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**Personal experiences of formerly obese individuals maintaining significant weight loss : a descriptive study : a project based upon an investigation at the Weight Management Program of San Francisco, Inc., San Francisco, California**

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*Smith College*

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Jennifer L. Simon  
(The Weight Management  
Program of San Francisco,  
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Personal Experiences of  
Formerly Obese Individuals  
Maintaining Significant  
Weight Loss: A Descriptive  
Study

## ABSTRACT

This study explored and described how psychological processes relate to maintaining significant weight loss. The goals for this study were to add to the weight literature the personal experiences of individuals maintaining significant weight loss and to better understand the needs of these individuals so as to develop psychological interventions that are effective in assisting with successful weight loss maintenance (WLM) and in reducing the perceived difficulty of WLM. Twelve formerly obese adults currently engaged in WLM, recruited primarily from The Weight Management Program of San Francisco, Inc., were interviewed about their perceptions, thoughts, emotions, and self-concepts as they reflected on both their past and current WLM efforts.

This study confirmed previous research suggesting: (i) the importance of sustained WLM-related behaviors to successful WLM; (ii) the importance of external support to successful WLM; (iii) the importance of sustained cognitive restraint around eating to successful WLM; and (iv) the persistent difficulty of, and effort required for, long-term WLM. This study also suggested areas for future intervention and study, including: (i) education of social workers about the difficulties of WLM and the importance of providing supportive and non-judgmental therapeutic environments; (ii) creation of courses to introduce social work students to issues

around weight; (iii) education of the public about the difficulty of weight loss and WLM to reduce the stigma of overweight and obesity; and (iv) further research on how individuals engaged in WLM can move from a place of struggling with WLM to a place of acceptance around WLM.

PERSONAL EXPERIENCES OF  
FORMERLY OBESE INDIVIDUALS  
MAINTAINING SIGNIFICANT WEIGHT LOSS:  
A DESCRIPTIVE STUDY

A project based upon an investigation at The Weight Management Program of San Francisco, Inc., San Francisco, California, submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

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2011

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## **CHAPTER ONE**

### **Introduction**

#### **Obesity and Its Health Risks**

The National Institutes of Health of the U.S. Department of Health and Human Services (NIH) and the World Health Organization (WHO) define obesity as a body mass index (BMI), which is an adult's weight in kilograms divided by the square of such adult's height in meters, equal to or greater than 30 (National Institutes of Health [NIH], 2007; World Health Organization [WHO], 2006). A BMI "of 18.5 to 24.9 is considered healthy. A person with a BMI of 25 to 29.9 is considered overweight, and a person with a BMI of 30 or more is considered obese" (NIH, 2007, BMI, para. 1).

From the early 1960s to the mid-2000s, "the prevalence [of overweight and obesity] steadily increased among both genders, all ages, all racial/ethnic groups, all educational levels, and all smoking levels . . . from 13.4 to 35.1 percent in U.S. adults age 20 to 74" (NIH, 2010, "Overweight and Obesity," para. 14; Jakicic et al., 2001). Indeed, from 1980 to 2004 alone, the prevalence of obesity in the United States doubled (Kraschnewski et al., 2010; Sjöström et al., 2007). Currently, the NIH estimate that 68.0% of U.S. adults are overweight or obese, and, of these adults, 33.8% are obese and 5.7% are morbidly obese (defined as having a BMI  $\geq$  40) (2010; Kirschenbaum, 1996; Kraschnewski et al., 2010). This issue is not unique to the United States. In fact, "WHO's latest projections indicate that globally in 2005: approximately 1.6 billion adults (age 15+) were overweight; [and] at least 400 million adults were obese" (WHO, 2006, Facts about Overweight and Obesity, para. 1).

Furthermore, race and economic status impact obesity rates. The NIH found that non-Hispanic Black women and Hispanic women have higher rates of obesity than do non-Hispanic white women, at 49.6%, 43%, and 33%, respectively. The difference in obesity among men across races is smaller but still exists, with non-Hispanic Black men, Hispanic men, and non-Hispanic white men having obesity rates of 37.3%, 34.3%, and 31.9%, respectively (NIH, 2010). Furthermore, a number of studies, including Black and Macinko's (2008) meta-analysis of studies on neighborhood factors as they relate to residents' BMIs, have suggested that lower socioeconomic status was positively correlated with BMI. Therefore, it appears that certain oppressed populations, such as ethnic minorities and low-income individuals, are at the greatest risk for being overweight and obese.

The vast majority of research indicates that obesity is correlated with increased mortality, such that the life expectancy of severely obese persons is five to 20 years shorter than that of normal weight persons (Sjöström et al., 2007). Indeed, "obesity significantly increases the risk of morbidity from hypertension, dyslipidemia, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea and respiratory problems, and endometrial, breast, prostate, and colon cancers" (Wysoker, 2002, p. 168). Additionally, "overweight and obesity are major risk factors for a number of chronic diseases, including diabetes, cardiovascular diseases and cancer" (WHO, 2010, Obesity, para. 2; Jakicic et al., 2001; Kirschenbaum, 1996; Kirschenbaum & Fitzgibbon, 1995) and are associated with clear increases in high blood pressure and high blood cholesterol (Kirschenbaum, 1996; Kirschenbaum & Fitzgibbon, 1995). Morbid obesity is linked with "severely reduced quality of life" (Zijlstra, Boeije, Larsen, van Ramshorst, & Geenen, 2009, p. 108). Overweight and obesity also take a toll on psychological health. Zijlstra, Boeije, Larsen, van Ramshorst, and Geenen (2009) note that "it is well

documented, and confirmed by our study participants, that being overweight can increase mental problems, social isolation, and feelings of shame” (Zijlstra et al., 2009, pp. 109–110).

Weight loss, even of as little as 10% of an obese person’s initial body weight, is associated with “improvement of intermediate risk factors for disease” (Sjöström et al., 2007, p. 742; Bond, Phelan, Leahey, Hill, & Wing, 2009). Indeed, weight loss is associated with “clinically and statistically significant improvements in blood pressure, heart morphology and functioning, lipid profile, glucose tolerance among diabetics, sleep disorders, and respiratory functioning” (Kirschenbaum & Fitzgibbon, 1995, p. 51; Kirschenbaum, 1996) and with a reduction in “risk factors for diabetes and cardiovascular disease” (Weiss, Galuska, Khan, Gillespie, & Serdula, 2007, p. 34).

Unfortunately, research has shown that few people are successful at losing weight and maintaining weight loss on their own (Kirschenbaum, 1996), and nonprofessional commercial weight loss programs “provide relatively little evidence of long-term effectiveness” (Kirschenbaum, 1996, p. 166; Kirschenbaum, 1992). Professional weight loss treatments (WLTs) appear to be more effective in assisting with weight loss (see, e.g., Anderson, Conley, & Nicholas, 2007; Anderson, Grant, Gotthelf, & Stifler, 2007; Foster, Kendall, Wadden, Stunkard, & Vogt, 1996). The most widely available professional WLTs are behavioral and pharmacological treatments (Byrne, Cooper, & Fairburn, 2004; Byrne, Cooper, & Fairburn, 2003; Harvard Medical School [HMS], 2008), including “Behavioural or Cognitive-Behavioural intervention . . . offered in conjunction with diet and exercise interventions” (Green, Larkin, & Sullivan, 2009, p. 998). However, even utilizing these best practices, most obese adults lose only 5%–10% of their initial body weight (Bond et al., 2009; Byrne et al., 2004; Green et al., 2009; HMS, 2008; Thomas & Wing, 2009).

While this small amount of weight loss is discouraging, far more discouraging is that the vast majority (80%–85%) of these adults return to, and in many cases exceed, their pre-WLT weights within three to five years following WLT (Bidgood & Buckroyd, 2005; Byrne et al., 2004; Byrne et al., 2003; Green et al., 2009; HMS, 2009; Weiss et al., 2007; Wysoker, 2002). Although only measured at one year following WLT, Kraschnewski et al.'s 2010 study of approximately 14,000 participants in the National Health and Nutrition Examination Survey (NHANES) found somewhat more encouraging results: of U.S. adults who had ever been overweight or obese, 36.6% reported weight loss maintenance (WLM) for at least one year of at least 5% of their initial body weight; 17.3% reported at least 10%; 8.5% reported at least 15%; and 4.4% reported at least 20%. Nevertheless, “some observers have asserted that long-term success rates are so low that providing long-term behavioral weight loss treatment may ultimately be futile” (Svetkey et al., 2008, p. 1145).

Given the high prevalence of obesity and its concomitant serious physical and mental health risks, both significant weight loss and its successful long-term maintenance are essential. The low 15%–20% success rate of WLM beyond the five-year mark utilizing the most commonly available WLTs suggests that important components of successful WLT may yet be undiscovered.

### **This Study**

Though there is a vast amount of research that has been done on obesity, weight loss, and weight loss maintenance, even a cursory review of that literature makes clear that the voices of those individuals who deal with issues of weight are largely missing from the research. This study is a descriptive qualitative study that aims to document and describe the personal experiences of formerly obese adults who are maintaining significant weight loss. The central

question of this study focuses on an exploration of how psychological processes relate to maintaining weight loss. This is addressed by examining the perceptions, thoughts, emotions, and self-concept (both positive and negative) of study participants as they reflect on both their past and current efforts in maintaining their weight loss.

The goals for this study are: (i) to add to the weight research literature the voices and personal internal experiences of these individuals around maintaining significant weight loss, and (ii) to better understand the needs of individuals maintaining weight loss to help inform further study and development of psychological interventions for this population that are effective not only in assisting with successful weight loss maintenance but also in reducing the perceived internal difficulty of maintaining weight loss. Because this population is particularly vulnerable to adverse health and mental health outcomes, understanding the internal experiences of this population around weight is particularly relevant to social work and psychological practice.

In order to address these goals, I conducted one-on-one in-person and phone interviews with 12 formerly obese adults meeting my study criteria which addressed these individuals' internal experiences around food, eating, and weight loss maintenance. The questions centered around what participants found easy and what they found difficult about maintaining weight loss; participants' day-to-day experiences regarding the mental and emotional time and energy they devoted to maintaining their weight loss and whether there were situations in which they tended to devote more or less time and energy to maintaining their weight loss; whether and how participants' weight factored into their self-concepts; how participants defined *success* with regard to the maintenance of weight loss and whether and how this definition had changed over time; participants' mental and emotional reactions to periods in which they perceived they were unsuccessful in maintaining their weight loss; and what participants found to be mentally and

emotionally supportive and unsupportive to maintaining weight loss. I also asked those follow-up questions that I deemed necessary for clarification.

Chapter Two of this study presents a literature review of the current research regarding non-surgical weight loss and WLM. Chapter Three discusses the methodology by which data was collected and analyzed and study limitations. Chapter Four sets forth the results of the data analysis, including key findings. Chapter Five considers the implications of the study's findings in relation to the previous research in the areas of weight and WLM, the purposes of this study, and clinical social work practice.

## **CHAPTER TWO**

### **Literature Review**

The purpose of this study is to describe the personal experiences of formerly obese adults who are maintaining significant weight loss through an exploration of how psychological processes, including perceptions, thoughts, emotions, and self-concept, relate to maintaining weight loss. The following literature review focuses on previous research on weight, overweight and obesity, weight loss, and WLM as it relates to this study's purpose. The first section briefly reviews the vast amount of research being conducted on a wide variety of issues related to weight and obesity. The second section discusses the current best practice approaches to significantly reducing weight in obese persons. The third section reviews the current information on weight loss and WLM derived from a large, U.S.-based data-aggregation tool on successful weight-loss maintainers, the National Weight Control Registry (NWCR). Because the current study focuses on formerly obese individuals maintaining significant weight loss, the bulk of this literature review is concentrated in the fourth section, which focuses on the research examining the effectiveness of long-term WLM among formerly obese populations, suggesting both behavioral and psychological factors that relate either to successful WLM or weight regain and models that have been developed synthesizing these factors. The final two sections review the relatively few studies examining issues of weight loss and WLM from the perspective of the dieters and maintainers themselves and discuss the need suggested by gaps in the previously discussed research for this study's further, in-depth examination of the psychological factors

related to WLM and weight regain from the perspectives of individuals maintaining significant weight loss and struggling with weight regain.

### **Areas of Research Relating to Eating, Weight, and Obesity**

There is a large volume of research on the biological, neurological, and genetic phenomena involved in eating, overeating, and obesity, including research examining the applicability of addiction models, most of which attempts to explain overweight and obesity (e.g., Jaffe, 2010; Johnson & Kenny, 2010) or to find neurochemical “cures” for overeating and overweight/obesity. For example, in a recent study, Johnson and Kenny (2010) found that rats with prolonged and unlimited access to highly palatable high-fat foods developed compulsive-like food seeking behaviors that were resistant to disruption by aversive stimuli, findings which “support previous work in indicating that obesity and drug addiction may arise from similar neuroadaptive responses in brain reward circuits” (Johnson & Kenny, 2010, p. 641).

Genetics have been implicated in overweight and obesity for many years. Prior to the mid-1990s, the majority of weight-related genetic research focused on demonstrating a genetic component to overweight and obesity (Martinez-Hernandez, Enriquez, Moreno-Moreno, & Marti, 2007). It has now been well-established, through quantitative genetics analyses of twins, siblings and families, that obesity is a highly heritable genetic trait, with 40%-70% heritability (Farooqi & O’Rahilly, 2005; Martinez-Hernandez et al., 2007). Since the mid-1990s, weight-related genetic studies have increasingly focused on uncovering the polygenic (many genes, each with a relatively small contribution) and oligogenic (few genes, each with a large contribution) genetic configurations related to overweight and obesity (Martinez-Hernandez et al., 2007). Further, moderate genetic heritability for eating behaviors thought to be related to overweight and obesity, such as binge eating, has also been established (Bulik, Sullivan, & Kendler, 2003).

Indeed, Bulik, Sullivan, and Kendler (2003) also found a modest genetic correlation between obesity and binge eating.

There are also a number of studies addressing external cues and triggers involved in overeating (e.g., Bond et al., 2009; Niembier, Phelan, Fava, & Wing, 2007). For example, in their study of formerly obese individuals who had lost weight either through bariatric surgery or through non-surgical means, Bond et al. (2009) discussed the importance of “cues that trigger overeating among individuals who have achieved large weight losses” (p. 179). Likewise, Niembier, Phelan, Fava, and Wing (2007) examined whether disinhibition of eating in response to external situational cues predicted weight regain among weight-loss maintainers.

Other studies have attempted to chronicle and classify eating behaviors in a variety of populations (e.g., Barberia, Attree, & Todd, 2008; Lyons, 1998; Macht, 2008). For example, Barberia, Attree, and Todd (2008) interviewed overweight and obese Spanish women enrolled in weight loss treatment about their eating behaviors and the beliefs and attitudes the women reported about those behaviors, noting that negative beliefs and attitudes about dieting and about the ability to control one’s eating were positively correlated with diet failure. Lyons (1998) explored the phenomena of compulsive overeating and binge eating through interviews with adult professional women, as discussed further below. Macht (2008) reviewed a considerable number of research reports which categorized styles of eating linked with overweight and obesity, including *restrained eating*, *emotional eating*, and *normal eating*. Macht (2008) found that emotions high in arousal or intensity tended to reduce eating, emotions low in arousal or intensity did not appreciably affect eating, but emotions moderate in arousal or intensity affected eating in different ways for the different types of eaters:

- (a) in restrained eating, negative and positive emotions enhance food intake due to impairment of cognitive control.
- (b) in emotional eating, negative emotions elicit the tendency to be regulated by eating and, as a consequence, enhance intake of sweet and high-fat foods.
- (c) in normal eating, emotions affect eating in congruence with their cognitive and motivational features. (p. 4)

Other studies have looked at environmental factors, such as socioeconomic status, food availability, and physical activity resources in neighborhoods, particularly in urban areas, to determine the environmental impact on overweight and obesity. Black and Macinko (2008) conducted a meta-analysis of a number of such studies, concluding that “neighborhood-level measures of economic resources were associated with obesity . . . . Availability of healthy versus unhealthy food was inconsistently related to obesity, while neighborhood features that discourage physical activity were consistently associated with increased body mass index” (p. 2).

### **Most Effective Currently Available Weight Loss Treatments**

There has been a great deal of research conducted on the most effective surgical and non-surgical WLTs. Surgical WLTs include a variety of bariatric surgeries, such as gastric bypass, vertical banded gastroplasty, and nonadjustable or adjustable gastric banding (Sjöström et al., 2007; Zijlstra et al., 2009), and are typically available to individuals with a BMI of at least 40 or a BMI of at least 35 with serious co-morbidity (Zijlstra et al., 2009). Even though bariatric surgery patients tend to lose about 25% of their initial body weights within the first year after surgery (Bond et al., 2009), for myriad reasons, including the physiological changes produced by bariatric surgery (Buchwald et al., 2004; Sjöström et al., 2007), a review of successful weight loss and WLM of formerly obese individuals who lose weight through bariatric surgery is beyond the scope of this study.

Of those individuals who non-surgically lose large percentages of their initial body weight, most do so through formal assistance (Bond et al., 2009). The most effective formal assistance has been found to be professional WLTs utilizing long-term behavioral treatment, including weekly classes throughout the weight-loss period, and very low-calorie diets (VLCD) of only 500–1000 calories per day, usually in the form of fortified meal replacements (Anderson, Conley, et al., 2007; Anderson, Grant, et al., 2007; Mooney, Burling, Hartman, & Brenner-Liss, 1992).

Participants in professional VLCD WLTs lose more weight and initially maintain more weight loss, in both pounds lost and percentages of their initial body weights, than do the general population of dieters discussed above, but long-term maintenance rates are mixed. One study of individuals enrolled in a professional VLCD WLT found that participants lost an average of 46.4 lbs after 6 months of participation in the WLT (Foster et al., 1996). An average of 58 months later, 81% had regained more than 75% of the weight lost (Foster et al., 1996). Fifty percent of participants were more than 11 lbs above their 6-month weight loss baseline, 33% had maintained their weight loss within 11 lbs, and 17% had lost more than an additional 11 lbs (Foster et al., 1996). Another study of individuals enrolled in three such professional VLCD WLTs indicated that participants lost an average of 20%–39% of their initial body weights and maintained losses of 12%–25% of their initial body weights at intervals ranging from 64–95 weeks post-weight loss, depending on the length of time they remained in treatment (Anderson, Conley, et al., 2007). In a longer-term study of similar VLCD WLTs, individuals who initially lost an average of 134 pounds regained 41% of the weight they initially lost over the first 36 months post-weight loss, then regained another 10% over the next 24 months, resulting in a

maintenance of approximately 50% of their initial weight loss (67 pounds) at 60 months post-weight loss (Anderson, Grant, et al., 2007).

### **National Weight Control Registry Data**

The NWCR was established in 1993 “to provide information about individuals who have been successful in long-term weight loss maintenance” (Hill, Wyatt, Phelan, & Ring, 2005, p. 206). The NWCR contains data on a self-selected group of successful weight-loss maintainers who are at least 18 years of age, have lost at least 30 lbs, and have maintained that 30 lb-loss for at least 1 year (Bond et al., 2009; Hill, Wyatt, Phelan, & Ring, 2005; McGuire, Wing, Klem, Land, & Hill, 1999; Phelan, Hill, Lang, Dibello, & Wing, 2003). Members of the NWCR have lost an average of 66 lbs and have kept the weight off for an average of 5.5 years (NWCR, n.d.).

A number of studies have assessed the weight loss and WLM of individuals enrolled in the NWCR, synthesizing the amount of lost weight regained by NWCR participants. Bond et al. (2009) found that their sample of NWCR participants had regained an average of 10 lbs (8% of initial weight lost) one year after entry into the registry. One year after entry into the NWCR, 35% of McGuire, Wing, Klem, Land, and Hill’s (1999) participant sample had regained more than 5 lbs since entry. Phelan, Hill, Lang, Dibello, and Wing (2003) found that, at two years post-entry, their NWCR participants had regained an average of 8.4 lbs, indicating that 96.4% of their participants remained 10% or more below their lifetime maximum weight.

