One's Life*." This theory is comprised of a three-phase process that entailed using both cognitive- and action-oriented sub-processes to establish a healthy lifestyle, successfully manage one's weight, and improve one's sense of health and well-being. The process was time-dependent: Participants went through Phase I (engaging), then Phase II (internalizing), and then Phase III (keeping one's commitment); (See Figure 1).

Figure 1. *"Taking Charge of One's Life":* The key to successful weight management.



Phase I: Engaging

Engaging, the first phase of *"Taking Charge of One's Life"* began as obese women noticed a decrease in their health and well-being and/or physical attractiveness. The obese postmenopausal women who participated in this study were experiencing symptoms or physical limitations that were bothersome and increased their concerns about their health and well-being. Women attributed these problems to their age and obesity. Symptoms and physical limitations that were problematic included: decreased energy, decreased ability to move around, shortness of breath on exertion, and an increased and often severe physical pain in their knees, ankles, and/or feet. "When you become so lethargic that it's a problem just to move around, you sleep more when you're carrying more weight." "I wasn't feeling like I thought I should. I had trouble going up and down steps, getting out of breath. Yea, getting out of breath. If I went to the malland walked very much I got out of breath." "My feet hurt so badly I could hardly walk and hardly get up. I'd have to take a step at a time to get up the steps. It just seemed like I had become an old fat woman."

In addition, concerns about present health led the women to think about and/or fear future health problems. Most women believed they were at high risk for developing one or more obesity- or age-related diseases including atherosclerosis, hypertension, heart

disease, and diabetes. Many of the women had a strong family history and/or actual physical signs that were consistent with high risk for acquiring at least one of these conditions. For a few women, concerns voiced by a health care professional reinforced the potential problems associated with obesity. Some women even perceived themselves at high risk for sudden death.

> Being heart healthy is a pretty good hook for me because one of the things we found out about my mother is she's got a lot of occluded arteries and so if I can avoid that that's good. Also, 6 months prior this program I had a complete physical and I had a really low cholesterol and when I started this program my cholesterol had shot way up so the heart healthy thing is a good thing. I'm motivated almost unconsciously about that.
>
> My father died of a heart attack, my mother had heart disease. I knew my cholesterol was high, and my first husband who had no hint of heart disease had an acute MI and just fell over like that. So when my second husband had a heart attack and died just as this program was beginning, I thought I really better pay attention to this heart healthy. It's given me the impetus to be successful with this program which I feel I have been very.
>
> I had a warning from my doctor. He thought that my blood pressure was becoming borderline (hypertensive) because of gaining all that weight in less than a year. I'm a stickler about blood pressure medication and like to brag about not having to take any medications at my age. So, that really grabbed me and I decided that I'm going to have to lose.
>
> I was really kind of worried about diabetes because each time I go into see my dentist he asks me how my blood sugar is. As my parents got older, they developed a form of diabetes that develops among the elderly. My father had an uncle who had diabetes and he had his feet amputated when I was a child. That made a significant impression on me. So I decided that I needed to get my weight under control because for sure you don't want to get diabetes if you can avoid it. It's the worst illness in the whole world because it leads to everything else.

Along with concerns about health and wellbeing, societal pressures to be thin confronted women who participated in this study. They were aware of the societal sanctions associated with violating the thin ideal such as, if you are thin you get the job, if you are fat you do not. "As a teenager I was heavy. I know how uncomfortable that is, how other people can be. I've had that battle all my life."

> The very first time I attempted to lose weight was when I was graduating from college. I weighed about 160 pounds at that point and I thought I might need to lose some weight to make a better impression for job interviews.

Societal sanctions coupled with obesity and age-related changes in their own physical appearance, led to the emergence of body image concerns.

> I'm extremely heavy. I might not look extremely heavy to you, but I'm extremely heavy to myself and I just wanted to look better in my clothes and feel better about myself. I don't mind being matronly, but I don't need to be fat. That's one thing. I don't need to be fat.

> I had stopped going shopping because the few times that I went shopping I found that I needed truthfully a size 16 and 16 was never a very flattering size for a person who has spent most of her years wearing a size 10 with no problem. So I was very unhappy about that and decided that I was going to have to do something.