These studies of NWCR participants suggest that among the United States’ most successful weight-loss maintainers, at least modest weight regain is still common. Unfortunately, it appears that relosing this regained weight may be quite difficult. Phelan et al. (2003) found that only 11% of NWCR participants who had regained some weight were able to reduce back to their baseline weight at year two after a weight regain at year one, even when the weight regains

were a modest 1%–3% of their initial body weight at year one. As the amount of regained weight increased over 5% of initial body weight at year one, only 4.7% of regainers were able to re-attain their baseline weight, and only 12.9% were able to re-lose even half of the weight they had regained (Phelan et al., 2003). This research makes it clear that understanding the difficulties of maintaining weight loss long term is paramount to reducing levels of overweight and obesity and their related health risks.

### **Weight Loss Maintenance and Weight Regain**

The two main approaches that have been used by researchers to examine the factors associated with WLM and weight regain are studying successful long-term weight-loss maintainers and conducting randomized trials to evaluate specific approaches in improving long-term WLM (Thomas & Wing, 2009). Therefore, this section of the literature review is organized similarly, while also including a sub-section on models derived from the WLM research.

**Studies of weight-loss maintainers.** A number of studies have examined the factors that contribute to the maintenance of large weight losses by initially obese adults (Bond et al., 2009; Foster et al., 1996; Hill et al., 2005; McGuire et al., 1999; Phelan et al., 2003; Phelan et al., 2009) and the factors that contribute to weight regain after large weight losses (Bond et al., 2009; McGuire et al., 1999; Niembier, Phelan, Fava, & Wing, 2007; Phelan et al., 2003).

In a qualitative study of formerly obese women who had lost weight and maintained it for at least one year and obese women who had lost weight but regained the weight lost, Byrne, Cooper, and Fairburn (2003) found that regainers, as compared to maintainers, were less likely to maintain a low-fat diet, regular exercise, and consistent weight monitoring and were more likely to have not achieved their weight loss goals, to be dissatisfied with their reduced weights, to place great importance on weight as a measure of self-worth, to lack vigilance with regard to

their weight, to show a dichotomous thinking style, to respond to adverse life events by eating, and to regulate negative moods by eating. The authors concluded that “psychological factors may, at least partly, account for many individuals’ lack of persistence with weight maintenance behaviour following successful weight loss” (Byrne, et al., 2003, p. 960). In a 2004 study of psychological predictors for weight regain among women who had lost weight, Byrne, Cooper, and Fairburn found that “one cognitive factor (dichotomous thinking) and one historical variable (maximum lifetime weight)” were identified as “prospective predictors of weight regain” (p. 1341).

In their study of NWCR participants who had lost weight either through bariatric surgery or through non-surgical means, Bond et al. (2009) found that non-surgical weight-loss maintainers consumed lower fat (but higher carbohydrate) diets, ate less fast food, ate breakfast more often, reported less “night eating,” and expended more calories through exercise, specifically high-intensity exercise, than post-surgical weight-loss maintainers (Bond et al., 2009). Furthermore, non-surgical participants reported higher dietary restraint throughout the study (Bond et al., 2009). The researchers concluded that those “participants who achieved large weight losses through non-surgical methods had to work harder to maintain their weight losses than the surgical participants, . . . [and the] non-surgical participants reported more conscious control over their eating” (Bond et al., 2009, p. 177). Indeed, “higher levels of disinhibition [around eating] at study entry and increases in disinhibition over 1 year emerged as the only significant predictors of weight regain in surgical and non-surgical participants” (Bond et al., 2009, p. 178), suggesting that “modifying disinhibited eating patterns” (Bond et al., 2009, p. 178) and “designing methods to increase resistance to cues that trigger overeating among

individuals who have achieved large weight losses” (Bond et al., 2009, p. 179) can improve weight-loss maintenance and prevent weight regain.

Foster et al. (1996) assessed the psychological effects of repeated weight loss and regain on women who were participating in professional VLCD WLT across five psychological variables – mood, binge eating, cognitive restraint (conscious attempts to monitor and regulate eating), disinhibition (disruptions in restraint in response to cues), and hunger. In addition to concluding that cycles of weight loss and regain did not negatively affect these five variables, Foster et al. found that, although there were changes in binge eating and disinhibition, only changes (reductions) in restraint were correlated with increases in weight from immediately post-weight loss to the 57-month follow-up. Interestingly, Foster et al. (1996) noted that their study participants tended not to begin another diet until their weight exceeded their initial pre-WLT weight, which caused the researchers to suggest that “research effort should focus on the nature of obese patients’ cognitions in the post-weight loss period and examine the factors that mediate patients’ decisions to reverse small weight gains and / or seek additional treatment” (p. 756).

Hill et al. (2005) found that NWCR participants as a whole reported consuming low-calorie, low-fat diets, consuming breakfast every day, engaging in high levels of physical activity (60 minutes per day), and weighing themselves on a daily basis, and those who maintained their weight loss reported better maintenance of the aforementioned behaviors. The authors also found that the longer NWCR participants maintained their weight loss, the more likely they were to continue to maintain it.

In examining demographic, behavioral, and psychological factors in an attempt to predict weight regain in a group who had successfully lost large amounts of weight, McGuire et al. (1999) found that those participants who regained weight had lost more weight, had maintained

their post-diet weights for shorter periods of time, and had higher levels of depression, dietary disinhibition, and binge eating when entering the study than did weight-loss maintainers. At a one-year follow-up, weight regainers reported greater decreases in physical activity and greater increases in percentage of fat intake as well as greater decreases in restraint and greater increases in hunger, dietary disinhibition, and binge eating than weight-loss maintainers (McGuire et al., 1999).

Niembier, Phelan, Fava, and Wing (2007) examined whether internal disinhibition (disinhibition of eating in response to internal cues such as thoughts and feelings) and external disinhibition (disinhibition of eating in response to external situational cues) predicted weight regain among participants in a behavioral WLT program and among NWCR participants. The authors found that higher levels of baseline internal disinhibition, but not of external disinhibition, predicted greater weight regain over time, even above other psychological variables, including baseline depression in the WLT group and depression, binge eating, and perceived stress in the NWCR group. Citing two studies that show that weight regain “relapses” often occur in concert with increased negative affect, Niembier et al. (2007) concluded that “despite considerable clinical interest, research on the role of eating in response to negative affect or dysfunctional cognitions on weight regain has been limited” (p. 2492).

In a study of the psychological, behavioral, and environmental differences between individuals maintaining large weight losses and treatment-seeking obese individuals, Phelan et al. (2009) found that weight-loss maintainers differed from treatment-seeking obese participants across all factors. Weight-loss maintainers “had higher dietary restraint and lower disinhibition, hunger, and depressive symptoms than the treatment-seeking obese groups” (Phelan et al., 2009, p.99). Weight-loss maintainers also engaged in different behaviors, weighing themselves and

eating breakfast more frequently, eating at restaurants and eating fast food less frequently, and expending more calories through physical activity. Finally, weight-loss maintainers' environments were different: they had more low-fat foods and fewer high-fat foods in the home and had fewer TVs and more exercise equipment in the home than did treatment seeking obese persons. However, the most consistent variables discriminating the weight-loss maintainers from the treatment-seeking obese groups were, besides more physical activity, more dietary restraint and less disinhibition (Phelan et al., 2009).

In relation to the between-group differences in dietary restraint and disinhibition found in their study, Phelan et al. (2009) discussed self-regulatory theory, which posits that “individuals have a limited resource of self-regulatory ‘strength.’ Empirical studies have shown that exerting self-control on one task impairs performance on a subsequent task requiring self-control, due perhaps to depletion of self-control resources” (p. 102). Importantly, the researchers pointed out that “the reasons why the weight-loss maintainers in this study were able to exert greater self-control than the treatment-seeking obese remain unclear” (p. 102). This echoes Phelan et al.’s 2008 study which found that, even though weight-loss maintainers practiced more stringent weight control behaviors during the holiday season, they reported greater difficulty controlling their weight during the holidays compared with normal weight participants. Furthermore, throughout the holidays, weight-loss maintainers’ attention to weight and eating decreased significantly more than did normal weight participants’, and more weight-loss maintainers gained weight than did normal weight participants over the holidays. They were also far less likely to lose the weight over the next month than normal weight participants (Phelan et al., 2008). Phelan et al. (2008) postulated, pursuant to self-regulatory theory, that “the demands of the holiday season may have overpowered resources typically reserved for weight control and

may thereby have led to greater perceived difficulty in control of their weight and weight regain” (p. 447).

In addition to finding that the larger the weight regain after a large weight loss, the less likely the regainer would be to re-lose all or even 50% of the regained weight, Phelan et al. (2003) also found that the “only other significant predictor of recovery [of baseline weight] was smaller increases in depression in the year preceding the weight regain” (p. 1082). The authors discussed this finding, showing that “approximately one-half of lapses in dieters occur during negative-affect situations in which the individual is alone” (p. 1082). The researchers suggested the explanation that “higher depressive symptomatology may deplete resources previously dedicated to weight control, ultimately leading to relapse” (p. 1082).

Somewhat contradicting Phelan et al.’s (2009) findings, Weiss et al. (2007) analyzed data from NHANES and found positive correlations between certain behavioral factors, such as “average weekly restaurant food consumption” and “average daily [TV, radio, and computer] screen time,” and weight regain after substantial weight loss (p. 37). Thus, substantial research shows that both internal psychological factors as well as environmental and behavioral factors are important in understanding successful weight loss maintenance.

A further subset of correlational studies of WLM and weight regain has specifically focused on self-monitoring and self-regulation as a component of successful WLM (Baker & Kirschenbaum, 1998; Butryn, Phelan, Hill, & Wing, 2007; Kitsantas, 2000; Phelan et al., 2008). Butryn, Phelan, Hill, and Wing (2007) examined the correlation between NWCR participants’ self-weighing frequency and maintenance of their weight loss. The researchers found that 36% of NWCR participants reported weighing themselves at least once a day at entry to the study and that more frequent weighing was associated with lower BMI. At a one-year follow-up, Butryn et

al. found that NWCR participants whose self-weighing frequency decreased from the beginning of the study gained significantly more weight than those whose self-weighing frequency remained the same or increased. The researchers also found that more frequent self-weighing was correlated with higher disinhibition and higher cognitive restraint, suggesting that “these individuals may be the ones who have the greatest difficulties controlling tendencies to overeat” (Butryn et al., 2007, p. 3094).

Kitsantas (2000) looked at the use of self-regulatory strategies, including goal-setting, self-monitoring, self-evaluation, environmental structuring, time management, social assistance, and information seeking among groups of overweight, weight-loss maintaining, and normal weight individuals. Kitsantas found that overweight participants not only used fewer self-regulatory strategies but also had lower self-efficacy perceptions about the effectiveness of implementing such strategies than did weight-loss maintaining and normal weight participants (who did not differ significantly from each other along these metrics). Further, self-regulatory strategy use and self-efficacy beliefs were strongly correlated with participants’ satisfaction with their current weights (Kitsantas, 2000).

The studies discussed in detail above point to a number of demographic, behavioral, environmental, and psychological factors common among those who, on the one hand, successfully maintain weight loss over the long term, and those who, on the other hand, tend to regain lost weight. Common behavioral variables among successful weight-loss maintainers are: eating a low-calorie, low-fat diet, including regularly eating breakfast and not regularly eating fast food, eating out, snacking at night, or binge eating; expending a high number of calories through regular exercise; spending little time watching TV or on the computer; and self-regulating consistently, including setting goals and planning, self-monitoring their weight,

structuring their environments, managing their time, and seeking social assistance and information. Demographically, successful weight-loss maintainers achieve their initial weight loss goals, have lower maximum lifetime weights, and have maintained their weight loss for longer periods of time than regainers. Environmentally, successful weight-loss maintainers have more low-fat and fewer high-fat foods, fewer TVs, and more exercise equipment in their homes than weight regainers.

Common psychological variables among weight regainers are: being dissatisfied with their reduced weights; placing great importance on weight as a measure of self-worth; exhibiting a dichotomous thinking style; responding to adverse life events by eating; regulating negative moods by eating; and reporting higher levels of depression, disinhibition (particularly internal disinhibition), and hunger, and lower levels of cognitive restraint and perceived self-efficacy.

Of these, the factors that appear to be most highly correlated with weight regain are: dichotomous thinking style; higher levels of dietary disinhibition, especially internal disinhibition; lower or falling levels of dietary restraint; lower or reduced levels of physical activity; larger interim weight regains; and lower or inconsistent use of self-regulatory strategies, especially self-monitoring of weight.

**Experimental WLT and WLM trials.** Wing et al. (2008), in a study of an 18-month intervention consisting of four weekly meetings followed by 17 monthly meetings either face-to-face or via the Internet aimed at preventing weight regain among individuals with large weight losses, found that weight regain was non-statistically greater with the Internet intervention than with the face-to-face intervention, but both intervention groups regained significantly less weight than a control group receiving only a monthly newsletter. While “changes in the frequency of self-weighing and changes in physical activity had the strongest independent effects on weight

regain” (Wing et al., 2008, p. 1020), supporting the findings of McGuire et al. (1999), “changes in the psychological variables (depressive symptoms, disinhibition, hunger, and restraint) also exerted strong effects on outcome” (Wing et al., 2008, p. 1020). Indeed, of the psychological variables, increases in disinhibition were most strongly associated with weight regain (Wing et al., 2008).

Similarly, Svetkey et al. (2008) randomly assigned approximately 1000 overweight or obese adults who had lost at least 8.8 lbs during a six-month weight loss program to one of three groups: monthly personal contact with an interventionist, unlimited access to an interactive Web site, or self-directed maintenance with minimal intervention. All participants regained weight, but those participants receiving monthly personal contact regained significantly less weight, an average of 8.8 lbs, than did those with Web site access and those with minimal intervention, who regained statistically similar amounts of weight, an average of 12 lbs (Svetkey et al., 2008). The authors concluded that, because “the mean effect was a modest 1.5 kg [(3.3 lbs)]” (Svetkey et al., 2008, p. 1145), “these treatment modalities are at the early stages of development . . . [and] lay the groundwork for the development of even more effective approaches to combating and reversing the obesity epidemic” (p. 1146).

Boutelle, Kirschenbaum, Baker, and Mitchell (1999) introduced an intervention of daily mailings and additional phone calls focusing on self-monitoring to one of two groups of participants in a long-term cognitive-behavioral WLT (Boutelle, Kirschenbaum, Baker, & Mitchell, 1999) to assist with weight maintenance over the holiday period. While both groups struggled to manage their weight during the holidays, the intervention group self-monitored their weight more consistently and managed their weight better throughout the holiday period than did the control group (Boutelle et al., 1999). However, many of the participants in the intervention

group reported not reading all of the mailings, causing the researchers to speculate that “the information in the mailings was less important than the therapeutic self-regulatory process stimulated by the increased contact by the therapist” (p. 367).

In a study examining whether the involvement of support partners in behavioral WLT affected weight loss participants’ outcomes, Gorin et al. (2005) found that weight losses at 6, 12, and 18 months were positively correlated with the weight loss success of support partners but not the number of support partners. Weight loss participants with at least one support partner who also lost weight lost significantly more weight than those weight loss participants with support partners who did not lose weight and those who did not have support partners.

These experimental studies also implicate the behavioral and psychological factors (particularly self-monitoring of weight, physical activity, depressive symptoms, dietary restraint, disinhibition, and hunger) identified in the studies discussed in the previous section. Further, these studies suggest that successful interventions for preventing weight regain among weight-loss maintainers also include frequent, long-term contact with weight-loss therapists and support partners who themselves are actively losing weight.

**WLT and WLM models.** Consistent, long-term intervention for successful WLM has also been supported by research. Jakicic et al. (2001) found that “maintaining contact with [WLT] participants long-term improves long-term weight loss outcomes” because “obesity is a chronic disease and should be treated with a chronic disease model to improve overall success” (p. 2150). Kirschenbaum and Fitzgibbon (1995) and Kirschenbaum (1996) also found that treatment length was particularly important because both experimental and meta-analytical research support treating weight-loss maintainers for years. Kirschenbaum (1996) and Kirschenbaum and Fitzgibbon (1995), along with colleagues, created a behaviorally focused

stages-of-change model for WLM that “make[s] it clear that participants usually struggle for long periods of time to persist at this highly challenging process of life changes” (Kirschenbaum, 1996, p. 168). They conceptualized primary stages of change experienced during two years of intensive WLT as: (1) Honeymoon, (2) Frustration, and (3) Tentative Acceptance, noting that stages two and three may be experienced multiple times (Kirschenbaum, 1996, p. 168; Kirschenbaum and Fitzgibbon, 1995, p. 56). Throughout the process of these primary stages, certain secondary stages that were experienced regularly by a minority of weight controllers were Shock / Ambivalence, Fear of Success, and Lifestyle Change (Kirschenbaum, 1996, p. 168; Kirschenbaum & Fitzgibbon, 1995, p. 56).

Related to their stages-of-change model and based upon some of the research detailed above, Kirschenbaum (1996) and Kirschenbaum and Fitzgibbon (1995) have suggested that the most effective cognitive-behavioral WLTs include the following elements:

(a) a thorough initial assessment of psychological issues, (b) a complete cognitive-behavioral therapy component, (c) a complete nutritional component, (d) a clear emphasis on increasing exercise, (e) staff who are well trained in cognitive-behavioral therapy, (f) at least weekly sessions for at least 1 year, (g) assistance provided for promoting support and otherwise managing social environments, and (h) use of protein-sparing modified fasting when appropriate. Some recent evidence also indicates that the impact of programs with these eight elements could be augmented by the appropriate use of modern appetite-suppressant drugs. (Kirschenbaum, 1996, p. 167; Kirschenbaum and Fitzgibbon, 1995)

Focusing solely on psychological factors, Wysoker (2002) set forth a four-phase conceptual model of weight loss and regain based on her 1991 qualitative dissertation research about women’s experiences of weight loss and weight regain. Phase I is the seeking weight loss phase characterized by desperation to lose weight. Phase II is the dieting phase, in which the dieter feels both the comfort of control and the pain of denial and dieting’s physiological effects. Phase III is the maintenance phase, in which “the comfort of being in control begins to erode,

and pain becomes a prime feeling. The desperateness to lose is no longer paramount” (p. 170). This, in turn, leads to Phase IV, the weight regain phase, in which “the pain continues because there is a perceived loss of control relating to unresolved issues in Phase III” (p. 170).

Throughout the four phases run 12 physiological and psychological themes identified by Wysoker (2002):

(a) long history of overweight and swings (losing and gaining repeatedly); (b) losing weight is hard, all consuming, painful; each time you try it is harder; (c) sense of desperateness; (d) not understanding why the weight is regained; (e) other people can not understand what the experience is like; (f) desire to lose weight to reduce discomfort and for long term health benefits; (g) negative physical effects of dieting; (h) psychological reasons for putting [sic] the regaining weight; (i) being thin has problems; (j) parents contribute to their weight problem; (k) control issues; and (l) sense of denial. (p. 169)

Along with the psychological factors of depressive symptoms, disinhibition, hunger, and restraint implicated in WLM and weight regain by much of the research discussed above, Wysoker’s (2002) identification of these themes is a helpful starting point for further exploration of psychological factors related to WLM and weight regain among weight-loss maintainers.

### **Insider Perspective**

Though there is a vast amount of research that has been done on obesity, weight loss, and WLM, the voices of those individuals who deal with issues of weight are largely missing from the research. Much of the research appears to be conducted from the perspective of outsider researchers examining individuals with weight issues (the other), studying and chronicling these individuals’ eating and dieting behaviors or other outsiders’ perceptions of these individuals.

Indeed, it appears that only a handful of studies have attempted to give a voice to individuals struggling with weight issues by examining the difficulties of WLM from the perspective of the weight-loss maintainers themselves. One such study examined the explanations of dieters for their current and previous weight loss failures using qualitative

methods and interviewing dieters who had failed to lose weight or to keep weight off. In this study, researchers identified five themes that unsuccessful dieters used to explain their inability to lose weight: Dieting Mode, a state of heightened self-discipline around eating; Multi-Me, an internal struggle characterized by ambivalence around restrained versus disinhibited eating; Not Me, biological factors, such as low metabolism, that were out of the dieters' control and thus afforded them a victim-like status; Modern Life, environmental and time constraints perceived to be out of the dieters' control that made dieting difficult; and Challenges of Emotional and Social Eating, eating as an emotional coping mechanism and facilitator of social connection (Green et al., 2009).

A second study described the meaning behind binge eating for adult professional women, finding that “the central meaning of compulsive overeating is an experience that has been, and continues to be, a difficult personal struggle, to achieve or maintain an acceptable weight and gain mastery over binge eating behaviours” (Lyons, 1998, p. 1163). The author further identified “seven categories that characterized the lived experience of compulsive overeating” (Lyons, 1998, p. 1160) – childhood experiences, descriptions of types of food most often eaten in the adult years, eating behaviors in the adult years, perceived lack of control, reasons for overeating, emotional consequences of overeating, and compensatory behaviors – each of which was found to be directly or indirectly related to past affective experiences or current emotions.

A study addressing only affective factors attempted to integrate the earlier research around restrained and emotional eating by proposing a five-factor affective model to predict how fluctuations in affect states influence both restrained/emotional eaters and “normal” eaters (Macht, 2008). Macht's (2008) five factors included: emotional control of food choices,

emotional suppression of food intake, impairment of cognitive restraint around eating, eating to regulate emotions, and emotion-congruent modulation of eating.

Mycroft (2008) examined the morality and accountability woven into the internal processes around food and dieting of women enrolled in commercial weight loss programs, finding that “both the group leaders and group members could not orient to their behaviour or food without reference to a moral or accountable framework” (p. 1040) in which “food [was] good or bad and we as women are good or bad for eating it” (p. 1048). Mycroft’s (2008) research suggests that morality may be an important lens through which to view and interpret individuals’ WLM experiences.

Of greatest relevance to the present study, Bidgood and Buckroyd (2005) conducted a qualitative study “to explore obese adults’ accounts of their experiences and feelings during their attempts to lose weight and to maintain a reduced weight” (p. 221) in order “to inform strategies for promoting enduring weight loss” (p. 212). The study states that “participants were ‘given a voice’ . . . by empowering them to express their various issues in regard to their size and weight” (Bidgood & Buckroyd, 2005, pp. 212–213) in individual interviews or focus group discussions. The authors identified a central theme, striving for a thinner self, and five sub-themes, food addiction, stigmatization, the ineffectiveness of dieting, the disregard of society for obese people, and the difficulty of maintaining life style changes without ongoing help (Bidgood & Buckroyd, 2005, p. 223). The authors concluded that “the participants presented with a range of psychological issues” that “are familiar to counsellors [sic], yet apart from CBT, there appears to be a dearth of research literature on the use of counselling [sic] in the treatment of obesity” (Bidgood & Buckroyd, 2005, p. 227).

## **Gaps in the Research**

The literature reviewed above demonstrates that although behavioral and emotional factors are important for understanding WLM, research from an insider perspective is necessary to illustrate the broader psychological component to WLM, including the roles of self and identity, social psychology, and morality. Bidgood and Buckroyd (2005) suggest the need for a larger scale study to “canvas the views of obese people in a wider area” (p. 228). A more pressing extension of the authors’ research may be the approach of the present study, which looks at participants’ perceptions, thoughts, emotions, and self-concept (both positive and negative) around their experiences of WLM in more depth and in a more human, and less quantitative, way. As suggested by Zijlstra et al. (2009) in describing a “stages of change” model for weight loss, the general population’s perception of individuals who struggle with weight issues may be that “[p]atients with successful enduring weight loss will likely match the ‘Termination’ stage of change” (p. 111) – i.e., that once individuals have lost the amount of weight they desired to lose, they will be finished dealing with issues of weight. The hope is that this study will elucidate the personal internal processes that continue to remain very present for these individuals as they navigate WLM throughout their lives.

Indeed, Hill et al. (2005) caution that “obesity experts recognize that obese individuals are never cured, no matter how long they maintain a weight loss” (p. 208), concluding that “although NWCR participants report that maintaining their successful weight loss gets a little easier over time, they still have to work hard to keep weight off even 15 to 20 years after losing weight” (p. 208). In a meta-analysis of the WLM literature, Thomas and Wing (2009) found that “successful weight loss and weight maintenance is possible, but requires sustained effort” (p. 56). Thomas and Wing indicated that the average NWCR participant “devotes a substantial

amount of time and energy to behaviors aimed at weight control” (Thomas & Wing, 2009, p. 56). They did note, however, that some successful NWCR long-term weight-loss maintainers report that over time it becomes easier to maintain weight loss (Thomas & Wing, 2009). This finding is tempered by Phelan’s 2008 lecture, which discussed NWCR participant perceived effort of WLM reported on a scale from 1 (no effort at all) to 8 (extreme effort). Phelan’s work indicated only a very slight decrease in perceived effort over time: even at 6+ years, perceived effort was rated at approximately 4.50, which was a reduction of only 0.75 points from the 5.25 perceived effort rating at 2 to 3 years (Phelan, 2008, slide 39). Likewise, Kirschenbaum (2005) has indicated that “most successful weight controllers list weight loss near the top of their priorities, usually higher than hobbies – sometimes more important than their jobs” (p. 13).

Bidgood and Buckroyd (2005) indicated that “apart from CBT, little is known about the use of other forms of psychotherapy for the treatment of obesity” (p. 222). Wysoker (2002) highlights this issue in the context of WLM and weight regain, stating: “Many weight control programs provide little emphasis on underlying psychological reasons for regaining weight. Additional [psychological] issues . . . are also ignored. Emphasis is placed on . . . behavior modification techniques to facilitate and maintain weight loss” (p. 173). Likewise, in their 2009 study, Phelan et al. highlight that “more attention has been paid to behavioral . . . than to psychosocial . . . factors, despite all being frequently implicated in the development of obesity” (p. 95). Indeed, many of the studies discussed above call for further exploration of psychological variables such as dietary restraint, disinhibition, hunger, binge eating, and depression in order to develop more successful interventions in the maintenance phase of weight loss to prevent weight regain (e.g., McGuire et al., 1999; Phelan et al. 2003; Phelan et al. 2009; Thomas and Wing, 2009; Wing et al., 2008).

Thus, missing from the research is an in-depth exploration of the psychological processes that relate to maintaining weight loss, including the perceptions, thoughts, emotions, and self-concept (both positive and negative) of individuals maintaining significant weight loss. Specifically, this study asks how individuals who have maintained significant weight loss for a significant period of time understand the roles that their thoughts, feelings, and self-concept have played in their successes and set-backs in their WLM. The exploration undertaken by the current study will add to the weight research literature the voices and personal internal experiences of these individuals around maintaining significant weight loss and may lead to a better understanding of the needs of this population to help to inform further study and development of psychological interventions that are effective not only in assisting with successful WLM but also in reducing the perceived internal difficulty of maintaining weight loss.

## **CHAPTER THREE**

### **Methodology**

The purpose of this study is to explore and describe the personal experiences of formerly obese adults who are maintaining significant weight loss. Specifically, this study asks how individuals who have maintained significant weight loss for a significant period of time understand the roles that their thoughts, feelings, and self-concept have played in their successes and set-backs in their WLM. As discussed above, missing from the research literature on weight loss and WLM is an in-depth exploration of the psychological processes that relate to maintaining weight loss, including weight-loss maintainers' perceptions, thoughts, emotions, and self-concept (both positive and negative) as they relate to maintaining weight loss. One of my goals for this study was to add to the weight research literature the voices and personal internal experiences of these individuals around maintaining significant weight loss. To that end, I chose qualitative research methods because they are best suited to “generat[ing] deeper understandings of the meanings of human experiences” (Rubin & Babbie, 2010, p. 34) and would more likely fully elicit the subjective psychological experiences of formerly obese adults maintaining significant weight loss. Data was collected through one-on-one interviews primarily with participants in The Weight Management Program of San Francisco, Inc. (WMP). Semi-structured, open-ended questions elicited narrative responses that described individuals' personal internal experiences in maintaining significant weight loss.

## **The Recruitment Process**

**Sample.** I used an availability sampling technique, supplemented by a snowball sampling technique, to recruit 12 formerly obese adults who are currently maintaining significant weight loss (defined as a loss of at least 10% of the individual's initial body weight) and have maintained this weight loss for at least one year primarily from a group of adults enrolled in the weight loss maintenance program at WMP.

WMP is a professional WLT program located in San Francisco, California, which combines VLCD and behavioral treatment that includes a long-term behavioral maintenance component. Participants must have a BMI of at least 27 and undergo initial medical screening to enter the weight loss phase of the program. Once medical appropriateness for WLT has been determined, participants join "fasting" groups run by a staff of medical doctors, psychologists, nutritionists, and exercise physiologists in which they are required to eat a VLCD of 800 calories per day, consisting only of meal replacements and fiber and potassium supplements, and are required to attend weekly weigh-ins and weekly behavioral and educational group meetings until they either terminate or achieve the amount of weight loss determined jointly by them and by WMP's medical professionals to be desirable and medically appropriate. This weight-loss phase can last anywhere from four to 18 months, depending on the amount of weight a participant is losing.

After completing weight loss, participants may return to eating food but are encouraged to supplement their diet with meal replacements in order to maintain weight loss. They are also encouraged to join WMP's maintenance program, in which they attend voluntary weekly meetings led by staff which contain behavioral and educational components but which are more loosely structured than the fasting meetings. The maintenance phase at WMP can last

indefinitely, and, indeed, some maintenance group members have been attending meetings on and off for over 20 years. WMP also offers restart groups for initial weight losers who have regained substantial portions of their lost weight and wish to be medically re-evaluated and go back into the fasting phase. More informally, many maintenance group members use partial fasts, consisting of meal replacements and low-calorie foods, to combat smaller weight regains.

WMP incorporates almost all of the behavioral techniques for WLM shown to be effective in the literature discussed in the previous chapter, including encouraging at least weekly weigh-ins, weekly meeting attendance, high levels of physical activity (over 2000 calories per week), daily records of all Caloric intake, environmental structuring (keeping only low-calorie, low-fat, non-triggering foods in the home and office environments), and pre-planning strategies for triggering eating situations (such as dining out, parties, and the holidays). WMP also prescribes weight-loss medications as indicated to help participants maintain, rather than lose, weight.

All of the individuals who attend WMP's maintenance program are adults and English-speaking. The majority of these individuals are white, although some racial/ethnic minorities are represented, and the slight majority are women. The age range of the individuals attending groups at WMP is approximately 30-70, although the majority appears to fall in the 50-70 age group. Generally, these individuals appear to be in good health, other than some typical age- and weight-related health concerns. These individuals also tend to be middle or upper-middle class, likely due to the fees associated with WMP's weight loss and maintenance groups. Thus, my sample of 12 study participants, while as representative as possible of the individuals enrolled in WMP's maintenance program, is likely not representative of all formerly obese individuals maintaining significant weight loss.

**Recruitment of participants.** I presented my study orally and in person to each of the four WMP maintenance groups of which I am not a member at the beginning or the end of particular group sessions as agreed between me and the staff of WMP over the period of January 24, 2011 to January 27, 2011. I explained my study and my confidentiality procedures using the descriptions in the Recruitment Flyer (Appendix A) and the Informed Consent (Appendix B). I requested that those group members interested in participating in my study provide me with their name and contact information at the end of the group session. One group member spoke with me after the group concluded and orally gave me their contact information, while six chose to hand me a slip of paper with their contact information. I provided each interested group member with a recruitment packet, including the Recruitment Flyer, a copy of the Informed Consent, and a self-addressed, stamped envelope, for his or her perusal and information.

I also left some recruitment packets with WMP, explaining that these were for members who might prefer to contact me in the manner set forth in the Recruitment Flyer rather than providing me with their contact information in person or for any members who missed my presentations. I requested that the staff of WMP make these recruitment packets available in subsequent meetings of each maintenance group and requested that they introduce my study as set forth in Appendix C. Four individuals contacted me at my contact information listed on the Recruitment Flyer. One individual who otherwise met my study criteria but was not involved with WMP was referred to me by a study participant at the end of our interview.

After receiving notifications of interest in my study in the manner set forth above, I called or emailed with each potential participant to screen for inclusion criteria, to answer any questions about the study, and to set up a time for the interview. To screen individuals, I ascertained whether each potential participant met the criteria of my study population by collecting certain

weight-related data from each potential participant, including initial pre-diet weight in pounds, pre-diet BMI, number of pounds lost, current weight, current BMI, the length of time that the potential participant has maintained significant weight loss. While I made every effort to recruit a diverse sample in regard to gender, race, age, and amount of time weight loss had been maintained, because I received only 12 responses from interested individuals, I chose to interview all 12 respondents.

### Sample Demographics

Table 1 below sets forth certain general demographic data about the participants in this study. These data were collected either through preliminary screening interviews conducted by phone or through email responses to a list of demographic questions sent by email, depending on each participant's preference.

Table 1

#### *General Demographics of Study Participants*

Ethnicity	Gender	Age	Educational Attainment	Socioeconomic Status	Employment Status	Sexual Orientation	Partnership Status
11 Caucasian	11 Female	2 40-49	4 Some College	6 Middle Class	3 Employed Full Time	12 Heterosexual	3 Single
1 Jewish Caucasian	1 Male	1 50-59	5 College Degree	2 Upper-Middle Class	2 Employed Part Time		9 Married
		9 60-69	3 Doctoral Degree	4 Unknown	7 Retired		

Table 2 below sets forth certain relevant weight-related demographic data about the participants in this study. These data were also collected either through preliminary screening interviews conducted by phone or through email responses to a list of demographic questions sent by email, depending on each participant's preference.

Table 2

*Weight-Related Demographics of Study Participants*

WLM Length (years)	Pre-Diet BMI	Current BMI	Pre-Diet Weight (pounds)	Weight Lost (pounds)	Final Diet Weight (pounds)	Current Weight (pounds)	Current Weight vs. Final Diet Weight (pounds)	Number of Major Losses	WLM Medication Usage
2 1-2	4 30.0- 34.9	1 15.0- 19.9	2 150.0- 199.9	2 20.0- 49.9	6 100.0- 149.9	4 100.0- 149.9	2 more than 5 pounds below final weight	5 1 Loss	2 current
4 3-5	5 35.0- 39.9	2 20.0- 24.9	7 200.0- 249.9	4 50.0- 74.9	6 150.0- 199.9	5 150.0- 199.9	4 within +/- 5 pounds of final weight	5 2 Losses	6 recent past
2 6-10	1 40.0- 44.9	5 25.0- 29.9	2 250.0- 299.9	4 75.0- 99.9		3 200.0- 249.9	6 more than 5 pounds above final weight	2 3 Losses	3 long ago past
3 11-19	0 45.0- 49.9	3 30.0- 34.9	1 300.0- 349.9	1 100- 149.9					3 never
1 20-29	1 50.0- 54.9	0 35.0- 39.9		1 150.0- 199.9					
	1 55.0- 59.9	1 40.0- 44.9							

**Data Collection**

I conducted one face-to-face or telephone interview with each study participant. I interviewed 11 study participants over the phone and 1 study participant in person at a local coffee house. The settings were determined according to convenience and preference of the interviewees. Each interview ranged from 20 minutes to one hour, depending on the length of the

particular study participant's answers. Participants were asked a total of seven open-ended questions, as well as follow-up questions, addressing the participants' internal processes and experiences around food, eating, and WLM, with a focus on their perceptions, thoughts, emotions, and self-concept (both positive and negative) related to maintaining their weight loss (see Appendix D). The interview guide was piloted in a WMP maintenance group from which I did not recruit study participants, and questions were expanded, clarified, and refined based on the group's feedback. The questions centered around what participants found easy and what they found difficult about maintaining weight loss; participants' day-to-day experiences regarding the mental and emotional time and energy they devoted to maintaining their weight loss and whether there were situations in which they tended to devote more or less time and energy to maintaining their weight loss; whether and how participants' weight factored into their identities; how they defined *success* with regard to the maintenance of weight loss and whether and how this definition had changed over time; participants' mental and emotional reactions to periods in which they perceived they were unsuccessful in maintaining their weight loss; and what participants found to be mentally and emotionally supportive and unsupportive to maintaining weight loss. I also asked those follow-up questions that I deemed necessary for clarification. Narrative data were gathered by means of audio recording. I later transcribed the interviews and disguised or removed identifiable information to ensure confidentiality.

### **Ethics and Safeguards**

Approval for this research was obtained on September 28, 2010 (see Appendix E) from WMP and on November 16, 2010 from the Smith College School for Social Work Human Subjects Review Committee (see Appendix F). I explained to each participant the purpose and design of the research project, and the nature, benefits, and risks of participation. I informed each

participant that participation is voluntary and that all the information gathered would be protected with strict measures of confidentiality per Federal Guidelines. I informed each participant that he or she was free to withdraw at anytime during the interview, or after the interview had been conducted, and that all of his or her information would be withdrawn from the study and immediately destroyed provided the withdrawal was requested on or before March 31, 2011. No participants chose to withdraw from the study.

For in-person interviews, I verified that participants had brought the signed Informed Consents with them to the interview or signed the Informed Consent in my presence. For those interviews that took place by phone, I verified that the participants had sent me a signed Informed Consent by mail in the provided self-addressed, stamped envelope. I gave participants the opportunity to ask any questions they had about the Informed Consent prior to signing it.

Participants were informed that there would be no financial compensation for their participation in the study. They were informed that although they may not directly benefit aside from sharing their experiences, their participation could provide assistance regarding identifying and understanding the counseling and support needs of individuals maintaining significant weight loss. They were told that this study may also help inform the development of psychological interventions for individuals maintaining significant weight loss that are effective not only in assisting with successful weight loss maintenance but also in reducing individuals' perceived internal difficulty of maintaining weight loss.

To ensure confidentiality per Federal Guidelines and the mandates of the social work profession, once I transcribed the data from the digital audio recordings, all identifying information was removed and/or disguised. The coded information and other documents were

password protected during the research process and will be stored for at least three years in a secured location, after which time all information will be destroyed if no longer needed.

### **Data Analysis**

Data were analyzed by conducting a content analysis that involved looking for common patterns and themes among the participant responses. Participant responses were first grouped into six organizational categories based on the seven interview questions. Then responses for each question were further sorted into categories of general emerging themes based on the way participants tended to organize their responses to the questions. Next, using the method of constant comparison, participant responses were further sorted into coded descriptive categories based on emerging subthemes, phrases and words (Maxwell, 2004).

The subthemes and concepts that emerged in this process were organized and compared, and the frequency with which participants mentioned each subtheme was noted. When subthemes were repeated, this was noted as a pattern, and these data were included in the findings. Using a case comparison method, the data were analyzed for any impact of general and weight-related demographic characteristics on participant responses and the resulting themes and subthemes. The data were then further examined for connections between subthemes and connections between organizational categories, and the findings were set forth in theoretical categories derived from inductive, researcher-developed theories (Maxwell, 2004).

The openness of the content analysis used, more inspired by exploration and inquiry than confirmation of a hypothesis, invited unexpected findings as well. Through this process, certain issues emerged among several respondents that were not specifically and directly targeted in the interview guide. For example, as discussed in Chapter Four, a minority of participants (N = 2) who expressed that their WLM had become easier over time also reported different WLM

strategies than other the other participants who had reported that their WLM remained consistently difficult.