> You don't gain weight and lose and gain weight and lose it unless you're unhappy about being fat. If you're quite happy about being fat, you don't worry about it. Those people aren't here. They're enjoying life and more power to them.

Body image and health concerns created the basic social psychological problem, decreased health and well-being. The basic social psychological problem led the women to pay attention to advertisements in newspapers and/or work bulletins in an effort to identify potential sources of help, and to inquire further when they saw the advertisement for the parent study. After contacting the study coordinator, each woman attended the group orientation meeting in which the study was explained to her in greater detail. It was during this meeting that the women began the process of internalizing.

Phase II: Internalizing

Internalizing is a cognitive process whereby outcome expectations and self-efficacy beliefs are incorporated within the self through learning or socialization. An outcome expectation is the belief that if one carries out specific behaviors, reducing fat and caloric intake and exercising three times per week, certain outcomes such as weight loss and improved health and well-being will be achieved. Self-efficacy is the belief that one is capable of carrying out the behaviors required to produce the desired outcomes (Bandura, 1977). The desired outcomes for the women who participated in this study were weight loss and improved health and well-being.

Outcome expectations and self-efficacy beliefs were internalized as the women attended the group orientation meeting in which the parent study was explained to them. It was during this meeting that the women began to internalize the notion that to successfully manage their weight and improve their sense of health and well-being, they would need to make permanent changes in their eating and exercise habits and establish a healthy lifestyle (outcome expectations). The idea that they could do something to intervene on their own behalf helped to strengthen their self-efficacy beliefs. Internalization of self-efficacy and outcome beliefs created the context, which enabled

the women to make the commitment to successfully manage their weight and to improve their health and well-being.

The women in this study made the commitment to successfully manage their weight when they consented to participate in the parent study. Most of the women had a history of multiple, prior weight loss attempts with varying degrees of success, and most had been unable to maintain their weight loss over time. This coupled with the fact that they were getting older, experiencing physical problems, and anticipating future health problems, motivated them to join a weight loss program that was part of a major study. Also, another motivating factor was that the study was designed to assist them in establishing a healthy lifestyle. It was as if they now were ready to make major changes in their lives. "I decided to join because it was explained to me that it would be more for health reasons. I understand that the weight loss is essential to be more healthy, but it was a healthier way of living."

> Knowing it's not a diet, but a new way of life motivates me. Most of us will be living 75, 80, 85 years and we want to live those years very healthy. If our arteries are clogged up with fat and our memories start fading because oxygen can't get through the blood vessels, then it's our fault. But we can live right up until we die and that's wonderful.

The women were hoping that the study would produce solutions to their own weight management problems, and/or benefit others with weight problems in the future. Most of them viewed being accepted into this program as quite an accomplishment. The physiological testing was seen as potentially beneficial to their own health, and the chance to receive help without obligating oneself financially was viewed as a golden opportunity. These multiple benefits further enhanced their sense of commitment to the study and to their own weight management success. As they made the commitment to their own weight management success, they entered the third phase of *"Taking Charge of One's Life,"* keeping one's commitment.

Phase III: Keeping One's Commitment

Keeping one's commitment, the third phase of *"Taking Charge of One's Life,"* was characterized by attending weekly group meetings, sticking to the suggested dietary and exercise routines, keeping the daily written food records, and participating in the physiological testing procedures that were part of the broader study. Several strategies were utilized by these women in order to keep their commitment to the study and to their own weight management success. These strategies were acquiring knowledge, negotiating support, overcoming temptation, protecting oneself, and evaluating progress.

Acquiring knowledge

Acquiring knowledge is the process of gaining information, understanding, or skill in a particular area through study, instruction, or experience. The women acquired two types of knowledge as they proceeded through this weight loss program: technical and personal. Technical knowledge is practical knowledge that one needs (dietary

instruction) in order to achieve a desired aim (improved eating habits). As one woman commented, “The dietitian taught us how to translate a food label into exchanges.” Another woman stated, “You learn from the comments, changes, and figures made by the dietitian on your food records.”

Personal knowledge is knowledge relating to or affecting a single individual that is acquired with or without intervention from others. The acquisition of personal knowledge facilitated movement toward weight management success.