### **Biases and Limitations**

The transferability and generalizability of the results this study has certain limits because of the small sample size and the recruitment of 11 of the 12 participants from one professional WLT program. Also potentially limiting the generalizability of the results of this study was the lack of gender, racial, age, and socioeconomic diversity of the participants as set forth in Table 1 above. On the other hand, as noted in Table 2 above, participants represented a wide range in the periods of time during which they had been maintaining weight loss, from 1.25 years to 26 years; a range in the amount of weight initially lost, from 24 pounds to 154 pounds; a range in whether participants were currently maintaining their weight below, at, or above their initial weight-loss goals (defined as the weights reached at the end of the dieting phase of WLT); and variation in the current and past use of weight-loss medications, which may be significant in that the use of weight-loss medications is assumed to decrease the difficulty of WLM.

A possible introduction of bias is the fact that I have been attending WMP's WLT and maintenance programs regularly as a participant since October 2008, so I am familiar with the struggles of WLM and with some of the individuals attending WMP's maintenance groups. However, I did not recruit study participants from the weekly maintenance group that I currently attend.

My personal familiarity with issues of weight loss and WLM may introduce a bias into the results of my study. For example, the interview questions themselves may have been subject to my bias and assumptions about WLM. Although the interview guide was reviewed by appropriate and relevant members of the WLT field and was piloted to a group of weight loss

maintainers, the guide was nevertheless self-developed. However, I have remained cognizant of these potential biases and limitations when analyzing the data and have been careful not to discount or minimize those lived experiences of the study participants that differ from my own.

On the other hand, because this study is a qualitative exploration of concepts and themes relating to the psychological factors implicated in WLM, I believe my participation as a WMP member has aided me in shaping my study's focus and in honing my interview questions. Further, I believe my own journey with weight loss and WLM enhances the insider perspective that this study set out to capture.

## CHAPTER FOUR

### Findings

The purpose of this study was to explore how psychological processes relate to maintaining significant weight loss. This was addressed by examining the perceptions, thoughts, emotions, and self-concept (both positive and negative) of study participants as they reflected on both their past and current efforts in maintaining their weight loss. The goals for this study were: (i) to add to the weight research literature the voices and personal internal experiences of these individuals around maintaining significant weight loss, and (ii) to better understand the needs of individuals maintaining weight loss to help inform further study and development of psychological interventions for this population that are effective not only in assisting with successful weight loss maintenance but also in reducing the perceived internal difficulty of maintaining weight loss.

This chapter contains the findings from interviews conducted with 12 individuals maintaining significant weight loss who met the selection criteria for the study. The seven interview questions were organized into the following six categories: what participants found easy and what they found difficult about maintaining weight loss; participants' day-to-day experiences regarding the mental and emotional time and energy they devoted to maintaining their weight; how participants' weight factored into their self-concepts; how participants defined *success* with regard to the maintenance of weight loss and how this definition had changed over time; participants' mental and emotional reactions to periods in which they perceived they were unsuccessful in maintaining their weight loss; and what participants found to be mentally and

emotionally supportive and unsupportive to maintaining weight loss. These six categories and the themes within them are described in detail in this chapter, and a full table of these categories, themes, and subthemes may be found in Appendix G.

### **Perceived Difficulty of Maintaining Weight Loss**

To begin the interviews, participants were asked whether they perceived maintaining weight loss to be easy or difficult and what was easy or difficult about WLM for them. All 12 participants indicated that maintaining their weight loss was at least somewhat difficult. Seven participants indicated that maintaining weight loss was unquestionably difficult. One noted that it was “very difficult . . . um, yeah, it’s really hard,” and one indicated that it was “harder to maintain weight than actually lose it.” One of these participants even chuckled at the question, as if to indicate that maintaining weight loss was so obviously difficult that asking whether or not it was difficult was somewhat absurd. One participant stated, “it’s difficult, there’s no doubt about it,” even going so far as to opine, “I would find it hard to believe that maintaining a huge weight loss over a long period of time becomes easier. . . . I don’t know how it becomes easier.”

However, the remainder indicated that it was only somewhat difficult to maintain their weight loss, giving answers such as, “I don’t know that I would say it was difficult to maintain, but I certainly wouldn’t say that it was easy to maintain”; and “Yes, it is difficult. . . . But let me qualify that . . . I guess the more accurate answer . . . is yes and no.” One participant stated, “It’s somewhere between easy and difficult,” but this participant later revised this answer to include that “actually, the difficulty of it pales by comparison to the easiness of it.” Of these participants, a few noted that, while it was difficult, it had become somewhat easier over time. For example, one participant noted that it was difficult at one point but that now “it’s not as hard as it was.”

**What makes WLM difficult.** Almost all of the participants (N = 11) cited that the constant effort that they had to expend to maintain their weight loss as a primary reason that WLM was difficult. Other reasons participants mentioned were: their current lifestyles or the impact that WLM had on their lifestyles (N = 8); the desire to be “normal” or for WLM to be easier (N = 7); feeling “different” from those around them due to their WLM efforts (N = 6); environmental reasons (N = 5); biological reasons (N = 4); physical hunger (N = 3); an enjoyment of food and eating (N = 2); feeling “stressed out” (N = 2) or bored (N = 1); obsession with food when focusing on maintaining weight (N = 1); and finding it difficult to waste food by leaving it on the plate (N = 1).

Eleven participants mentioned their constant effort and vigilance two to seven times throughout the interviews, with the majority of respondents mentioning it four to seven times (N = 7). Several participants cited that they had to maintain “constant awareness” or “constant vigilance” or had to “stay totally awake and aware,” “think about it constantly,” or “think in terms of what you’re putting in your mouth all the time.” A number described WLM as “a constant battle and work,” “stressful from the standpoint of always having to be on alert . . . it’s been a continual battle,” “a constant drain during the day,” “this nagging notion in the back of your mind,” and “pervasive,” with one participant noting “there are days when it takes over my entire day.” Half of the participants (N = 6) also indicated that they felt that maintaining their weight loss would continue require constant effort for the rest of their lives. One participant joked, “No, it never goes away. That would be true Zen enlightenment if it just completely went right out of my brain! Hasn’t happened, not gonna happen! . . . It’s a lifetime sentence!” Others were less glib, stating things like, “It’s never over,” “I know it’s the rest of my life,” and “Do

you think you have this weight thing licked? And the answer would be definitely a resounding ‘No.’ I think I’m going to be struggling with this until my last day on earth.”

As part of the constant effort, half of the participants (N =6) discussed that managing their weight required constant choices. One participant noted: “you make a choice every time you eat. Every single time I eat I make a choice to either eat well or not, and that’s three meals and snacking every day.” Another stated: “Absolutely on a day-to-day basis I’m very mindful that there are almost countless choices I make every single day that support my maintaining my weight.” One participant compared it to the relative ease of dieting, saying, “When you’re on the diet, especially the fast, you don’t have any choices to make. Once you’re on maintenance you have to choose wisely all the time.”

Eight participants also discussed their current lifestyles, or the impact that maintaining their weight loss had on their lifestyles, as a further reason that WLM was difficult for them. With regard to the former, one participant noted that she does not often get enough sleep which causes her to “eat more calories . . . to get more energy,” while another indicated that “I am by nature a sloth, but I can see over all these years . . . that there is a direct correlation between how much exercise I get and what happens on the scale.” Other participants (N = 4) indicated that they are very social and much of their social lives involve eating out or other activities that involve food. Several indicated that WLM was particularly difficult for them because “you really have to change your way of life.” One participant indicated that “what’s difficult is also sometimes having to say no because I don’t want to put myself in nine eating situations a week . . . Sometimes I have to pass on things or say ‘Sorry, I can’t go to that restaurant because there isn’t anything I can eat there.’” Another felt “I have to give up an entire social life.” However,

one participant indicated that lifestyle did not make WLM more difficult, noting “I’m not a terribly social person to begin with, so I didn’t have to restructure my life a lot.”

Somewhat related to lifestyle issues, several participants (N = 5) also indicated that environmental features made their WLM difficult. One participant phrased it thus: “For me it’s really hard because I live in a world of other people and other people’s food and eating styles, and I don’t have a lot of control . . . over my environment.” Three participants specifically mentioned their work environments, including food being constantly available in common lunchrooms or working in industries that required lots of entertaining and lunch and dinner meetings. Two of those participants noted that they either felt “put in the situation of bringing my own food” or felt the need to “work at home some days just because, after Halloween especially or Girl Scout cookie season, I couldn’t tolerate passing it up 10 times a day.” Two participants mentioned that they had trouble controlling their home environment vis a vis food because of either kids in the house or partners who do not have “weight problems.”

Half of the participants indicated that WLM was difficult for them because trying to maintain their weight loss made them feel different from those around them. One woman who participated in a phone interview stated: “Right now, I have the TV in front of me on mute, and the Super Bowl commercials are nothing but food. . . . I almost feel like I can’t be a normal person and eat pizza.” Several participants also discussed having to explain their WLM behaviors, such as their food choices, to those around them, sometimes even having to argue about why their WLM behaviors were important to them. One participant stated: “You make your own rules, and they’re not conventional in society . . . , [so] I’m always explaining . . . and it’s always questioned.” Others did not like drawing attention to themselves and to the fact that they were doing things differently than those around them. One participant explained: “When

you start asking for stuff different, you're asking to be noticed, and maybe even labeled as 'odd.'" Another indicated: "That's hard because when you're the odd man out, it's not always comfortable. . . . I just have to not care what other people think."

Potentially related to a feeling of being different or odd, a majority of participants (N = 7) also expressed the wish to be normal or for WLM to be easier. Three participants mentioned wishing there were a "magic pill," and three participants mentioned "resenting" or wishing they did not have to work to maintain weight loss. One participant noted, "I sometimes wish I had had a life without this in it. . . . It would have been nice, you know, a nice long stretch of time I didn't have that." Another participant stated, "So, let's just say in my whole long life, there haven't been many periods of time when I'm not thinking about the struggle, and that I resent."

A third of participants (N = 4) also talked about biological features that they felt made their WLM more difficult. Two discussed being predisposed from early ages to be overweight, with one describing how, at two-and-a-half, she would eat butter and sugar straight from the jars, noting "that was the beginning of a long term romance with butter and sugar in various forms!" Three mentioned concerns with changes in cravings with hormonal fluctuations or with decreasing metabolism due to aging.

As noted above, other subthemes related to the theme of the difficulty of maintaining weight loss, but that were only mentioned by a few participants, were physical hunger (N = 3), an enjoyment of food and eating (N = 2), feeling "stressed out" (N = 2) or bored (N = 1), obsession with food when focusing on maintaining weight (N = 1), and finding it difficult to waste food by leaving it on the plate (N = 1).

**What makes WLM less difficult.** Participants also discussed two main subthemes related to what helped make the maintenance of their weight loss less difficult: accumulating experience with successful WLM (N = 8) and change in palate or appetite (N = 4).

Eight participants mentioned that accumulating experience successfully maintaining their weight loss helped make at least certain aspects of WLM less difficult. One participant explained: “I feel like I built up my chops about the need to respect what I want most over what the temptation of the moment might be during my weight loss journey.” Another participant noted, “Every day builds on the day before.” Several participants pointed to practical tips and behaviors that they had learned over their time maintaining that also helped WLM feel easier. One participant stated, “Now one thing I haven’t done is stop weighing myself, and there’ve been a number of things that I’ve learned about dealing with weight that I’ve really tried to hang on to.” Another noted, “I have really gotten my chops up on eating in restaurants because I eat out a lot . . . , so I have no trouble anymore asking for a takeout box while I’m ordering my meal.” Others explained that certain aspects of their WLM had become habitual. One participant stated, “That is a habit that I have now, so in one sense it’s easier because it’s something that I always do.” Another woman explained:

I feel there’s this . . . you get into kind of a zone mentally and emotionally when you’re feeling, let’s say, on track. When you’re feeling good about the choices you’re making, when you’re not resenting the process you’re going through, when you feel that what you’re consuming, what you’re eating is sustaining and fulfilling and nourishing. There are periods of time when it doesn’t feel difficult.

However, one participant felt that experience made her WLM more difficult rather than easier, “It gets harder and harder to remember sometimes that I need to be as vigilant now as when I first came off the fast . . . and, well, . . . it gets harder and harder.”

Four participants found that the change that occurred in their palates and appetites both as a result of sustained careful eating and of advancing age made their WLM less difficult. Two participants indicated that they had “lost the taste” for unhealthy foods, while two others noted that the amount they wanted to, or could, eat had shrunk over time.

### **Time and Energy Devoted to WLM**

Participants were asked to describe their day-to-day experiences regarding the mental and emotional time and energy they devote to maintaining their weight loss. As follow up questions, participants were asked how this time and energy influences their actual WLM-related behaviors and what situations tended to cause them to think more about their WLM.

**Daily WLM behaviors.** Most participants initially discussed their WLM behaviors as a way to explain the extent to which their WLM affected their daily lives. Eight participants indicated that the first thing they do every day is weigh themselves, and one participant noted that she weighs herself first thing three days a week. Almost all of these nine participants noted that their daily thinking about their WLM thus started first thing in the morning when they weighed. One participant explained: “I’ve made a commitment to be conscious about what my weight is on a day-by-day basis, [so] I weigh everyday.” Another participant noted, “I need the discipline of seeing that number.”

Ten participants described closely watching and thinking about what they ate throughout the day. They described “think[ing] ahead constantly” about what they planned to eat during a given day, such as looking ahead of time at restaurant’s menus and “try[ing] to plan what I’m gonna eat and kinda do[ing] a rough calculation of what the calories are going to be” or “be[ing] more conscious of planning when I’m gonna be under stress or if my schedule is going to get busier.” One woman, who had a planned lunch out the day I spoke with her explained:

I thought about what I'm going to do as early as this morning. Maybe I can order all vegetables. It's a restaurant where my husband intends to order the prix fixe meal, it's an Italian restaurant, so I know it's going to be difficult, so I'm trying to think ahead. . . . I thought about having eggs and something for breakfast. I realized it wouldn't work because I'd just start a spiral of eating, so I just had two [diet shakes] this morning.

Five participants discussed how they had certain eating routines that they followed on a daily basis. One participant explained:

What I try to do is I go what I call brainless as much as I can. I don't mind eating the same food over and over, so for periods of time I try to do things I don't have to make choices in. I might for two or three weeks or a month or six weeks eat the same breakfast every day.

Other participants echoed this, such as one woman who stated: "I've made up a set of rules for myself that over time seems to work. One of them is to have breakfast, which I never used to do, and a very boring breakfast." Another noted, "I have essentially the same breakfast every morning of the world," while another indicated, "every morning I start out with one of my [diet] shakes and then some coffee." Five participants indicated that they had entirely eliminated certain foods, such as sugar, processed foods, or certain "trigger" foods, from their diets. Three discussed dietary "trade-offs" that they would make throughout the day. One participant explained:

If I've reached my max, or near it, by dinner, I give [my husband] dinner – no matter what we planned to eat, I'll cook for him – and I'll have a [diet] shake, usually a double shake, and that's it. I mean, I just won't eat food at night if I've eaten my maximum calories throughout the day.

Eight participants discussed the importance of incorporating strict exercise routines into their weeks, exercising anywhere from three to seven days per week. One participant indicated, "I plan out a week of exercise, and I exercise at least four times a week out of seven days, so it's something that again I do think about and I do plan for," while another talked about maintaining her daily exercise even while on vacation, "I still have the same routine. . . . I make sure that I

exercise every day, frequently more because we're on vacation, but I make a point of taking a walk, no matter what kind of weather."

Seven participants also cited the importance to their WLM of recording the calories of everything they ate on a daily basis, as well as all the calories they burned from exercise. One participant explained:

The only thing that keeps me from having to diet is if I'm constantly recording everything that goes into my mouth and every bit of exercise. So, if I'm on track, I'm recording all my calories and all exercise and knowing exactly what's going in and how much and everything else. And if I stop recording, I usually absolutely freefall and gain weight.

Others echoed this sentiment, stating things like, "The times that I'm able to [maintain] is [sic] when I've kept records of what I've eaten"; "It is the tracking [that's helpful], even if I don't write it down, I'm still sort of mentally tracking"; and "I keep records still, so a few times a day, I'm making notes in my little notebook."

Five participants also noted the importance of maintaining strict control over their environments regarding nearby or available foods. One participant noted, "I try to keep my desk at work stocked with [diet shakes]" as snacks. Another indicated, "At home, I'm queen of my realm. And I find it relatively easy [there] cuz if there's something that doesn't support me, I don't bring it into the house." One participant discussed how she controlled her home environment while living with a partner who does not have a weight problem:

We have these really high cabinets, and [my husband] buys a year's worth of [cookies] at a time, . . . and they are either in his clothes closet or up on the top shelf of this cabinet that I have to climb on a ladder to get to and out of my sight. I've been known to go in and eat some when I'm really out of control, but 98% of the time, if it's out of sight and far away, I don't stoop to eating it. You know what? I have a safe for my jewelry, and I've told [my husband] that it may come to the point where we have to lock the cabinet, or, it doesn't have to be a safe, but something with a lock on it, and you have the key.

**Moods related to WLM.** Five of the eight participants who discussed their moods in relation to their daily WLM efforts mentioned the emotional impact of weighing themselves.

One participant explained:

I guess the real emotional thing is knowing that I can avoid the scale, and sometimes if I know that I'm probably not going to be happy, forcing myself to get on the scale anyway. It's kind of like 'come to Jesus time,' and I have to do it because if you avoid the scale, you keep avoiding the scale and pretty soon all the weight is back on. And you know that can be an emotional jolt. . . . So, it's just before I get on [the scale] is the real emotional time.

Another participant indicated, "I used to never weigh myself because it would be horrible. I just didn't want to do it because I knew it would wreck my day." More recently, the same participant noted that, when she weighs herself daily now, "Sometimes I'm disappointed, but I'm not usually surprised." Echoing this, another participant noted, "Every morning I have to sort of face myself, and depending on what my weight is, I feel happier or less happy. Sometimes I'm just satisfied that I haven't gone up, but recently it's been, 'Oh no!'" Another participant indicated that, when the scale stays the same, "it doesn't throw me into a crazy tizzy."

Two of the eight participants discussing their moods indicated that they at times, though not frequently, felt resentful of their WLM struggles, especially when those around them, such as partners or friends, were not experiencing the same struggles with weight. One other participant noted that, "Emotionally I don't see any huge changes," but then went on to discuss "periods of irritation, frustration, and mild depression" related to WLM efforts.

**Thinking related to WLM.** Related to the constancy required in their efforts to maintain their weight loss mentioned in the previous section, 10 participants also discussed their day-to-day thinking patterns regarding WLM. One participant indicated, "Right off the bat I'm thinking about it the first thing of the day . . . and then usually a couple times during the rest of the day I'll

think about it.” Other participants found their WLM to be more mentally time-consuming. One participant put it thus: “It has to do with thinking, rather than strictly weight loss, because I’m totally convinced that it’s entirely a mind game. . . . And my body follows as the night to day when I keep my head in the game.” Another participant noted, “Well, the thinking about it, the intellectual part of it, is I’m pretty much absorbed,” while another indicated:

And then during the day, I have to make sure, convince myself that I have to go out for my walk, . . . and then each meal is a food choice, and I recognize when I’m choosing badly, but sometimes I just say to myself, “Oh, you want that, and it’s 100 calories,” or whatever. So it’s a constant drain during the day.

Another participant explained further:

There are days when it takes over my entire day . . . . It’s never far away, thinking about what I’m going to eat, what I have eaten, what I’m going to eat again. . . . So let’s just say in my whole long life, there haven’t been many periods of time when I’m not thinking about the struggle, and that I resent too. Because I often think about all the time and energy I have spent thinking about what I’m eating, my weight, how I look, when I think I could have solved bigger problems in the world!

Echoing this sentiment, another participant said, “Then I just rebelled. There was a part of me that said, ‘I don’t wanna do records anymore, I don’t wanna have to count calories, I don’t wanna have to go exercise just in order to maintain my weight.’”

### **Identity as Related to Weight and WLM**

Participants were asked to describe whether and how their weights and WLM play a role in their identities and self-concepts. Almost all participants (N = 11) indicated that their weight was tied to their identity to at least some extent. The one participant who denied that weight affected the participant’s concept of self stated, “I think of myself as fat. . . . It’s a description. It’s an accurate description, I can’t deny it. . . . But it doesn’t make me feel unworthy, it’s just what I am.” Most of the other 11 participants indicated that their identities were still that of fat people (N = 7) and that they were surprised when they noticed they were no longer fat (N = 5),

that being fat carried negative connotations (N = 6), and that they felt good or better about themselves only when they felt thin (N = 8). However, two participants now felt that their identities had transitioned over time (N = 2), another two identified as thin (N = 2).

**Identity as a “fat person.”** Even though many of the participants could acknowledge that they were objectively no longer overweight, seven expressed sentiments such as: “Well, I guess I have to say I still think of myself as fat. I probably always will. And I do not think of myself as some people have said, ‘Oh, you’re so tiny!’”; or “I became so used to being the big girl, so now that I’m not the biggest girl in the room all the time, I still have a hard time wrapping my head around that I’m almost normal”; or “I don’t want to think of myself as a fat person anymore, and, even though I’ve kept the weight off for a long time now, I sometimes have a hard time convincing myself that I have a reasonable size.” One participant, who though maintaining significant weight loss is still significantly overweight, explained how weight affects her identity thus:

I remember something that resonated with me in a very small way, so believe me, I’m not comparing myself to Oprah Winfrey except in weight issues, but . . . I’ve been on stages many times accepting awards . . . and here I am going up on stage and making an acceptance speech, and all I’m thinking about is how fat I am. . . . And I remember Oprah Winfrey when she was nominated for an Academy Award, she was thinking, “Please don’t let me win because of my size.”

Another five participants discussed their surprise at either having gotten so heavy in the past or at being an average weight instead of overweight. One participant summarized the former feeling, stating:

I think friends have a tendency to just see you in a certain way, and they don’t think beyond it, which, in a way, . . . is the way I look at myself. . . . I mean it wasn’t until I looked at myself in the mirror at the gym that I looked again and thought, “Oh my God, look at that weight.”

Another participant reflected on the latter feeling, noting: “I don’t know if you’ve ever experienced the sensation of having lost a lot of weight and having walked past a plate glass window and looked in it and thought, ‘Oh my God, that can’t be me!’”

Six participants discussed ways in which they felt being fat carried negative connotations that affected how they felt about themselves. One participant explained: “Being fat is an immense handicap, and it does affect how people view you, and it affects how I view other people. . . . I try to be aware of the false opinions I’m getting . . . but they’re there anyway, it’s part of our culture.” Another participant felt she had to defy these opinions of fat people, stating: “I think that at times my weight has been an impetus to prove myself, to prove that I’m not my weight or I’m not merely the pounds that I have.” One participant related a painful story, which she indicated was something of a turning point for her:

I was working, . . . and a man came up to me that I recognized as a customer for many, many years, and he wanted to know where the fat girl was that used to help him. And I said, “That would be me.” And it was an epiphany. It was just, “Oh my God, people really don’t see you if you’re really big, or they really think of you as just being big, they don’t see your face.” Clearly, this man had never looked at my face and didn’t even pay attention to my voice, which is pretty distinctive. . . . So many things sort of fell into place at the moment that that happened, on one hand, and, on another other hand, I don’t know if I’ve ever been angrier. And it was sort of like my whole life flashed before my eyes, and I thought all of those people who never noticed me because of size.

Another way in which participants felt that their weight affected their identity was that eight participants felt good about themselves when they were their conception of “thin.” One participant indicated, “I think of myself as an attractive person if my weight is down and not if it’s up,” while another stated, “I’m way more confident if I have less weight, . . . so I had a better sense of self worth at what someone would refer to as a normal size.” One participant reflected on what she felt was the absurdity of defining her self-worth by her weight, stating:

My first few years, I was a sylph, and everybody should turn around and look at me as I walked down the street. And then I realized the first time my weight crept up to a place where, when I was coming down, I felt like a swan, you know, as it crept up to that, I felt like an ugly duckling again, and I sort of came to the realization that that was nuts, that was very weird.

**Transitioned identity or identity as a “thin person.”** One participant whose identity transitioned indicated, “My identity now, I’m the chubby person, not the fat person. . . . I can’t process other people’s perceptions because I’m so busy processing my own.” Of the two participants who now identify as thin, one explained:

I’m very comfortable with who I am at this point and the weight, and I feel like this is really me. I feel like when I had the extra weight on that wasn’t who I was. . . . My mind’s eye and my actual body are more in sync at this time.

The other participant stated: “You know, it’s absolutely central to my identity. . . . And so, every time I stand up and align my body, I’m getting back in touch with it. I so identify as a thin, fit, healthy woman. It’s core to my identity.” However, that same participant later discussed experiencing moments in which:

I was living my life like a person! Not like a fat person, not like a thin person, but like a *person!* You know to have that whole weight thing that had been such an obsession for so many, really virtually all my adult life until I finally got a handle on it, to get it that I had stepped beyond that was just a huge, huge epiphany and gift.

**Identity around weight complicated by being single.** Two participants also discussed identity issues in which their weight was tangential to their main concerns. Both participants identified their relationship status as single. One explained:

I’m single. And I was so convinced that the minute I lost weight some man would pop into my life, and all these things about how did I feel about my body, and it didn’t work out the way I had kind of envisioned because I’m still single. . . . And that was sort of an interesting thing to assimilate. . . . So [my weight and other aspects of my identity], it’s all sort of smooshed together.

On the other hand, the other participant felt that being single had an effect on her ability to maintain her weight loss. She explained:

One of the problems I've had is being single all these years, and, therefore, I wasn't cooking on a regular basis for anybody else . . . . I only know that I hate cooking for myself, . . . so for years I have taken the easy way out, made scrambled eggs, eaten cereal, eaten cheese and crackers, whatever. I'll go out with people. . . . I really think this is the only way I'm going to get this squared away is to make some meal plans. . . . I do think that's been my single biggest problem is just that I never really learned how to just cook cuz I didn't have a weight problem when I lived with three other girls because we took turns cooking, and we were, I don't know, it was just more like a family thing and being by yourself isn't.

### **Definition of Successful WLM Over Time**

Participants were asked to discuss how they defined *success* with regard to their WLM and whether and how this definition has changed over time. All participants expressed that their definitions of success included certain tangible and intangible concepts, including how they looked or felt, but a sizeable minority (N = 5) also defined success in terms of continuing WLM-supporting behaviors. The most commonly mentioned definitions, or themes, had to do with how the participant looked (N = 8); the number on the scale (N = 7) or weighing substantially less than their highest weight (N = 5); and health concerns (N = 7), physical abilities (N = 5), or physical comfort (N = 4). Other definitions of success included how other people viewed them (N = 3) and feeling in control (N = 2). Among those who also defined success in terms of their WLM-supporting behaviors, two mentioned addressing any gains immediately, one cited weighing daily, one noted maintaining certain changes in diet, and one mentioned keeping active.

In addition, half of the participants (N = 6) also indicated that how they defined success had changed at least somewhat over time. However, a minority of participants (N = 3) denied any change to how they defined success.

**Conceptual measures of success.** Eight participants cited how they looked or what clothes they could wear as a primary measure of success in managing their weight. One participant explained:

I'm also vain! I mean, I definitely am vain. I love to shop, and I love clothes, and I love the fact that I can buy them off the rack and I no longer have to be searching and searching for something that looks good to cover up my body, and the whole time knowing that it wouldn't really matter what I put on, I was still going to look overweight. So, you know, that sounds kind of shallow, but that's the shallow end of the spectrum.

Others echoed the foregoing sentiment, reporting things like: "the fact that you've got all these new cute clothes, . . . the fact that I can wear my clothes is enormous"; "I do know that having a couple size 6 things has been really fun!"; and "The payoff for me is getting into clothes that I can buy in a store that I don't have to buy in a catalogue because I don't want to go to a store and try on clothes." Other participants mentioned their looks more specifically, such as one participant who stated, "Despite all the good advice about the benefits of weight loss for our health, my concentration is more how I look," or another who noted:

I have totally transformed my body. I don't quite have a six-pack yet, but, at the dewy age of [60-69], I have some vertical lines down on sides of my abdomen and down the middle when I stand up and look at my reflection in the mirror. I have actual biceps!

Also important to seven participants was the number on the scale. One participant explained:

Success is keeping it under a magic number I have in my head because that's danger if I go above, and I'm currently four pounds away from that number. . . . The goal is to keep it 10 pounds below that number, that for me is real success.

Others echoed this sentiment, noting things like, "The number on the scale is still huge to me"; "I'd like to weigh [X] pounds again or even less"; and "If my weight goes over [Y], I immediately start cutting back on something in a conscious way, and as long as it's, [Z] is my goal, and as long as it's [Y] or below, I kinda keep doing what I'm doing." Five participants tied

their success less to a particular number and more to maintaining a weight significantly less than their highest weight. One participant explained: “Even when I go up a little bit, . . . I still look at myself going ‘I still wear six sizes smaller pants than I used to. I mean, I used to be a 16 and now I’m not, and yay!’” Another participant noted, “I feel really good about having maintained at least an 80-pound weight loss for . . . at least an 18-month period. . . . I have varying degrees of success, . . . but I feel that I have partially succeeded.” Another participant found that keeping two-thirds of her initial weight loss off was success, and another defined success as “keep[ing] a lower weight.”

Seven participants discussed better health as a major marker of success in WLM. Participants cited health concerns, such as “I didn’t do the program for clothes, I did it for health reasons. . . . It was some of the health numbers . . . that began to creep into areas that could become problematic”; it’s “more about being healthy and not having the stress on your limbs and your joints, and getting a good night’s sleep. . . . I want to feel better; I don’t like feeling poorly”; and

I’m sure part of it is that I’m older now, . . . so I’m really much more concerned about my health. . . . So I think that if I can get to a weight range where I’m not putting extra stress on my heart or on my replaced knees and all of that, then I feel like I’m doing something more for my health to maintain better health as I grow older.

Notably, it was older participants (60+) who cited health concerns as main reasons for their impetus to lose weight and keep it off. Some of these older participants, as well as some of the younger participants, also discussed comfort and physical ability concerns as important markers of successful WLM. For example, one participant discussed her constant airplane travel, noting:

I was never comfortable when I was overweight. . . . It is a million times easier to fly on an airplane when you're slightly underweight than when you're slightly overweight. Any of the pain you can take out of flying for me is a positive.

Another noted that, as she has gotten older, "It really affects my well-being, my physical pain. Just a few pounds makes a difference in my knees and my ability to hike and work out and be pain free." Another participant also cited her increased abilities, stating:

The fact that I can do all these things I used to not be able to do, that I can actual go to the gym every day, and that I can do yoga, and I can do all this physical stuff, whereas before I would be gasping in agony, so that's how I measure [success].

While another noted, "Having the extra pounds limited what I did. I didn't do certain things, go to a swim party, say. . . . So having the weight on was limiting; not having the extra weight, there are less limitations."

**WLM-supporting behaviors as a measure of success.** Among those participants who also defined success in terms of their WLM-supporting behaviors, two defined success in terms of addressing any weight gains immediately, one noting that "success is when there is a gain, getting it off as quickly as possible." Another participant mentioned watching the scale, noting, "I never stopped weighing myself every day. . . . Now I would term that a success." Another felt that success for her was "to keep exercising, to keep walking, to make sure I do that," while another participant noted that "being abstinent from sugar, for me, and eating healthy, which means not eating a lot of sugar," was a success.

**Changes to definition of success.** Among the six participants who mentioned that their definitions of success changed over the time they had maintained their weight loss, two specifically noted that their definition of success had changed as they aged. One of these participants remarked, "When you get to be a certain age, your expectations do change, and what you're after is less looking like the thinnest of your girlfriends and more about being healthy."

Other participants (N = 4) noted that, as they gained experience with WLM, their definitions of success changed. For example, these participants noted things like, “It’s changed a little bit in that it’s not quite as locked into the number”; “Now I’ve sort of worked out a modus that I’m not really going to kill myself to get rid of that extra 25 pounds, I’m just gonna work as hard as I can stand to work to make sure it’s not 75 again”; and “Whenever I walk into a room, I’m always aware of how I’m perceived. . . . But I must admit, this seems to be diminishing. I don’t obsess about this as much as I used to.”

### **Experiences of Being Unsuccessful at WLM**

As shown in Table 2 in Chapter Three above, seven participants went through more than one significant weight loss over the time period from when they first successfully lost a significant amount of weight. Therefore, participants were asked about their emotional, cognitive, and self-concept experiences during times in which they perceived they were unsuccessful in WLM. Six participants noted that they felt unsuccessful near the beginning of their WLM, four participants felt unsuccessful at various points in their period of WLM, and five participants felt they were currently struggling with feeling unsuccessful with WLM. All participants discussed how their perceived WLM failures made them feel, while a large minority (N = 5) also discussed what actions they took to alleviate those feelings.

The two most commonly cited feelings fell into the areas of motivation (N = 6) and helplessness (N = 6). Similar to motivation, several participants (N = 4) also experienced feelings in the area of “not giving up” (N = 4) and “becoming more conscious of WLM” (N = 4), while, similar to helplessness, several participants experienced feelings in the area of “fear of regaining the weight” (N = 4). Other responses included internalizing responses in the areas of “beating oneself up” (N = 5), “feeling like a bad person” (N = 4), and “frustration” (N = 4), as

well as externalizing responses of “ignoring the weight gain” (N = 4), and “externalizing the causes for the weight gain” (N = 2). The most commonly cited behavioral responses to these feelings associated with WLM failure were seeking professional assistance (N = 5), going back to stricter WLM behavioral measures (N = 3), and analyzing why the weight gains had occurred (N = 2).

**Emotional responses to lapses in WLM.** Six participants discussed that one of the main emotional reactions they had to periods of weight gain was to find motivation in their setbacks. One participant noted that she didn’t “feel like I was a failure, but I’ve got to get myself into gear. It was more of a motivator than a depression.” Other participants expressed it thus: “I know that if I don’t suck it up and go back to the gym or not eat that Oreo, then I’m just gonna go back to this big ole me. . . . I try to keep that in mind to keep from getting derailed”; “The things that are useful . . . to me are, well, like guilt. I find guilt a useful tool . . . , it’s just a reminder for me”; and “Ok, I fell off the wagon, ok, well I stayed off the wagon for a long time, but it’s not the end of the world, ‘Get with it, [self].’”

Similarly, four participants expressed feeling the setback but refusing to give up on their efforts at WLM. One participant insisted, “I’m not going to go back. . . . It’s not a negative feeling because I know I can do it, and I know how to do it.” Other participants echoed this sentiment, stating things like, “I know now and am more confident with my own ability to self-regulate and take the weight back off again”; “[I have] the determination that I’m not giving up and that I’m working on these strategies”; and “I felt like I know what I’m doing, and I’ll be able to get back on track, or I’ll be able to start eating in a way that I will begin losing weight again.” Four participants also discussed utilizing their WLM setbacks to begin “thinking more consciously about what I have to do.” One participant explained, “What it does is it makes me

realize I'm not paying attention to myself and what I need for myself," while another remarked that "what's happening now is I'm more conscious about it, and I intervene to some extent."

Six participants reported that experiencing failures in their WLM caused them to feel helpless or discouraged. One participant expressed, "I felt very discouraged . . . sort of the disappointment each day when I get on the scale," while another indicated, "it's just so discouraging to me when my weight goes flipping up and down." Another expressed feelings "the usual cycle of shame and guilt and sense of failure, despair . . . I think every aspect of despair, unhappiness." Several participants also expressed feeling a lack of control, reporting things like, "a sense of lack of control"; "ultimately I realized, no, I am in control of this, it's just that I'm a failure, I can't control this"; and "when my weight is out of control, it feels like my life is out of control."

Similarly, four participants expressed a fear that a set-back in their WLM would lead to a larger backslide. One participant explained:

It's kind of like giving up smoking. You know, once a smoker, I mean you could probably always go back. . . . [But,] if I allowed it to get to [X], it would all be over because then I'd be [X + 20], and then I'd be [X + 40], and then I'd be [X + 60]. All of that would happen overnight.

Others expressed similar fears, noting things like, "I felt I needed to do something quickly because I think that if you let it go too far, you start the reverse spiral [up in weight]"; and "If you do get into letting it slide, then 10 pounds, that would be a fear for me, that 10 pounds would be 20 pounds, and then you're in trouble." One participant stated:

There are other people [in my maintenance group] who are really heavy, and they've lost a lot of weight, but then they've gained a lot of it back, and I kept thinking, "I don't want to do that, I don't want to do that." Now I'm beginning to feel like, "Oh my God, I'm beginning to do that."

Underlying these fears seemed to be what one participant expressed thus, “It’s like I could explode and be fat, really fat, any minute without a lot of effort.” Another participant echoed this as “I feel every day like that 50 pounds is out there saying, ‘Eat me! Eat me!’” Some participants (N = 3) expressed that this fear has diminished over time. One participant explained: “I’ve learned over time, it’s time as much as intent, that, no, it’s not all gonna come back. Maybe a little of it is gonna come back, and if it’s just come back, it’s easier to take off.”

Among those who internalized negative feelings that came up around failures in WLM, five participants discussed berating themselves, expressing sentiments such as “I can beat myself up so easily, and I’ve been trying not to do that too much”; “At what point do you stop beating yourself about the head and shoulders, and it doesn’t come easily, and it doesn’t come automatically”; and “inwardly directing the anger toward me.” Likewise, four participants felt bad about themselves. One participant expressed her strong negative feelings, saying, “The feeling is always self-loathing. Loathing does not minimize how I feel. I hate myself, I feel unworthy, I feel, I just loathe who I am.” Another talked about the “shame and guilt and sense of failure, despair, anger at myself. . . . I’d feel demoralized, and then I’d have to overcompensate by pleasing the world and making everyone else happy because I was so inwardly unhappy with myself.” Finally, four expressed frustration with regard to failures in WLM, saying things like “Well, I’m not sure whether the word is frustrating or angering”; “It makes me kind of frustrated with myself”; and “There have been times when I’ve been frustrated.”

Some participants externalized their feelings about perceived failures in their WLM. Four discussed ignoring the setbacks, stating things such as: “I might try and convince myself that it didn’t really make any difference, and I should be able to do what I wanted to do, it’s my life, blah blah blah”; and “I don’t want to know, I pretend that I haven’t gained the weight, you know,

wishful thinking, magical thinking, I'm not as fat as I think I am." Similarly, two participants attributed their weight gain to external forces. One participant maintained, "The reason I went through the [diet] program a second time is everybody said, 'You need to eat more for breakfast, you need more calories in order to be able to work,' . . . and so I found myself back at [X] pounds." Another participant reacted to weight gain by experiencing feelings of "blaming the world" and "the sense that forces other than myself were in control."

**Behavioral responses to lapses in WLM.** Five participants noted that they sought professional assistance when they felt unsuccessful in maintaining their weight loss. Three of those participants mentioned working with WMP, mentioning "I do have people at clinic to talk to about it if it does creep up"; and how "sticking with the program helped. I mean I can see if I hadn't done that part of it, I'd be right back where I started." Another participant, who lost weight with another professional WLT, indicated, "If [my weight] were to go to [X pounds], I would go back on the [professional WLT] program, chapter and verse, as it's designed, which would include writing everything down, which I don't do now." Another participant indicated that during her first few years of WLM, "I was feeling unsuccessful, and I went to spas a couple of times, weight loss places. . . . To try to bring the weight back down when it had gone up." Two other participants also noted the importance of resuming strict record-keeping of what they were eating when they began gaining weight.