> I eat because I want control. When my husband’s not doing what I want him to do, I go to the refrigerator. When I talked to the people here about this, they sort of smiled and said, “we’ve had problems like that too.” So this program has really opened my eyes to control. Now, the control is not controlling others, but controlling myself.

Negotiating support

Negotiation of social support also helped facilitate the women’s movement toward weight management success. Negotiating support is the process of arranging for or bringing about assistance from others through compromise and/or mutual agreement. These women negotiated two kinds of support: formal and informal. Formal support was negotiated through an official agreement. The women negotiated formal support from the professional leaders/investigators and from the other women who were participating in the weight loss program. Some women commented that the investigators always asked, “How’d you do this week,” and called them when they missed a class to say, “You can do this, the weight loss will come.” Women also reported that fellow group members often made helpful comments, “You’re looking better,” “You’re looking good,” and “You’re working on it. It’s showing.”

Informal support was negotiated casually with familiar persons such as family, friends, and co-workers. Study participants negotiated support from their husbands, sisters, daughters, and/or women friends. Family and friends were found to be both helpful and unhelpful.

> And when I learn something in class I tell my girlfriend and she says, “that program has done you so much good.” And she used to call me in the morning to go to the spa and I’d drag myself out and then afterwards feel happy about what I did for myself.

“My husband sometimes irritates me because he’s not that supportive and that’s been a deterrent. He’ll say, ‘All this fat free food around here. I don’t eat all this fat free stuff.’” Successful negotiation of social support helped women as they worked to overcome temptation.

Overcoming temptation

Overcoming temptation was the process of gaining power over something that seemingly controlled one’s behavior, and was another strategy these women used to keep

their commitment to weight management success. In this study, the women specifically were trying to gain power over food. Several strategies emerged as facilitators to them in this struggle: stimulus control techniques, dietary flexibility, self-awareness, and exercise.

Stimulus control techniques were strategies that the participants used to avoid stimuli that elicited problem behaviors. One woman provided an example in her comment, "I try to keep busy when I'm sitting around with nothing to do because it's all too easy to wander into the kitchen."

Dietary flexibility was a facilitator and supported overcoming temptation. As one woman explained, "On this plan you can eat what you want as long as you count it in and I find that makes it easier." Self-awareness was evident in comments like,

> Once we write something down, that makes us more aware of what we are eating. I mean you don't really know that you reach for something all the time but then when you reach and have to write it down you say oh well I'll put that back.

Exercise was also a facilitator of overcoming temptation. One woman shared,

> When I'm walking and doing some exercise, I'll be a little more hesitant to eat something because I don't want to mess up all it took me to do that walking. It takes walking a mile to work off 100 calories and it doesn't take long to put 100 calories in your mouth.

Concomitantly, several factors emerged as hindering the women in their struggle to achieve control over food: stressful life experiences, lifestyle, special occasions, and weather conditions. Women often coped with stressful life experiences through food. "When we were furloughed I was very anxious and I tend to eat when I'm anxious about something so my weight hit a plateau during that time."

Lifestyle created difficulty for women who lived with others, managed a business, or were retired with little purposeful activity in their lives. As one woman commented, "I live with my younger sister and she wasn't very supportive initially. I had a nonfat cookbook and tried to fix things and she'd say things like that's not my favorite you know." Another woman reported, "I manage my own business and right now things are real busy here and I'm coming in early and getting home late so I'm not going to walk. When this is over I'll walk more." Yet another woman stated, "My biggest problem since I retired is trouble falling asleep and when I'm up at night I eat."

Special occasions such as holidays, vacations, family reunions, and company in one's home also created challenges for the women in their efforts to maintain their commitment to weight management success. As one woman commented, "When the holidays come around, it's very difficult to follow any kind of strict eating plan when you have things around you only get once a year." Another woman stated, "I hit a plateau a couple of times when I was on vacation or had company and we were eating out a lot." This same woman reported, "I went home for a week, and we had family reunions and community picnics and I gained a couple of pounds." Finally, weather conditions hindered the women as evidenced by the following comments. "My husband had walked

a couple times with me outside, but then we had all those snowstorms and I wasn't getting anything done."