Two participants felt that it was important to them to spend time examining and analyzing why it was that they were having an unsuccessful period. One participant explained:

Identifying what the problem is and dealing with whatever the issue is rather than trying to medicate with food. . . . I think sometimes when we're very overweight, there is some desperation there, you know, maybe you're packing on the pounds because of something you're not recognizing in yourself, and there are some self-inflicted issues, and I think

when you can figure out what those issues are and can move forward, you do less of that self-defeat.

The other participant echoed this sentiment, stating that, when she had been unsuccessful maintaining her weight loss, “I’ve had to kind of look . . . back on the patterns in my life and how did I choose that path or that path, or why didn’t I go a different direction and that kind of thing.”

### **Supportive and Unsupportive Themes in WLM**

Participants were asked what they considered to be both mentally and emotionally supportive and unsupportive to their successful WLM. Participants’ responses were categorized into themes of internal and external features that were either supportive or unsupportive to successful maintenance of their weight loss.

**Internal features.** Eleven participants described internally supportive features, including maintaining focus on their weight management goals (N = 6), feeling better about themselves when they were successfully maintaining their weight loss (N = 5), acceptance of the changes and dedication required for successful WLM (N = 4), being an example for, or helping, others with weight struggles (N = 3), taking the time to analyze and understand root causes of their weight issues (N = 3), the control they felt when successfully maintaining their weight (N = 3), past successes with WLM (N = 3), and learning to be more assertive of their needs around successfully maintaining their weight (N = 2). Other internally supportive features mentioned by only one participant included learning as much as possible about WLM, allowing oneself to accept external support regarding WLM, no longer berating oneself for perceived failures in WLM, learning to control one’s stress level and mood through exercise, using guilt as a motivator, and learning not to obsess too much about day-to-day WLM efforts.

Eight participants described internally unsupportive features, including using food to soothe or reward themselves or feeling addicted to food (N = 6), putting the feelings and needs of others before their own needs around WLM (N = 3), self-sabotaging their WLM efforts (N = 3), and engaging in negative thinking patterns (N = 2).

*Internally supportive features.* One of the most frequently discussed internally supportive features was participants' focus on their WLM goals. One participant noted, "I think concentrating on the job of keeping the weight off helps me," while another stated, "I just realized that this was work I have to do, and its worth it. I don't want to live the other way. . . . The work is worth it." Other participants discussed shifting their mindsets. One noted, "I have to sort of give myself positive reinforcement, that has to come from me ultimately, it's all in my head. . . . I do recognize when I feel I'm not giving myself the opportunity to stay on track," while another stated, "a mindset . . . is 'Oh, that's right, I don't really need to have more of that. I remember what that tastes like, and it tastes good, but I don't need it right now.'" Another participant explained her shift in mindset thus:

I read somewhere about the power of going from "I can't do this" to "I wonder if I could," as a kind of an interim step between "I can't do this" and "I can do that." And, so, I started saying in my head, "I wonder, I wonder, I wonder if I could." I kind of left the jury out in my mind about whether I could or could not really do it. I hung with the notion of wondering if I might. Somehow I could say that with integrity, I could say, "I wonder if I could." There was no kickback in my brain about I must be smoking something to even say that. So I could hang with that, I could hang with I wonder if I could.

Another frequently mentioned internally supportive feature was participants' feeling both physically and emotionally better about themselves when they maintained their weight loss successfully. One participant put it thus: "There's also just the fact that I feel so much better, that, it's a little bit internal. . . . I've managed to develop a healthy enough sense of self-esteem."

Another participant explained, “After a while, then it wasn’t a question of ‘I have to keep doing this,’ it was more of a question of ‘I get to keep doing this’ because it feels better. It feels a lot better.” A third participant noted, “I think that emotionally, fitting into my clothes and looking nice in my clothes is a real boost to me. . . . That mentally, that reinforces it.”

Four participants discussed the helpfulness of being an example for and helping others with WLM struggles. One participant explained that the leader of her WMP maintenance group:

keep[s] pointing to me [and two other participants] in the class as the sort of successes, and so I feel a real obligation to not fall off the wagon. . . . I’m sure he does it in part because he knows that it’s effective for us, and so I feel a responsibility as a role model. And that’s been for me, it’s not been a burden, it’s been a boost. To be put on a pedestal makes me feel proud of myself, and so I feel a social responsibility to fill that role.

Another participant phrased it thus:

I really feel as if we, those of us who have kept a great deal of weight off for a long period of time, sort of need to carry a banner for it and say to people who want to know what our experience has been and how we lived through it. . . . We’re always looking for something that motivates us, and, a lot of times, it’s just one person who happens to make a difference, one person’s story, a good friend’s experience, just something that can do it that will make you think, “You know, I can do this, and I want to do it because I’m healthier if I do.”

Three participants also discussed a level of acceptance about the challenges of WLM that they felt was helpful to them. One participant put it bluntly: “I know what I can do and what I can’t do, so I just don’t try to do [what I can’t do] anymore. What’s the joke here? It’s the old formula: exercise count your calories, and keep records. It’s the only thing that works.” Another echoed this, saying that what helped him was “accepting that there are things you need to do and attempting to do them.” Another participant discussed her struggle for acceptance:

When I got to my goal of [X pounds], I went to work for [my professional WLT] immediately. And [the professional WLT] actually recommends that employees go to meetings like a member, which I thought was absurd. I’m not only familiar with this topic, I’m leading this topic, why in the world would I want to sit in a meeting room and listen to somebody else lead this topic? So, I found for the first couple of years, there was

a fair amount of struggle that went with keeping my weight in check, and, at some point, I think my commitment to listening to my own wisdom about this journey called the thought into my brainpan that, “You know, girl, the way you lost this weight was to surrender to the program the way it’s designed, and maintenance for employees has a design as well, and the design includes attending a meeting every week.” So I started attending a meeting. I attend a meeting on Friday mornings . . . as a member. Now, the [professional WLT] week starts on Sunday and runs through Saturday, so by Friday morning I will have led the topic five times in my current schedule. . . . And I swear to God I don’t hear one new thing in the meeting I attend as a member, . . . *and yet*, I don’t struggle so much, so I do it. I notice attending that meeting as a member seems to make the struggle less intense, and so that’s what I do.

Three other internally supportive features discussed by minorities (N = 3) of participants were taking the time to analyze and understand root causes of their weight issues, the control they felt when successfully maintaining their weight, and past successes with WLM. With regard to understanding the causes of her weight struggles, one participant explained:

I strongly believe that if you’re a person who has struggled with keeping off a great deal of weight . . . something triggered your eating disability. So what was it? Are you going to try and figure out why you’re an emotional eater, or are you just going to go up and down and up and down and never really get to the root of the problem? So, . . . as an older woman, I decided what I needed to do was to figure out what the problem had been, why I got there to begin with.

With regard to elements of control, one participant stated, “[Successful WLM] gives me a sense of control, which is very important to me. And, when I don’t have it, I feel out of control.”

Another noted:

After I lost the majority of the weight, I did go through the closet and get rid of the larger sizes. . . . If I were to put on a few pounds, I know I have to get that off in a certain amount of time because I will not go out and buy larger clothes. . . . That’s kind of my forced way of not letting it get out of control.

With regard to past success with WLM, participants noted things like, “I have a pattern that I can successfully repeat,” and “I have to keep reminding myself that, even though I wouldn’t say things are going great, but I’m happy with the way things have gone.”

*Internally unsupportive features.* Of the eight participants described internally unsupportive features, the most frequently mentioned feature was participants' use of food to soothe or reward themselves or their feeling that their eating was an addiction. One participant explained, "Generally speaking, I would say that I am an emotional eater and always have been. . . I'm gonna look for the comfort where I can find it, and food is my drug of choice." Another participant stated, "I have a recollection of sugar and fat being my very best friends in the world, never critical, always there, always numbing me out." Yet another noted, "If I'm depressed, ice cream sounds better than if I'm feeling good about myself. Like everybody who has a weight problem, I eat according to my moods." Another participant phrased it a bit differently: "Not helpful for me is being under stress and not taking the time to recognize the stress and mow through the refrigerator." One participant discussed food as a reward, reporting, "It makes it harder, but I still reward myself with food." Regarding food addiction, one participant put it bluntly: "What we're talking about is either an addiction to fat or an addiction to eating, but the addictive behavior is in there somewhere." Another indicated, "It's difficult because food is an acceptable addiction. . . . I don't know 'addiction' is the right term, but I do think that a lot of people . . . use food as a way to soothe or comfort."

Three participants also discussed worrying about or focusing on others' needs ahead of their own needs around their WLM. One woman joked that her efforts to lose a bit of weight during her WLM journey was the cause "of the worst holiday my family ever had! . . . I think they were feeling like they shouldn't eat anything because of me." Another woman felt guilty that her WLM efforts had a negative impact on her husband. She explained:

I don't think [my husband] had any idea what he was getting into when we married, around my food. And it's really affected him . . . because he's very conscious that I can't

eat what I want to. . . . I have to pretend to like what I'm eating so [my husband] will enjoy what he's eating without guilt.

Another woman felt that, as the youngest of a large family, she spent a great deal of time focusing on the needs of her siblings as they aged without paying attention to her own needs, which made her WLM more difficult.

Three participants discussed elements of self-sabotage that they found unsupportive in maintaining their weight loss. One participant explained it thus:

When there is a type of inertia that takes over, we call it, it's "taking the governor off." When you want to defy your, and I'm using the word diet when I should be saying a sensible eating plan . . . or making mindful choices, you kind of want to defy that in a way. And I think that's some of the old thinking that comes back. It's like, "I want to eat what I want to eat when I want to eat it." I deserve it, I need it. There's always this good cop / bad cop, angel / devil on either shoulder, at least for me.

Another participant indicated:

Unhelpful is my need to occasionally be creative in the kitchen. . . . So that's really unhelpful when I get one of these urges to back. It's almost like I'm sabotaging myself . . ., and what's emotionally not helpful is that I feel like I must be sabotaging myself on purpose, but I don't even want to go there, I don't even what to analyze that!

Somewhat similar to self-sabotage, two participants discussed negative thinking patterns that they found were unhelpful to their WLM. One participant stated, "I can't attribute outside forces to being not supportive, I really can't, because, ultimately, I think it's what's in my head that's not supportive." The other participant noted, "The detriment, if I look at myself and think, no matter what, . . . 'oh my gosh,' . . . it's unfair, but in a way, I perceive that other people must see you're out of control again, you know, if you've gained weight."

**External features.** Eleven participants described external features that were supportive to them in their WLM, which included the support of their particular maintenance groups, either WMP or other professionals WLTs, and their particular WMP group leader (N = 11), as well as the accountability they felt to those groups or to others (N = 8) and strategies they learned from

those groups (N = 1), the support of family members and friends (N = 9), the support of their partners (N = 5), and outside psychotherapy (N = 2).

However, of the eight participants who described externally unsupportive features, several cited some of the same features that they themselves, or other participants, found externally supportive. For example, four participants found their home or other environments to be unsupportive, four participants found their partners to be unsupportive, three participants found their family members and friends to be unsupportive, and two participants found their maintenance groups at WMP to be unsupportive and subsequently dropped out. Two participants also mentioned that drinking alcohol when out with friends was unsupportive of their WLM.

*Externally supportive features.* Eleven participants indicated that the support of their particular maintenance groups, either WMP or other professional WLTs, or of their particular WMP maintenance group leader was important to their successful WLM. Of these 11 participants, one goes to a professional WLT group, seven regularly attend the WMP maintenance groups, and three no longer attend the WMP maintenance groups but continue to check in with their group leader on an individual basis. One participant found it helpful “to continue with maintenance, the therapeutic part of the maintenance, you know, going into clinic and talking to people, . . . part of that is the support network, going into clinic.” Other participants noted things like, “I think group sessions help this a lot, just knowing that these struggles are almost universal in a way”; “It helps to go to group and get the reinforcement that I can do it’; “the support of the group [is important]”; and “there are some people in the group who have similar orientations to what I have, and that’s very supportive.”

Of the participants who are involved with WMP, nine (six who attend the maintenance groups regularly and the three who check in individually) specifically mentioned their group

leader as a particular source of support. One participant put it succinctly: when asked what was mentally or emotionally supportive for her in her WLM, she answered simply, “[My group leader].” Other participants elaborated on this sentiment, describing qualities they found supportive, saying things such as, “I can’t not mention [my group leader] . . . [He] is such an awesome guy, he’s so supportive, he’s so nice and encouraging”; “[My group leader] is wonderful. He’s totally non-judgmental. He thinks I’m a great success story, and it’s good to hear that, to be reinforced, and that probably has something to do with [my success at WLM]”; and “I have to tell you that I think that [my group leader], in particular, . . . has really made a difference in my keeping it off as long as I have . . . because [he] has always been supportive.” One participant explained further:

[My group leader] is a remarkable man who practices what he preaches, and so when you watch this man who has watched everything that’s gone into his mouth for who knows how many years now, certainly it’s got to be at least 20 or more, and he stands up in front of you and talks to you or sits with you in his office and talks to you about the emotional aspects of eating and what’s going on in your life without being your psychiatrist or your psychologist, this is a person who really has empathy for what it is you’re going through.

In addition to the support that most participants received from their groups and from their particular group leader, eight participants discussed the importance of the accountability they felt to those groups or to others, and one participant specifically cited WLM strategies learned from the groups. Regarding accountability, participants noted things such as: “I’m a person who needs the accountability, so that’s why I do the maintenance group, and that’s been important to me because that’s my accountability”; “that has a lot to do with sticking with it, just the knowledge that I’m gonna have to get on their scale . . . the regularity of having to step on the scale”; and “that level of accountability is huge.” Some participants also mentioned that they experienced weight gain when they did not attend groups regularly. One participant noted, “I’ve definitely

noticed if I don't go, if I skip the group for a couple of weeks, I'm guaranteed to be up when I do make it back. . . . It's just that having to go and check in somewhere [is important]." Another reported:

I think for the last five or four years I've been going to the maintenance class. And I did it once before for about three years, and this time I have no plans to end this. I did last time, and then over about five years my weight crept back. But I think without being answerable to [my group leader] in our class or someone else, I'm just not as successful.

Yet another indicated:

I just renewed for another year of maintenance, and I said to [my group leader], "Ok, come on, I've been doing this for two years, come on, what do you think, is it time for me to fly solo?" And he says, "It's up to you, but," he says, "let's do this, let's go through your chart," and he says, "Ok, let's go back to the beginning. You come in on a regular basis and everything looks really good," and then he finds a gap where I've been away for like a month or two or something, "Oh, look at this, you creep up slowly," and then he says, "Then you come back and look what we do." So it is being held accountable!

Regarding specific WLM-related strategies, one participant noted:

It helps to go to . . . group and . . . to talk about different strategies. . . . I've also acquired a lot of foods, I mean I have this whole shopping list, . . . so that's been great because we entertain a lot, and I have a whole repertoire of stuff that I can serve as hors d'oeuvres that I can also eat and know exactly how many calories are in them.

Nine participants mentioned the support of family and friends as important to successful WLM. Participants reported things such as: "I have a really good support system"; "I think it's helpful to have set up this system, a group of people, like the people I exercise with . . . because they're sort of a guideline for me"; "I think what's really healthy for me and has been really supportive has been a group"; "I have a walking partner, a friend, who also did the [WMP] program, so that's been good emotionally because it's someone who's sharing the same struggles"; "my friends are very supportive, my family is very supportive"; and "I have a couple of friends who have really been helpful." Likewise, five specifically noted that their partners were particularly supportive, saying things such as: "my husband is really great, he is

encouraging . . . without being obnoxious or pushy”; “my husband is great about defending me on [my WLM], and asserting it, and trying to protect me”; “as far as being mentally supportive and emotionally, [my husband] would be number one”; and “I am supported and sustained by a husband who is usually, 99% of the time, understand[ing].”

Two participants also indicated that outside psychotherapy was something that was helpful to them in successful WLM or that they thought would be helpful. One participant explained:

I know that even though it might not be preached that you should look for the psychological reasons, you really, in my opinion, should. . . . A lot of people who come into the [WMP] program, . . . if they’re not looking for the emotional support outside the program, they’re probably doomed to go right back where they were, if not worse.

Another participant discussed her own experience with psychotherapy around her WLM, stating:

I think having some place like . . . a psychologist or psychiatrist, somebody to talk to about this and finding out what your triggers are because I think the more you know about your own personality and your own triggers, you can get through it much more easily. . . . When I first started, the person who was my instructor [said] . . . , “When I was going through the weight loss and was taking it off . . . , I was also seeing a therapist in order to find out what my triggers were,” and I did the same thing and it was helpful for me.

***Externally unsupportive features.*** Four participants reported that their home or work environments were unsupportive, noting things like, “I do have a family. I have two [children]. So what’s difficult for me is having the snacky kind of stuff in the house because you know how kids can eat that with no problem”; “It’s bizarre, but I confess to an addiction to cheese, and my wife eats a lot of cheese, so I can’t get her to quit buying it”; or “We probably have 35 pints, our freezer is almost exclusively filled with ice cream of the highest quality.” One participant explained:

So much has to do with environment for me. . . . There are places that are awful. When I come out of [the subway] . . . to come to [the WMP] meeting, I come up at . . . the

farmers' market, where . . . they have the kettle corn! I *love* the kettle corn because it has sugar on it. So every single time I come up from [the subway] . . . I go through "I'm not gonna buy kettle corn, I'm not gonna buy kettle corn, I'm not gonna buy kettle corn!"

Including the ways in which their partners affected their home environments, four found their partners to be unsupportive for their WLM. One participant noted,

In those moments when [my husband] has really wanted to have something, lots of sweets, or something is going on and, because he's not battling weight, he might choose to say, "Ok, we're gonna get a little bit bigger birthday cake than normal," then I don't feel supported. Then I feel like, "Oh, if you bring that in here you know I'm gonna eat it." So I feel like he might be [at those times] my saboteur.

Another participant indicated, "Well, [my husband is] unhelpful in the sense that [he] is sort of at the opposite end of the spectrum, and for his own health interest, he wants to gain weight."

Three participants also found certain family members and friends to be unsupportive to their WLM efforts. One participant noted, "And then some people are just flat out saboteurs [sic], 'Oh, come on, if we go out and have a couple of drink and we have dessert, it's no big deal.'" Another echoed this sentiment, saying,

I have friends who . . . try to sabotage: "Oh, certainly you can just have this or just have this." . . . Or call me up and say, "Do you want to have lunch?" No, I don't want to have lunch, are you an idiot?!

Another discussed how doctors can be unsupportive around issues of weight: "When it's presented that way, you don't feel like they're in your corner at all. You know, it's sort of like you're this person who eats too much, and, therefore, you're obese."

Two participants found their maintenance groups at WMP to be unsupportive and subsequently dropped out, noting, "I dropped out of maintenance because I just didn't fit the profile that they push"; and

I was in a group when I first started, . . . but I didn't like it. For one thing, I was doing better than everyone else, so I kept getting held up as a good example, and I was like, "Wait a minute, what about me? What about my issues?" And I just didn't like it.

Two participants mentioned that drinking alcohol when out with friends was unsupportive. Both participants who discussed alcohol indicated that it reduced their ability to monitor their food intake. One participant explained, “It’s very difficult for me if I go out for social situations, and . . . I have one or two glasses of alcohol, and then tell myself I’m not gonna overeat because, for me, I know if I’m having alcohol, I’m gonna overeat.” Another echoed this sentiment, stating, “When I’m out with my sister or other people, I’ll have wine, and I know that drinking wine leads to my eating more or more hors d’oeuvres or whatever.”

### **Relationships Among Responses and Participant Demographics**

**Current weights as compared to final diet weights.** Interestingly, very few demographics related to whether participants were maintaining weights below, at, or above their final diet weights. Although one might expect either that participants would “get better” at WLM over time or that, conversely, long periods of WLM would give participants more chances to “mess up” their WLM, length of WLM at the time of the interviews did not appear to be related with whether participants were maintaining weights below, at, or above their final diet weights. The six participants who had maintained their weight loss for five years or less reported that three were at, and three were above, their final diet weights, while the five participants who had maintained their weight loss for 10 years or more reported that two were below, one was at, and two were above their final diet weights.

Further, while one might expect that older participants might have more trouble maintaining weight loss due to slowing metabolism and more limited mobility, the age of the participants did not appear to relate to whether participants were maintaining weights below, at, or above their final diet weights. Of the three participants under 60 years of age, two were maintaining at, and one was maintaining above, their final diet weights. Of the nine participants

over the age of 60, two were maintaining below, two were maintaining at, and five were maintaining above their final diet weights. As noted by several participants (N = 4), one of whom was 50-59 years of age, and three of whom were 60-69 years of age, palate and appetite changes over time may have compensated for any negative changes to metabolism or mobility.

Only one possible relationship was discernable between whether participants were below, at, or above their final diet weights at the time of the interviews and demographic features. All of those participants who had attained doctorate level degrees reported that their current weights were at or below their final diet weights, while a slight majority of participants who had attained bachelors degrees reported that their current weights were above their final diet weights, and strong majority of those participants who had attained “some college” reported that their current weights were above their final diet weights. The reasons for this possible relationship are unclear, and, due to the small sample size, it is possible that this potential relationship may simply reflect noise in the data.

Further, there appeared to be no relationships between the number of significant weight losses reported or employment status and whether participants were, at the time of the interviews, below, at, or above their final diet weights. In addition, because of the sample’s lack of diversity in gender, ethnicity, partnership status, and sexual orientation, no relationships can be suggested concerning those demographic characteristics. Likewise, no relationships could be suggested regarding socioeconomic status because of insufficient data.

**Perceived difficulty of maintaining weight loss.** Very few general or weight-related demographic features appeared to relate to whether the participants found maintaining their weight loss to be very difficult or only somewhat difficult. While the one male participant found it to be not as difficult to maintain his weight loss, it is likely premature to suggest a relationship

between gender and difficulty of WLM both because only one male participated in this study and because, across all interview questions, his responses tended to be unique.

Further, perceived level of difficulty of WLM also did not appear to relate to the age of the participants, to the length of time for which they had maintained their weight loss, to the number of significant weight losses they reported, or to whether participants were currently at or below their final diet weights. Likewise, there was no apparent relationship between being on a weight loss medication at the time of the study and the perceived difficulty of WLM: one of the two participants currently taking weight loss medications found WLM to be moderately difficult, while the other found it to be quite difficult.

The only potential relationship with demographic features that could be suggested was a relationship between level of educational achievement and perceived difficulty of WLM, with the five participants who perceived WLM as only moderately difficult having achieved “some college” (N = 4) and a bachelors degree (N = 1), while those who perceived WLM as definitely difficult had achieved bachelors degrees (N = 4) or doctorates (N = 3). The reasons for this potential relationship are unclear and are, in any event, beyond the scope of this study. However, it is interesting to note that, although those participants who had achieved higher levels of education found WLM to be more difficult, as noted immediately above, they also appear to be more successful at keeping their current weights at or below their final diet weights.

**Time and energy devoted to WLM.** All participants reported significant amounts of time and energy, including mental and emotional time and energy, devoted to maintaining their weight loss, so no particular demographic relationships can be drawn between this descriptive category and demographic features.

**Identity as related to weight and WLM.** Interestingly, whether a participant's current weight was below, at, or above that participant's final diet weight did not appear to relate to whether that person described their identity as that of a "thin person," a "fat person," or in transition. Employment status, partnership status, and number of significant losses also appeared unrelated to participants' identities regarding their weight and WLM. However, length of WLM appeared to bear some relationship to participant identity in that only one participant who had been maintaining weight loss for five years or less identified as thin, while three participants who had been maintaining weight loss for 10 years or more identified either as thin (N = 1) or in transition (N = 2). Interestingly, those participants who had higher levels of educational attainment were less likely to identify themselves as thin.

**Definition of successful WLM over time.** Perhaps not surprisingly, older participants mentioned better physical health as a part of how they defined WLM success. Indeed, eight of the nine participants over 60 years of age mentioned their physical health concerns, while none of the three participants under 60 did. However, all three participants under 60 mentioned either their physical comfort (N = 1) and their physical abilities (N = 2) as important aspects of WLM success, while only two participants over 60 mentioned physical comfort, and only one mentioned physical abilities.

However, older participants were also concerned with "the number on the scale" and how they looked. Six of the nine participants over 60 years of age mentioned that their definition of success was tied to a number on the scale, and six mentioned that it was tied to how they looked, while one of the three participants under 60 years of age mentioned a definition of success that was tied to a number on the scale, and two mentioned a definition tied to how they looked. But, several of the over-60 participants (N = 5) also discussed that, as they aged, the importance of

the number on the scale and how they looked diminished, while the importance of maintaining their physical health increased. One over-60 participant explained, “I think I would have answered that before five years ago, success was only a certain number on the scale, over or under, but now, it’s still that, but . . . as I’ve gotten older, it really affects my well-being, my physical pain.” Another noted, “Part of it is that I’m older now, and I’m not in the dating game anymore, so I’m really much more concerned about my health than I am about trying to attract the opposite sex,” but then went on to state, “When I’m feeling best about myself is of course when I get on that scale each day and I’ve either maintained or gone down a little bit.”

Interestingly, whether participants’ current weights were below, at, or above their final diet weights showed some relationship to participants’ definitions of success. The two participants currently below their final diet weight did not mention health concerns, but did mention the number on the scale (N = 1) and how they looked (N = 2), as measures of success. Of the four participants currently at their final diet weight, only two mentioned their health, while three mentioned the number on the scale and three mentioned how they looked. Of the six participants currently above their final diet weights, five mentioned their health, while four mentioned the number on the scale, and four mentioned how they looked.

Partnership status, employment status, number of significant weight losses, duration of WLM did not appear to be related to participants’ definitions of success.

**Experiences of being unsuccessful at WLM.** When describing how they felt when they experienced periods in which they felt unsuccessful at WLM, participants generally described four negative emotions – helplessness, fear about regaining significant amounts of weight, feeling bad about themselves, and “beating themselves up” – and two positive emotions – motivation and determination not to give up. Whether participants felt more positive or negative

feelings did not appear to relate to their age, employment status, partnership status, number of significant weight losses, or whether participants were currently below, at, or above their final diet weights. However, the six participants who had been maintaining their weight loss for more than five years mentioned slightly more positive and slightly less negative emotions as a group (6 positive, 7 negative) in response to periods in which they felt they were unsuccessful than did the six participants who had been maintaining their weight loss for less than five years (5 positive, 12 negative). Participants in both groups also reported shifts in their thinking as they got further along into their WLM. Some participants who had been maintaining their weight loss for over five years mentioned that, over time, they experienced less fear that a small weight gain would become a larger weight gain, that they became more confident that they could re-lose any small weight gains, and that they became less hard on themselves when they experienced small weight gains. A few participants who had been maintaining weight loss for less than five years also seemed to note this transition in mindset as well.

**Supportive and unsupportive features in WLM.** Interestingly, the six participants who currently report weights at or below their final diet weights reported slightly more external (22 to 15) and overall (40 to 37) supportive features and slightly fewer internal (6 to 11), external (5 to 13), and overall (11 to 24) unsupportive features than did the six participants who currently report weights above their final diet weights, while participants above their final diet weights reported slightly more internal supportive features (22 to 18) than did participants at or below their final diet weights.

In addition, the three participants under 60 reported a slightly higher average of external (3.67 to 3) and overall (7 to 6.44) supportive features and slightly lower average of internal (0.67 to 1.67), external (1 to 1.56), and overall (1.67 to 3.23) unsupportive features than did the nine

participants over age 60, while participants over 60 reported slightly more internal supportive features (3.44 to 3.33) than did participants under 60. Employment status, duration of WLM, number of significant weight losses, and partnership status did not appear to be related to supportive and unsupportive features.

### **Other Themes**

Certain themes emerged from analysis of the data that were not initially anticipated by the research questions used in this study. One of these themes had to do with the differences in mindset and practical approach to WLM of the two participants who were, at the time of the interviews, maintaining weights below their final diet weights from the other study participants. These two participants were among five participants who indicated that WLM was only somewhat difficult for them. Interestingly, the other three participants were maintaining weights that were significantly above (30 to 45 pounds higher) their final diet weights. A brief discussion of their mindsets follows as well, as they also provide insights relevant to the purposes of this study.

#### **Mindsets of three of the participants who found WLM only moderately difficult.**

The first of these participants was a noted outlier in both mindset and practical approach to WLM, reporting little appetite, putting “almost no thought into meal planning” by eating “almost nothing that doesn’t have the calories on the side,” “[not] think[ing] about food an awful lot,” and “emotionally [not] see[ing] any huge changes.” This participant did mention a measure of acceptance around WLM, explaining “equanimity is the most helpful thing I have. . . . Not caring too much, but accepting that there are things you need to do and attempting to do them.”

The second of these participants experienced periods during which WLM was difficult, interspersed with periods during which it was easier. This participant described periods in which

WLM has “take[n] over my entire day” and has been “kind of pervasive.” However, this participant also described periods of being “in the zone” marked by an absence of negative emotion, freedom from pervasive thoughts of WLM, and enjoyment in choosing and eating nutritious foods.

The third of these participants explained that WLM required consistent effort and was “something that is on my mind” but did not require so much effort that she would call it difficult. Perhaps, then, what differentiates this participant from the seven participants who felt it was very difficult to successfully maintain their weight loss was that this participant also, to a certain extent, had accepted and had some equanimity about the WLM process. Possibly also helpful was that this participant had always identified as a “thin person” and had only gained weight later in life after bearing children.

Also notable by its absence in this participant’s interview, but its presence in many of the interviews with participants who found WLM difficult, was any discussion of yo-yo dieting or periods of large regains. However, this participant also reported two significant weight losses, so there must have been a time at which she felt she had regained enough weight that a significant diet was required. It is interesting to note that she did not discuss this in the interview and that her responses to time periods in which she felt unsuccessful in maintaining her weight loss were entirely focused on positive action. Indeed, and of great relevance to the present study, was this participant’s discussion of utilizing WMP resources and outside therapy as a support for her WLM and as practical approaches to handling periods of weight gain. Peppered throughout her interview were mentions of therapeutic features and analyzing her own thoughts, feelings, and behaviors around weight and eating. For example, at one point, she discusses the importance of

“finding out what your triggers are because I think the more you know about your own personality and your own triggers, you can get through it much more easily.”

**A discussion of the two participants who found WLM to become easier over time.**

Interestingly, the two participants who indicated that WLM became easier for them over time were the only two participants maintaining weights below their final diet weights. Further, both had been maintaining their weight loss for 10 years or more. Most relevant to this study, in that time of WLM, both came to a level of acceptance and commitment about their maintaining weight loss that caused a shift in mindset and in practical WLM-related behaviors.

One participant explained:

I would say that [I] locked into that sort of weight loss, that occurred maybe six years ago, and it hasn't changed since then. I haven't been fooling around with it. . . . That takes a long time! . . . I think it was a combination of things. One thing, I began to recognize the signals that I was letting go of myself, not keeping records. . . . I think all those things sort of clicked in together. . . . [So, now] it has become easier. . . . I just don't play around with it. I'm just very strict with myself. Cuz I know what I can do and what I can't do, so I just don't try to do it anymore. . . . I just gave into the inevitable, and for me that didn't mean 400 lbs, the other inevitable.

What is perhaps most notable about the change this participant describes is that she felt that maintaining her weight loss became easier once she stopped allowing herself to yo-yo up and down in her weight.

This contrasts sharply with most of the other participants' WLM strategies that included “time off” from WLM. One participant who has been maintaining for over 20 years but still finds it quite difficult helped elucidate these participants' mindsets by explaining her WLM pattern: “I usually watch it pretty carefully when I'm by myself, . . . but when I go out, . . . I'm excused, and when I go on vacation, I'm excused.” This weight yo-yoing also sets up a cycle of deprivation during the diet phase, followed by the “reward” of “letting go,” which results in another weight

gain that requires another deprivation phase. It is perhaps not surprising, then, that these yo-yoing participants also expressed great difficulty with getting weight gains back off.

The other participant who has been maintaining her weight below her final diet weight and who reported that her WLM has gotten easier over time expressed a shift in her mindset to that of acceptance and “surrender,” noting:

“You know, girl, the way you lost this weight was to surrender to the [professional WLT] program the way it’s designed,” . . . and so that’s what I do. . . . I sure wish I’d gotten awakened and smelled the coffee earlier, but I didn’t. I didn’t get it until now: you get it when you get it.

So, for this participant the turning point was, like the other participant who found her WLM becoming easier over time, surrendering to her maintenance program and maintaining her weight consistently instead of continuing to yo-yo. Indeed, she mentioned several times her commitment to her WLM goals and to remaining “conscious about what my weight is on a day-by-day basis.” Further, this participant cited the accountability of being a [professional WLT] leader as something that she found important to her consistent WLM.

Throughout her interview, this participant also mentioned a number of specific behaviors she began to employ to support consistent WLM, such as insisting upon a take-out box to put away half of each restaurant meal she has before she begins eating. Also notable is that her strategies for consistent WLM did not include diminishing her social life by refusing invitations or avoiding eating out with friends, as many of the other participants have felt the need to do. Thus, her commitment to consistent WLM, combined with her acceptance of the necessity to engage in WLM-supporting behaviors, appears to have been the key for this participant in decreasing the difficulty of WLM for her.

## **CHAPTER FIVE**

### **Discussion**

The purpose of this study was to explore how psychological processes relate to maintaining significant weight loss. This was addressed by examining the perceptions, thoughts, emotions, and self-concept (both positive and negative) of study participants as they reflected on both their past and current efforts in maintaining their weight loss. The goals for this study were: (i) to add to the weight research literature the voices and personal internal experiences of these individuals around maintaining significant weight loss, and (ii) to better understand the needs of individuals maintaining weight loss to help inform further study and development of psychological interventions for this population that are effective not only in assisting with successful weight loss maintenance but also in reducing the perceived internal difficulty of maintaining weight loss.

As discussed in Chapter Two, few studies have researched WLM from the perspectives of the maintainers themselves (Bidgood & Buckroyd, 2005; Green et al., 2009; Lyons, 1998; Macht, 2008; Mycroft, 2008). Further, those studies that did use qualitative methods and interviews with individuals maintaining weight loss did so from an outsider-researcher's perspective and often as part of the construction of models with which to explain WLM failure or to deduce which behaviors are most helpful in maintaining weight loss (Green et al., 2009; Macht, 2008). However, pursuant to one of its goals, this study sought simply to capture what it is like to be someone struggling to maintain significant weight loss. The present study's findings thus shed further light on those aspects of WLM which are most difficult for maintainers, suggest

ways in which the clinical social work profession can work with weigh-loss maintaining individuals on the mental, emotional, and social aspects of maintaining significant weight loss, and give direction future areas of research regarding the psychological aspects of WLM.

### **Confirmation of Previous Research on WLM**

**The importance of sustained WLM-related behaviors to successful WLM.** Many of the findings of this study confirm what is already known about WLM. For example, most of the participants of this study reported engaging in, and finding important to their success with WLM, those WLM-related behaviors previously suggested to be effective and necessary to WLM, such as weighing frequently and regularly (Boutelle et al., 1999; Butryn et al., 2007; Byrne et al., 2003; Hill et al., 2005; Kitsantas, 2000; Phelan et al., 2009; Wing et al., 2008), carefully monitoring what and how much they ate (Bond et al, 2009; Byrne et al., 2003; Hill et al., 2005; McGuire et al., 1999; Phelan et al., 2009; Weiss et al., 2007), exercising frequently and rigorously (Bond et al, 2009; Byrne et al., 2003; Hill et al., 2005; McGuire et al., 1999; Phelan et al., 2009), regularly recording caloric intake and output (Byrne et al., 2003; Kitsantas, 2000), and maintaining control over the foods available in their environments to the extent possible so as to reduce the number of external cues that could trigger overeating and reduce the impact of internal cues triggering overeating (Black & Macinko, 2008; Bond et al., 2009; Kitsantas, 2000; Niembier et al., 2007; Phelan et al., 2009).

**The importance of external support to successful WLM.** This study also confirmed the findings of previous research that external support, either professional or social, is also important to successful WLM (Boutelle et al., 1999; Gorin et al., 2005; Jakicic et al., 2001; Kirschenbaum, 1996; Kirschenbaum & Fitzgibbon, 1995; Svetkey et al., 2008; Wing et al., 2008). Indeed, many of these studies touted the importance to long-term WLM of frequent,

ongoing contact with weight-loss therapists and support partners (Boutelle et al., 1999; Gorin et al., 2005; Jakicic et al., 2001; Kirschenbaum, 1996; Kirschenbaum & Fitzgibbon, 1995). In the present study, almost all participants specifically cited the support of either their particular WLM groups or their WLM group leader as important to their WLM success. A majority of this study's participants also found the accountability they felt to their groups or to their group leader, the support of family members and friends, and the support of romantic partners to be important in their WLM success.

**The importance of sustained cognitive restraint and reductions in disinhibition around eating.** The findings of this study also lend support to previous research that found that reductions or lapses in cognitive restraint around eating, as well as increases in disinhibition around eating, were correlated with or predictive of weight gains or lack of WLM success (Bond et al., 2009; Butryn et al., 2007; Foster et al., 1996; Macht, 2008; Niembier et al., 2007; Phelan et al., 2009). Indeed, most of the participants of present study that found WLM to be only moderately difficult or to become easier over time reported that they did not yo-yo in weight. Two of these participants specifically discussed the points in their WLM journeys in which they stopped allowing their weights to yo-yo and began to regulate their weights more consistently and noted that it was only after they stopped yo-yoing in weight that WLM became easier and that they were able to maintain weights consistently below their final diet weights. In contrast, other participants, even those who had maintained weight loss for 10 years or more, reported periods of time in which they, for myriad reasons including mental fatigue, either stopped monitoring their weights or consciously excused themselves from monitoring their weights closely. These participants tended to report that WLM was quite difficult, and a number of them

felt currently unsuccessful in their WLM and reported current weights higher than their final diet weights.

**WLM is difficult, requires consistent effort, and does not get easier.** Perhaps the least surprising, yet of the greatest importance to this study, was the clearest finding from the present study: WLM is quite difficult, it requires constant, sustained effort, and for most weight-loss maintaining individuals, it does not get appreciably easier over time. Previous research has shown that maintaining significant weight loss is extremely difficult and long-term success rates are low (Bidgood & Buckroyd, 2005; Byrne et al., 2004; Byrne et al., 2003; Green et al., 2009; HMS, 2009; Weiss et al., 2007; Wysoker, 2002). Thomas and Wing (2009) found that “successful weight loss and weight maintenance is possible, but requires sustained effort” (p. 56) and that maintainers must “devote[] a substantial amount of time and energy to behaviors aimed at weight control” (p. 56). Indeed, Kirschenbaum (2005) indicated that “most successful weight controllers list weight loss near the top of their priorities, usually higher than hobbies – sometimes more important than their jobs” (p. 13). While some research has indicated that some long-term weight-loss maintainers found that, over time, it became somewhat easier to maintain their weight loss (Phelan, 2008; Thomas & Wing, 2009), the decreases in perceived effort were usually quite small (Phelan, 2008).

Indeed, all participants of the present study indicated that WLM was at least moderately difficult, with seven of those participants maintaining that WLM was unquestionably difficult. Further, almost all participants in this study cited as a primary reason that they found WLM to be difficult the constant mental, emotional, and behavioral effort (discussed above) that they had to expend to maintain their weight loss. Nor did the effort that participants expended on WLM lessen appreciably over time. While most participants noted that accumulating successful

experience with WLM helped make at least certain aspects of WLM somewhat less difficult, participants' overall perceived level of difficulty of WLM did not appear to relate to the length of time for which they had maintained their weight loss, with participants who had maintained their weight loss for over 10 years still finding WLM to be quite difficult.