> I do my walking in my neighborhood and when it's icy out as it has been for a long time, it's not easy to walk because some have cleaned the pavement and some have not. So I know I need to exercise more.

"Rain doesn't stop me, but snow and sleet do because I'm afraid of falling. And if the winds are real high I'm afraid of branches falling, but I can walk seven days a week most of the time."

Protecting oneself

The process of protecting oneself entailed shielding oneself from injury. The women in this study tried to avoid two types of injury: physical and psychological. Exercise was the primary focus of the women as they worked toward protecting themselves from physical injury. One woman commented, "When I come home after dinner, I think it's too late to exercise because they say if you exercise late it keeps you up at night." Another woman commented, "I don't exercise outside in the wintertime because I don't want to catch a cold." Yet another woman reported, "I exercise indoors because I'm in the city. Even though there are individual homes and a lot of area to walk, it's still not safe."

Avoidance tactics were the main strategy women used to minimize psychological injury. These strategies helped women keep their frustration low and their self-efficacy intact. "I'd be happy to get down to 150 or 160 pounds. I can't see fighting to get to some unrealistic weight. I'd be defeating myself before I start." "I tend to resist the psychological exercises because I 'm a little afraid to really get down and find that reason why I'm fat. Maybe I don't want to know why."

> Exercise is probably the key to everything because when you lose weight as you get older your skin can't adjust and your arms tend to get a little flabby. Exercise keeps you toned and keeps it tighter than it would be otherwise.

Evaluating progress

Evaluating progress was the process of determining the significance or worth of something through careful appraisal. The women in this study were evaluating their progress throughout the weight loss program. They were evaluating their progress towards their goal weight, changes in eating and exercise patterns, and improvements in exercise tolerance, and this helped them maintain their commitment to successful weight management.

> I was 170 pounds when I started. And I'm now at 158. I was 165 forever. I said I needed to get out of the 160s. I got down to 161 and I said I have only one more pound. So I look at each pound as a step in the right direction.

"I've changed a lot of things about my eating. I'm much more observant of fats; changed a lot of that, cut out the fatty stuff." "I think walking is a big, big factor. So I plan to do that for the rest of the time. I've come to enjoy it, and I think that's really important.

> I mean even the walking and how much more I can walk on that treadmill now than when I first started out. I mean just staying on there 20 minutes was a big deal. Now I'm on it 50 minutes, 55 minutes altogether…When I'm walking and doing some exercise I'm more hesitant to eat something.

Achieving Outcomes

The three phases, engaging, internalizing, and keeping one's commitment led to *achieving outcomes*. The women in this study achieved many outcomes. Most were pleased with the number of pounds they lost, but wanted to lose more because they had not yet achieved their goal weight. Despite not reaching their goal weight, most women felt successful because they had achieved important outcomes and made lifestyle changes to support weight loss: new eating and exercise habits, an improved sense of health and well-being, and strengthened self-efficacy and outcome beliefs. "It's just funny how I've changed. It's so much fun to go to the grocery store now. I read everything. I'm super conscious of what the label says and there are some things I don't even buy anymore." "It has definitely helped going up and down steps. I've noticed that more than anything. And I can walk faster and with more ease than I could back before I lost weight." "My knees are hurting less than before. It stands to reason that when you've got 24 less pounds bearing down on your knees that should make them ache less."

> But when you think the study has gone on for a year, 38 pounds is less than a pound a week so it's really been very, very gradual which I think holds a brighter future for not putting it back on fast.

> I guess where I am now is sort of just really beginning to have a real weight loss, a sense of losing and wanting to lose more, and finding out that if I cut back I can lose. I can certainly lose more. I know that I can.

Discussion

In this study, *"Taking Charge of One's Life"* emerged as a substantive theory for successful weight management for obese, post-menopausal women. *"Taking Charge of One's Life"* is consistent with a formal theory for obesity treatment, the behavioral self-management model. Both theoretical models assume that individuals can be educated to use self-control methods to make improvements in lifestyle behaviors (Goodrick & Foreyt, 1991). Lifestyle intervention strategies that have been found useful in behavior modification for weight loss include setting goals, raising awareness, confronting barriers, handling stress, cognitive restructuring, avoiding relapse, using social support, and contracting (Foreyt, 2005). The women in this study reported experiencing and/or

using the majority of these strategies during their involvement in the weight loss program that was part of the parent study.

Cognitive restructuring, one of the lifestyle intervention strategies, involves changing the way one thinks about oneself in a more positive, realistic manner (Foreyt, 2005). During the process of "*Taking Charge of One's Life,"* the women in the present study not only changed the way they thought about themselves, but they also changed their perceptions of their own ability to carry out the behaviors necessary for weight loss and their expectations of these behaviors. More specifically, they came to believe that changing their eating and exercise habits would result in weight loss and improved health and well-being (outcome expectations), and that they were capable of carrying out these behaviors (self-efficacy). Incorporating this form of cognitive restructuring into standard weight loss treatments aimed at behavioral modification might help strengthen them and improve weight loss and other health outcomes for participants. Another lifestyle intervention strategy is social support and involves eating and exercising with family, friends, or colleagues, supporting one another to stay the course (Foreyt). In "*Taking Charge of One's Life"* the aspect of social support was an important strategy that could both benefit or negate women's goals with weight loss. "*Taking Charge of One's Life"* assumes that negotiating social support is an ongoing process that must be continued indefinitely in order to maintain one's new eating and exercise behaviors. This view of social support as a necessary requirement for successful weight management is well-documented in the literature (Hogan, Linden, & Najarian, 2002; Nothwehr, 2004; Reicks, Mills, & Henry, 2004; Young, Northern, Lister, Drummond, & O'Brien, 2007).

The women who participated in the present study negotiated social support from both naturally occurring support systems, family and friends, and from the professionals and peers affiliated with the parent study and their respective weight loss groups. Social support from individuals as well as within groups has been reported to affect outcomes positively (Hogan et al., 2002). In some instances, however, one's social support can have a negative influence. In this study, family members were found to be both helpful and unhelpful. This finding is consistent with a study conducted to examine the influences of different types of support on weight control (Marcoux, Trenker, & Rosenstock, 1990). These findings reveal the complexity of interactions among family members and weight loss participants, indicating the multidimensional characteristics and contributing factors related to weight loss and obesity (Senekal, Albertse, Momberg, Groenewald, & Visser, 1999). Clearly there is some overlap between the lifestyle intervention strategies, confronting barriers and social support in "*Taking Charge of One's Life*." Sometimes family members, friends, and others are helpful and supportive, and other times they can present challenges and become a barrier to successful weight management. Incorporating strategies for dealing with support persons who are presenting challenges to weight management success into weight loss programs designed to facilitate behavioral self-management is likely to improve weight loss and other outcomes for participants in these programs.

Consistent with the finding that interactions among support persons and individuals trying to lose weight are complex, social cognitive theory (Bandura, 1971), assumes that behavior occurs as a result of a complex interplay among inner forces and environmental influences. Earlier experiences create expectations within individuals that certain behaviors will have desirable effects, other behaviors will produce unwanted

outcomes, and still others will have little significant impact. Thus, behavior is regulated to a large extent by anticipated outcomes (Bandura). In the present study, not only did anticipated outcomes, or outcome expectations, improve during weight loss treatment, the strengthening of outcome expectations facilitated the process of making a commitment to one's own weight management success.

Not only was the strengthening of outcome expectations helpful to the women as they proceeded through their weight loss program, but also helpful was the strengthening of self-efficacy beliefs. This finding is consistent with Wamsteker et al.'s (2005) study examining self-efficacy within a regulation model framework: They found that one's beliefs in his/her ability to lose weight at the beginning of a diet was predictive of one's ability to lose weight. In the current study, even though most women did not lose as much weight as they desired, their self-efficacy beliefs remained intact. The women attributed their failure to achieve their goal weight to low personal effort or to a highly stressful period in their lives reflecting a self-regulatory focus on negative outcomes (Vartanian, Herman, & Polivy, 2006). Although most women in this study did not succeed in achieving their full weight loss goal, most felt successful because of other important outcomes they achieved. These findings support Allan's (1994) contention that health promotion care related to weight management must include a whole range of health outcomes, not merely reduced body weight.