Some of the other reasons that participants in this study cited that WLM was difficult have been found in previous research as well. For example, participants in this study noted that the impact their current lifestyles had on their WLM or the impact that their WLM had on their lifestyles made WLM more difficult, as did a desire to be “normal” or feeling different from those around them due to their WLM efforts. Similar features have been found in previous research, such as the “challenges of emotional and social eating” discussed by Green et al. (2009), and the stigmatization and disregard of society for obese people and their struggles found by Bidgood and Buckroyd (2005).

### **Implications for Clinical Social Work Practice and Potential Directions for Future Research**

Even though almost all the participants of the current study were engaging in the well-researched WLM-supporting behaviors discussed above and were obtaining consistent external professional support by attending WMP or other professional WLT groups or meeting with WMP professionals, as noted above, almost all the participants found WLM to be quite difficult and to remain difficult even after years of maintaining lower weights. This suggests that pieces of the WLM puzzle are remain missing or obscured.

The second goal of this study was to better understand the needs of individuals maintaining weight loss to help inform further study and development of psychological interventions for this population that are effective not only in assisting with successful weight

loss maintenance but also in reducing the perceived internal difficulty of maintaining weight loss. To that end, what follows are suggestions derived from the findings of the present study and the previous research literature on weight loss and WLM of ways to inform clinical social work practice with individuals attempting to maintain significant weight loss as well as potential future areas of research.

**Implications for the clinical social work profession.** One of the most interesting findings of this study, mentioned briefly above, was that the vast majority of participants specifically cited that their WMP group leader, who is, incidentally, a psychologist by training, was their most important external source of mental and emotional support. As discussed more fully in Chapter Four, these participants reported particular qualities of the WMP group leader that they found most helpful, including that the leader was supportive, encouraging, empathetic, and non-judgmental; that he recognized and reinforced participants' successes; that he addressed the emotional and psychological aspects of WLM in groups and one-on-one; and that he "practiced what he preached" by keeping detailed food and exercise records for the entirety of the several decades he has been working at WMP. Several participants noted that, despite not struggling with weight issues himself, the group leader seemed truly to understand what the participants were going through in their WLM journeys in a way that these participants' social sources of support – friends, family members, and romantic partners – did not.

Given the importance of ongoing support in WLM discussed above and in Chapter Two, the lesson for the clinical social work profession seems clear: psychotherapists working with WLM clients should become better educated about the difficulty of WLM and the struggles associated therewith so that they can provide the supportive, non-judgmental, and truly understanding environment described by the participants of this study in addition to the

traditional CBT-based weight management treatments currently available (see Anderson, Conley, et al., 2007; Anderson, Grant, et al., 2007; Byrne et al., 2004; Byrne et al., 2003; Foster et al., 1996; Green et al., 2009; HMS, 2008; Mooney et al., 1992). Further supporting the importance of psychotherapy and psychotherapist education around issues of weight, two participants specifically discussed that psychotherapy outside of WMP regarding their weight issues was an integral part of their WLM process. These participants mentioned the importance of finding out what their triggers were around eating as well as looking at the underlying psychological reasons for their struggles with their weight.

In addition, current research on the biological, genetic, and neurochemical processes involved in certain individuals' struggles with food, a sampling of which is discussed in Chapter Two, is demonstrating that issues of controlling eating and weight have a lot in common with, and may soon be classified as, addiction (see Bulik et al., 2003; Farooqi & O'Rahilly, 2005; Jaffe, 2010; Johnson & Kenny, 2010; Martinez-Hernandez et al., 2007). While current social work curricula tend to include myriad courses on chemical and process addiction, few include courses specifically addressing eating issues other than courses on "eating disorders," which usually primarily address anorexia nervosa and bulimia. Indeed, Smith College School for Social Work's (SSW) own curriculum for the 2011 summer term includes two courses on theory and practice with addicted clients and one course on substance abuse policy and services but does not include any courses addressing eating issues (Smith College School for Social Work [SSW], 2011). Such a course would likely be welcomed by SSW students, who have already demonstrated the need for support around weight issues by establishing a student organization called "Size Matters," which is a "size-positive, fat acceptance and health-at-every size group addressing matters of size oppression on campus and in the community" (SSW, 2010). A further

area of exploration for schools educating clinical social workers would thus be the possibility of creating courses to introduce social work students to a wider variety of issues around eating, including the most current understanding of eating as an addiction.

Finally, in addition to micro-level clinical practice, the social work profession also emphasizes macro-level advocacy and social justice as part of its mission. Indeed, the National Association of Social Workers (NASW) states in its bylaws that one of the purposes of the NASW is “to further the broad objective of improving conditions of life in our democratic society through utilization of the professional knowledge and skills of social work and to expand through research the knowledge necessary to define and attain these goals” (National Association of Social Workers, 2010, p. 2). As has been demonstrated above and in Chapter Four, WLM and weight issues have emotional and psychological components that cause them to fall under the rubric of “mental health,” however defined. Therefore, it may be argued that the social work profession has a responsibility to help educate the public about the difficulty of weight loss and WLM and to work to reduce the stigma of overweight and obesity, as the profession would do with other mental health issues. Indeed, half of the participants in the present study indicated that one of the reasons that WLM was difficult for them was because their efforts in trying to maintain their weight loss made them feel different or abnormal. Several participants also cited the difficulty of having to adopt and explain their new WLM-related behaviors in a culture that is often indifferent or even hostile to their efforts. In addition, many participants found partners, family, or friends to be unsupportive, in part from a lack of understanding about the weight-loss maintainer’s experience with WLM. Previous qualitative research has also suggested that individuals struggling with weight and WLM have felt stigmatized, disregarded, misunderstood,

and even immoral (Bidgood & Buckroyd, 2005; Mycroft, 2008; Wysoker, 2002), which is echoed by the mission statement of Size Matters, discussed immediately above.

**Directions for further research.** One of the more interesting findings of this study, discussed in Chapter Four, was that the two participants who found that maintaining their weight loss had gotten easier over time and who were also consistently maintaining weights below their final diet weights spoke about their WLM journeys differently than most of the other participants. Both of these participants, as noted above, cited the points in their WLM journeys at which they stopped allowing their weight to yo-yo and became stricter and more consistent in their WLM efforts, and it was at these points that these participants felt that WLM became easier for them. Most noteworthy was the language with which these participants talked about WLM, using phrases such as not “playing around” or “fooling around” with, and “locking into” or “getting a handle on,” their WLM; discussing how things “clicked in together,” how they had “gotten awakened,” or how they felt they had “stepped beyond” some barrier in their WLM; and repeating concepts such as “commitment,” “surrender,” or “giving in to the inevitable.” This suggests that these two participants had reached a level of acceptance around WLM that other participants had not yet realized which made their WLM both less difficult and more successful.

In contrast, as discussed in Chapter Four, many of the other participants, even those who had been maintaining significant weight loss for over 10 years, discussed struggling with yo-yoing weight and noted times in which they either consciously or without noticing had stopped practicing many of the WLM-related behaviors, which, participants reported, inevitably led to weight regain. These participants used phrases when discussing their WLM such as, “I’m excused,” “I don’t wanna,” “I just rebelled,” or “I can’t deal with it.” This would suggest that there were times in these participants’ WLM journeys in which the immense mental, emotional,

and behavioral efforts, discussed above and in Chapter Four, simply overwhelmed these participants. Indeed, as discussed further in Chapter Two, previous research (Phelan et al., 2009; Phelan et al., 2008) has noted this phenomenon as well, discussing it through the lens of self-regulatory theory and coming to basically the same conclusion that an individual's limited resources to focus on and control any one thing, in this instance WLM, at times simply become overwhelmed by other demands on that individual's resources. Thus, one of the key questions to be addressed by further research becomes: How does an individual engaged in WLM move from a place of struggling with WLM, in which that individual is expending intense mental, emotional, and behavioral energy on WLM and thus that individual's psychological resources are in danger of becoming overwhelmed, to a place of acceptance around WLM, in which that individual can continue successfully to maintain his or her weight while at the same time attaining some respite from the energy expenditure previously required for successful WLM?

A model that may be potentially useful in such future research may be adapted from the stages of change model applied to weight and WLM by the 2009 research of Zijlstra et al., which categorized individuals struggling with WLM after bariatric surgery as moving both forward and backward through some of the following six stages – pre-contemplation, contemplation, preparation, action, maintenance, and termination. Though the present study casts doubt on the existence of a sixth, “termination,” stage of change in which weight-loss maintainers experience “successful enduring weight loss” (Zijlstra et al., 2009, p. 111), the researchers' basic model may be a useful tool with which to frame further research into the characteristics, shifts in attitude, or life experiences which made possible the acceptance around WLM noted by two participants of this study. Indeed, perhaps a more appropriate sixth stage of change would be an “acceptance”

stage characterized by consistent awareness and commitment to prevent relapse but a marked reduction in the perceived level of effort required to do so.

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**Appendix A**  
**Recruitment Flyer**  
(see next page)

Have something to say  
about your experience maintaining  
weight loss?

Want to help others in their  
efforts to maintain weight loss?

**Participate in my study!**

I am documenting the experiences of individuals currently maintaining significant weight loss. I am conducting 60-minute face-to-face or telephone interviews asking open-ended questions about your psychological experiences of maintaining weight loss. If you think you might want to participate in my study, please contact me at:

**Jennifer Simon**

**xxx-xxx-xxxx**

**xxxxxxxxx@xxxxx.com**

I am conducting this study in connection with my master's thesis in social work at Smith College School for Social Work.

## **Appendix B**

### **Informed Consent**

Dear Potential Participant,

My name is Jennifer Simon, and I am a candidate for the Master of Social Work degree at Smith College School for Social Work. I am conducting a study to describe the psychological experiences of individuals who are maintaining significant weight loss. Data collected in this study will be used in contribution to my master's thesis and may be used in future publications and presentations.

I am interested in documenting and describing the psychological experiences of individuals who are maintaining significant weight loss. You are being asked to participate in this study if you are at least 18 years of age, you are currently maintaining a 10% weight loss, you have maintained this weight loss for at least one year, and your Body Mass Index prior to your weight loss was at least 30.0. As a participant you will be asked to take part in a face-to-face or telephone interview. Questions will be open-ended and will focus on your experience of maintaining your weight loss. The interview will take approximately 60 minutes. Interviews will be audio recorded with your consent. Each recording will be transcribed by me or by a transcriber who will be required to sign a confidentiality agreement.

You will receive no financial benefit for your participation in this study. However, you may benefit from knowing that you have contributed to identifying and understanding the counseling and support needs of individuals maintaining significant weight loss. It is my hope that this study will help develop psychological interventions effective in assisting with successful weight loss maintenance and in reducing the difficulty of maintaining weight loss. You may also benefit from being able to tell your story and having your perspective heard. The potential risk of participating in this study is the possibility that you might feel strong or uncomfortable emotions while talking about your experiences. In case you feel the need for additional support after participating in this study, you will be given a list of mental health resources in your area.

Your confidentiality will be protected by storing all physical data (including notes, tapes, and transcripts) in a locked file and by password protecting all electronic data, each for a minimum of three years. Should I need any data beyond this three-year period, they will continue to be securely kept and will be destroyed when no longer needed. I will use a code to protect your identity, and your name will never be recorded anywhere in the data collection or documentation materials. Therefore, your name will never be associated with the information you provide in the interview. No person besides me, my research advisor, and any transcriber I may employ will have access to the data; however, I will only provide the data to my research advisor and my transcriber after removing all identifying information. The data will be used in

the preparation of my master's thesis and may be used in other educational activities, publications, and presentations by me and by The Weight Management Program of San Francisco, Inc. The data will be presented as a whole, and, if brief illustrative quotes or vignettes are used, they will be carefully disguised.

Your participation in this study is completely voluntary. The Weight Management Program of San Francisco, Inc. will not know whether you participate in this study or not. You are free to refuse to answer specific questions and to withdraw from the study at any time. If you decide to withdraw, all data describing you and all materials relating to you will be immediately destroyed. In the event that you do decide to withdraw from the study, please contact me no later than April 2011.

Should you have any concerns about your rights or about any aspect of this study, please contact me at (xxx) xxx-xxxx or xxxxxxxx@xxxxx.com or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

**YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.**

Printed Name of Participant: \_\_\_\_\_

Signature of Participant: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Researcher: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS.  
THANK YOU AGAIN FOR YOUR PARTICIPATION.**

## **Appendix C**

### **WMP Staff Study Introduction**

One of our maintenance group members, Jennifer Simon, who attends our Monday evening Restart Group, is currently working towards her Master of Social Work degree at Smith College School for Social Work. She is conducting a research study to describe the psychological experiences of individuals who are maintaining significant weight loss. Data collected in her study will be used in contribution to her master's thesis and may possibly be used in future publications and presentations.

Jennifer is interested in documenting and describing the perceptions, thought processes, and emotional experiences of formerly obese individuals who are currently maintaining significant weight loss. She is looking for participants: (a) who are over 18 years of age, (b) who are currently maintaining a weight loss of at least 10% of their pre-weight loss body weight, (c) have maintained this weight loss for at least one year, and (d) whose Body Mass Index prior to their weight loss was 30.0 or higher. Each participant in her study will be asked to take part in one hour-long, individual, face-to-face or telephone interview with Jennifer. Questions will be open-ended and will focus on your perceptions, thoughts, emotions, and self-concept (both positive and negative) during the time you have been maintaining your weight loss.

The Weight Management Program has agreed to allow Jennifer to recruit participants for her study from our maintenance groups. Your participation is in no way required by The Weight Management Program and is not a condition of your participation in your maintenance group. Should you be interested in participating in Jennifer's study, she has left copies of her Informed Consent form with us that describe the study in further detail and explain how to contact her.

## **Appendix D**

### **Interview Guide**

1. Do you perceive maintaining your weight loss to be easy or difficult? What is easy / difficult about it?
2. Can you describe your day-to-day experiences regarding the mental and emotional time and energy you devote to maintaining your weight loss?
  - a. How does this mental and emotional time and energy influence your actual weight-loss maintenance-related behaviors, such as your eating, your exercise, etc.?
  - b. When or in what situations do you tend to think about your weight or maintaining your weight loss?
3. Do your weight and your maintenance of your weight loss play a role in your identity or how you think of yourself? If so, how?
4. How do you define “success” with regard to your weight and the maintenance of your weight loss?
  - a. Has your idea of what “success” is changed over time? If so, how?
5. Have there been times during which you perceived you were unsuccessful in maintaining your weight loss?
  - a. How did this experience make you feel?
  - b. What thoughts did you have during these times?
  - c. How did this experience or these experiences relate to how you thought about yourself or your identity?
6. What do you consider to be mentally or emotionally supportive or helpful for you in successful weight loss maintenance?
  - a. What do you consider to be mentally or emotionally unsupportive or unhelpful for you in successful weight loss maintenance?

7. Is there anything you would like to add or think it is important that I know about these topics?

**Appendix E**

**WMP Approval Letter**

**THE WEIGHT MANAGEMENT PROGRAM**  
of San Francisco, Inc, A Medical Clinic  
1 Daniel Burnham Ct. Suite 370-C  
San Francisco, CA 94109

**MEDICAL DIRECTOR**  
Joan Saxton, M.D.

TEL (415) 771-1821  
FAX (415) 771-3528

September 28, 2010

Smith College School for Social Work  
Lilly Hall  
Northampton, MA 01063

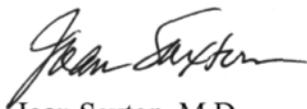
**RE: Jennifer Simon's Research Project with Smith College School for Social Work**

To Whom It May Concern:

The Weight Management Program of San Francisco, Inc. gives permission for Jennifer Simon to locate her research in this agency. We request that Smith College School for Social Work's (SSW) Human Subject Review (HSR) Committee perform a review of the research proposed by Jennifer Simon.

The Weight Management Program of San Francisco, Inc. will abide by the standards related to the protection of all participants in the research approved by SSW HSR Committee.

Sincerely,



Joan Saxton, M.D.  
Medical Director

## Appendix F

### HSR Approval Letter



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Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7950  
F (413) 585-7994

November 16, 2010

Jennifer Simon

Dear Jennifer,

Your revisions have been reviewed and they are fine. Your flier was a knockout! We are happy to give final approval to your project.

*Please note the following requirements:*

**Consent Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your recruitment and with your study.

Sincerely,

A handwritten signature in black ink that reads 'Ann Hartman' followed by a flourish.

Ann Hartman, D.S.W.  
Chair, Human Subjects Review Committee

CC: Kate Didden, Research Advisor



	Identity related to other issues	<p>Feels good if thin, bad if fat Identity very rigidly ruled by weight</p> <p>Losing weight will fix problems Struggle with the identity of single person Neither thin nor fat, just a person</p>
Definition of Success	Why success is important	<p>Looks / image / how clothes fit Physical comfort Control Other people's opinions Health issues Number on the scale Doesn't define success, just does WLM behaviors Still weighs much less than before diet Addressing any gain right away Physical abilities Commitment to goal</p>
	Behaviors defining success	<p>Behaviors relating to exercise Behaviors related to weight monitoring Behaviors related to food</p>
	How definition of success has changed	<p>No change Commitment level increased Still yoyo-ing a lot Aware of signals of losing control Change in what's important Think definition will change in the future Reduction of fear and anxiety about regaining Automation of behaviors Complacency around maintaining Acceptance of change in way of life</p>
Times When Unsuccessful	When unsuccessful	<p>Early on in maintenance Midway into maintenance Now or recently</p>
	Behaviors when unsuccessful	<p>Sought professional help Recorded calories from food and exercise Figured out why eating more and deal with root cause</p>
	How being unsuccessful felt	<p>Helpless / discouraged / hopeless / out of control Fearful / worried / alarmed Not giving up / fortified / determined Being more aware and conscious of weight Motivating Being fat carries negative connotations</p>

		<ul style="list-style-type: none"> <li>Externalizing responsibility</li> <li>Frustrated / angry</li> <li>Ignoring / not worrying about</li> <li>Feel like a bad person</li> <li>Beating self up / getting down on self</li> <li>Physically bad / poor health</li> <li>Resentful of the struggle</li> </ul>
Support	Internally supportive features	<ul style="list-style-type: none"> <li>Focus or concentration on goal</li> <li>Feeling of control</li> <li>Feeling successful / capable of success</li> <li>Guilt as motivator</li> <li>Not caring too much</li> <li>Acceptance</li> <li>Value comes internally</li> <li>Exercise to clear mind / de-stress</li> <li>Feeling better physically or about self</li> <li>Teaching others / being a role model</li> <li>Assertiveness around WLM needs</li> <li>The work is worth it</li> <li>Figure out why eating too much</li> <li>Learn about weight loss / maintenance</li> <li>Allow self to accept support</li> <li>Not beating self up when gain weight</li> </ul>
	Externally supportive features	<ul style="list-style-type: none"> <li>WMP group / group leader</li> <li>Reinforcement / support / understanding</li> <li>Behavioral strategies, tips, and tricks</li> <li>Other groups / people / friends</li> <li>Accountability to WMP</li> <li>Partner / family</li> <li>Therapy / therapist</li> <li>Control over environment / supportive environment</li> <li>Obligations / promises to others</li> </ul>
	Internally unsupportive features	<ul style="list-style-type: none"> <li>Food addiction</li> <li>Self-soothing with food</li> <li>Self-sabotage</li> <li>Food as a reward</li> <li>Guilt regarding how WLM affects others</li> <li>Focus on others, not on self</li> <li>Negative mindset</li> <li>Mental picture of self as one way / hard to notice weight gain</li> </ul>
	Externally unsupportive features	<ul style="list-style-type: none"> <li>Unsupportive partner</li> <li>Unsupportive environment</li> <li>Negative life change</li> <li>WMP group</li> </ul>

Drinking alcohol  
Saboteurs (unsupportive friends / family)  
Being held up as a role model

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