In Allan's (1989) ethnographic study of women who successfully managed their weight outside of formal treatment programs, two major reasons for wanting to lose weight emerged: self-focused (losing weight for oneself) and other-focused (losing weight for others). Most women in the present study wanted to lose weight for both self-focused and other-focused reasons.

Although women in the present study had both self-focused and other-focused reasons for wanting to lose weight, their reasons were not solely related to weight. Most women wanted to have more energy, feel better about themselves, and establish a healthy lifestyle. By the end of the weight loss program, many of these women had made significant changes in their eating habits, exercise routines, and interpersonal relations. These outcomes are significant in light of Allan's (1989) finding that older women must engage in the process of "changing one's whole life" by making permanent changes in their eating and exercise routines, to lose weight and successfully maintain their weight losses. The process of "changing one's whole life" appears similar to the process of "*Taking Charge of One's Life*" in that both help to initiate and maintain the evolution of a new lifestyle.

The process of "*Taking Charge of One's Life"* also involves three phases: engaging, internalizing, and keeping one's commitment. The first two phases, engaging and internalizing, are predominately cognitive-oriented subprocesses. The third phase, keeping one's commitment, uses predominately action-oriented strategies. These findings are consistent with the transtheoretical model of behavioral change (Sarkin, Johnson, Prochaska, & Prochaska, 2001), in which the stages of precontemplation, contemplation, and preparation are best described as cognitive processes prior to any action. These thinking stages are then followed by the action stages of action and maintenance. The transtheoretical model of behavioral change has been useful for researchers in monitoring and measuring weight loss and management behaviors (Krummel, Semmens, Boury, Gordon, & Larkin, 2004).

Conclusion

This study used a grounded theory approach to explore the process of weight loss in obese women who were participating in a formal weight loss program. As interview data were collected and analyzed a substantive theory for weight management success emerged. Given the high prevalence and rapid growth of obesity in society, chronic health problems associated with obesity, and the high cost of obesity treatment and related illnesses, this study may be helpful in understanding the importance of tailoring interventions to heterogeneous characteristics of those involved. This model may be helpful as clinicians begin to understand more of the complexities, facilitators, and inhibitors of successful weight loss programs for older women. This model describes formal weight loss program participation experiences for post-menopausal women; relevance to other groups should not be assumed as social support, food and lifestyle choices, and exercise facilitators and inhibitors will differ for children, men, and younger women. Additional inquiry and greater depth of analyses are needed to understand if this model is unique to this sample of older women or the specific program. Perhaps "*Taking Charge of One's Life"* is required to promote successful and sustained weight loss.

The unique contribution of this study is that it examined and identified the subjective processes that were used by women as they participated in a formal weight loss program from their perspectives. To date, this has not been done in other studies on obesity. There were also limitations. One important limitation is that the women were part of a larger study in which they were receiving many secondary benefits, which may have led them to censure what they shared about their experiences. Another limitation was that the women were already required to devote a significant amount of their time to meet the requirements of the parent study, and asking them to be interviewed for the present study was an additional request. Therefore, out of consideration for them and to address respondent burden, each women was interviewed only once.

Finally, as the substantive theory, "*Taking Charge* o*f One's Life,"* that emerged from this study is further developed and refined, it may become relevant for other problematic areas of life besides obesity and weight management. For instance, it would seem plausible that women in domestic violence situations, persons with migraine headaches, individuals who are depressed, and many others might go through the same processes of engaging, internalizing, and making a commitment before successfully managing or resolving these issues. If this were to occur, then "*Taking Charge of One's Life"* would then become a formal theory, the ultimate aim of grounded theory research.

References

Allan, J. D. (1988). Knowing what to weigh: Women's self-care activities related to weight. *Advances in Nursing Science*, *11*(1), 47-60.

Allan, J. D. (1989). Women who successfully manage their weight. *Western Journal of Nursing Research*, *11*(6), 657-675.

Allan, J. D. (1991). To lose, to maintain, to ignore: Weight management among women. *Health Care for Women International*, *12*(2), 223-225.

Allan, J. D. (1994). A biomedical and feminist perspective on women's experiences with weight management. *Western Journal of Nursing Research, 16*(5), 524-543.

Bandura, A. (1971). *Social learning theory*. Morristown, NJ: General Learning Press.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review, 84*(2), 191-215.

Berger, P., & Kellner, H. (1981). *Sociology reinterpreted*. New York: Anchor Books.

Centers for Disease Control and Prevention. (2006). *Prevalence of overweight and obesity among adults: United States, 2003-2004*. Retrieved December 20, 2006, from http://www.cdc.gov/nchs/products/pubs/pubd/hestats/overweight/overwght_adult_03.htm

Dennis, K. E., & Goldberg, A. P. (1996). Weight control self-efficacy types and transitions affect weight-loss outcomes in obese women. *Addictive Behaviors, 21*(1), 103-116.

Dennis, K. E., Tomoyasu, N., McCrone, S. H., Goldberg, A. P., Bunyard, L., & Qi, B. B. (2001). Self-efficacy targeted treatments for weight loss in postmenopausal women. *Scholarly Inquiry for Nursing Practice: An International Journal, 15*(3), 259-276.

Fabricatore, A. N., & Wadden, T. A. (2003). Treatment of obesity: An overview. *Clinical Diabetes, 21*(2), 67-72.

Finkelstein, E. A., Fiebelkorn, I. C., & Wang, G. (2003). National medical spending attributable to overweight and obesity: How much, and who's paying? *Health Affairs: The Policy Journal of the Health Sphere, W3*, 219-226.

Foreyt, J. P. (2005). Need for lifestyle intervention: How to begin. *American Journal of Cardiology, 96*(Suppl.), 11E-14E.

Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory*. Mill Valley, CA: The Sociology Press.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine De Gruyter.

Goodrick, G. K., & Foreyt, J. P. (1991). Why treatments for obesity don't last. *Journal of the American Dietetic Association, 91*(10), 1243-1247.

Hogan, B. E., Linden, W., & Najarian, B. (2002). Social support interventions: Do they work? *Clinical Psychology Review, 22*, 381-440.

Hutchinson, S. A. (1993). Grounded theory: The method. In P. L. Munhall & C. O. Boyd (Eds.), *Nursing research: A qualitative perspective* (pp. 180-212). New York: NLN Press.

Hutchinson, S., & Wilson, H. S. (1992). Validity threats in scheduled semi-structured research interviews. *Nursing Research, 4*(12), 117-119.

Krummel, D. A., Semmens, E., Boury, J., Gordon, P. M., & Larkin, K. T. (2004). Stages of change for weight management in post partum women. *Journal of the American Dietetic Association, 104*, 1102-1108.

Marcoux, B. C., Trenker, L. L., & Rosenstock, I. M. (1990). Social networks and social support in weight loss. *Patient Education and Counseling, 15*, 229-238.

National Center for Health Statistics. (2007). *Obesity among adults in the United States – No statistically significant change since 2003-2004*. Retrieved April 23, 2008, from http://www.cdc.gov/nchs/data/databriefs/db01.pdf

National Institutes of Health, National Heart Lung and Blood Institute, NHLBI Obesity Education Initiative, & North American Association for the Study of Obesity. (2000). *The practical guide: Identification, evaluation, and treatment of overweight and obesity in adults.* Bethesda, MD: NIH.

Nothwehr, F. (2004). Attitudes and behaviors related to weight control in two diverse populations. *Preventive Medicine, 39,* 674-680.

Prochaska, J. O., Norcross, J. C., Fowler, J. L., Follick, M. J., & Abrams, D. B. (1992). Attendance and outcome in a work site weight control program: Processes and stages of change as process and predictor variables. *Addictive Behaviors, 17,* 35-45.

Reicks, M., Mills, J., & Henry, H. (2004). Qualitative study of spirituality in a weight loss program: Contribution to self-efficacy and locus of control. *Journal of Nutrition Education and Behavior, 36*(1), 13-19.

Rew, L., Bechtal, D., & Sapp, A. (1993). Self-as-instrument in qualitative research. *Nursing Research, 42*(5), 300-301.

Rodgers, B. L., & Cowles, K. V. (1993). The qualitative research audit trail: A complex collection of documentation. *Research in Nursing and Health, 16,* 219-226.

Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science, 8*(3), 27-37.

Sarkin, J. A., Johnson, S. S., Prochaska, J. O., & Prochaska, J. M. (2001). Applying the Transtheoretical Model to regular moderate exercise in an overweight population: Validity of a stages of change measure. *Preventive Medicine, 33,* 462-469.

Senekal, M., Albertse, E. C., Momberg, D. J., Groenewald, C. J., & Visser, E. M. (1999). A multidimensional weight-management program for women. *Journal of the American Dietetic Association, 99,* 1257-1264.

Strauss, A. (1987). *Qualitative analysis for social scientists*. New York: Cambridge University Press.

Strauss, A, & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

Teixeira, P. J., Going, S. B., Houtkooper, L. B., Cussler, E. C., Metcalfe, L. L., Blew, R.. M.,.et al. (2006). Exercise motivation, eating, and body image variables as predictors of weight control. *Medicine & Science in Sports & Exercise, 38*(1), 179-188.

The Obesity Society. (2008). *Obesity statistics*. Retrieved April 23, 2008, from http://www.obesity.org/statistics/obesity_trends.asp

Vartanian, L. R., Herman, C. P., & Polivy, J. (2006). Does regulatory focus play a role in dietary restraint? *Eating Behaviors, 7,* 333-341.

Wadden, T. A., Brownell, K. D., & Foster, G. D. (2002). Obesity: Responding to the global epidemic. *Journal of Consulting and Clinical Psychology, 70*(3), 510-525.

Walcott-McQuigg, J. A., Chen, S., Davis, K., Stevenson, E., Choi, A., & Wangsrikhun, S. (2002). Weight loss and weight loss maintenance in African-American women. *Journal of the National Medical Association, 94*(8), 686-694.

Wamsteker, E. W., Geenen, R., Iestra, J., Larsen, J. K., Zellisen, P. M. J., & Van Staveren, W. A. (2005). Obesity-related beliefs predict weight loss after an 8-week low-calorie diet. *Journal of the American Dietetic Association, 105,* 441-444.

White, J. H. (1984). The process of embarking on a weight control program. *HealthCare for Women International, 5*, 77-91.

Young, K. M., Northern, J. J., Lister, K. M., Drummond, J. A., & O'Brien, W. H. (2007). A meta-analysis of family behavioral weight loss treatments for children. *Clinical Psychology Review, 27*, 240-249.

Appendix A

Interview Guide

1. How did you gain weight prior to joining this weight loss program? Prior to joining other weight loss programs?
2. Tell me about your prior weight loss attempts.
3. How did you decide to lose weight at this particular time? In this particular weight loss program?
4. Tell me about your experiences in this weight loss program?
5. What strategies did you use to lose weight as you participated in this weight loss program?
6. What made you select those particular strategies?
7. What helped you as you attempted to lose weight in this weight loss program? Within the program? Outside the program?
8. What made it difficult for you as you attempted to lose weight while participating in this weight loss program? Within the program? Outside the program?
9. How do you feel/what do you think about the number of pounds you lost? About meeting or not meeting your weight loss goals?
10. What positive changes have occurred in your life, in general, and within yourself, as a result of losing weight?
11. Have there been negative changes in your life, in general, and within yourself, as a result of losing weight?
12. What are the positive consequences, if any of not losing weight? Of not meeting your weight loss goals?
13. What are the negative consequences, if any, of not losing weight? Of not meeting your weight loss goals?
14. What pieces of this weight loss program worked particularly well for you? How did they work for you? Were there pieces that worked less well for you? If so, please elaborate.
15. Are there aspects of this weight loss program that you would change to make it more helpful to you in your weight loss efforts? If so, please elaborate.
16. Are there aspects of this weight loss program that you would not change? If so, please elaborate.
17. What factors outside this program impacted your weight loss effort? Factors within you? Factors external to you?
18. What would you need to change within yourself to facilitate your weight loss success in this weight loss program?
19. What would you need to change in your life (external to yourself) to facilitate your weight loss success in this weight loss program?

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