PROFESSIONAL DOCTORATES

Women's experience of obesity : an interpretative phenomenological analysis

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University of Wales, Bangor

Women's Experience of Obesity:
An Interpretative Phenomenological Analysis

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Literature Review

Research Paper

Women's experience of obesity: an interpretative phenomenological analysis

Abstract

Although obesity is known to pose significant health risks, the prevalence has recently increased rapidly, with almost one fifth of women obese in 1996. Although research suggests that most people understand the behaviour changes necessary for weight control, few people appear to be engaging in the required behaviour to improve their health. With reference to the literature this thesis considered how an understanding of psychological factors can contribute to understanding and treating the condition. The research was found to be at a relatively early stage in terms of understanding the experience of obesity. In such situations qualitative research methods can explore experience in detail, providing information about phenomena such as thought processes and emotions, and may be of heuristic value. To address these issues a community sample of obese women (n=7) were interviewed about their weight and related issues. Participants' accounts were subjected to an Interpretative Phenomenological Analysis to elucidate their views of their situation through an interpretative process. They presented their understanding of how they had come to be and remain in their situation (a collection of themes entitled 'Explanatory Models'). Although participants expressed the view that weight is under individuals' control, they indicated that weight-control was not currently possible or desirable for themselves ('Beliefs about the Controllability of Weight'). Being big had negative personal meanings and was associated with

emotional distress ('Personal Meaning of Being Big'). Interestingly participants described processes that appeared to mediate between being big and the personal impact of this, including not thinking of themselves as big, viewing size as unimportant in their lives, and making favourable comparisons between themselves and others or previous selves ('Mediating Processes'). These findings were discussed with reference to the literature and their implications for future clinical and research approaches. Issues related to the research process were also discussed.

Ethics Proposal

University of Wales, Bangor, School of Psychology

Application for Ethical Approval

1. Title of project

Investigation of the experiences of people with obesity.

Summary of proposal

This document outlines a proposal for a study of the experiences of people with obesity. It aims to gain insight into the condition of obesity through trying to understand the participant's accounts of the condition. It is proposed that a small sample of women with obesity be recruited from the Community Participant Panel held by the School of Psychology. Those invited to participate will deem themselves to be in average or good health and state that they have not been currently or recently receiving treatment for a major health problem, eating disorder or mental health problem. The women will be interviewed using a flexible semi-structured interview approach about their beliefs about weight control and their personal and social experiences related to their size. The data from the interviews will be transcribed and subjected to qualitative analysis, predominantly adopting an Interpretative Phenomenological Analysis (I.P.A.) approach. The approach is phenomenological in that it attempts to understand the world from the participant's viewpoint but recognises that this information is only available through the interpretative work of the analyst. The data will be reported in the form of the themes that emerge through the analytic procedure. In addition to this qualitative aspect of the study participants will be asked to complete questionnaires about their self-esteem and a self-report screening instrument designed to provide a profile of current

psychopathology. There will be insufficient data to use in a quantitative fashion but it is anticipated that information from the questionnaires will be useful for triangulation purposes.

2. Name of investigator(s):

Dr. Helen Delargy, Trainee Clinical Psychologist, N.W.C.P.C., School of Psychology, 43 College Road, University of Wales, Bangor.

Academic supervisor: Dr. Isabel Hargreaves, Clinical Director, N.W.C.P.C., School of Psychology, 43 College Road, University of Wales, Bangor.

3. Potential value of addressing the issue:

To gain insight into the views of people with obesity about obesity, effects of obesity on themselves and about any barriers to weight change. This may contribute to the overall understanding of the condition and may provide insight for clinicians into possible psychological interventions.

4. Brief background to study

The prevalence of obesity has increased at an alarming rate over the past twenty years and it is now recognised as a major health risk factor. Obesity may have considerable consequences for the individual's well-being. At the practical level there may be difficulty with mobility, buying clothes, day-to-day health etc. Furthermore, obesity is a highly stigmatised condition in western culture and may impact on the individual psychologically, in terms of their self-esteem and mental health. Lifestyle factors are strongly implicated in the development and maintenance of obesity, and in recent years

there has been increased public awareness of what constitutes a healthy lifestyle. However, levels of obesity have continued to rise and treatments are largely ineffective.

Although it is often acknowledged that psychological factors are likely to play a role in the treatment of obesity, there has been relatively little research directed toward psychological aspects of obesity. In particular, there is a dearth of research aimed at investigating the experience of obese people themselves (in relation to their weight), their views about obesity, its causes, and barriers to weight change. Insight into the views, thoughts and feelings of people with obesity themselves may add to the understanding of the condition and its treatment. In addition, many of the studies that have been carried out into psychological aspects of obesity have used clinical samples, that is, people who require some form of treatment for their weight-related problems. This is likely to produce a skewed view of obesity, since it selects people who have a physical or mental health problem of sufficient gravity to require treatment in addition to obesity.

5. The hypotheses

Since little is known about the views of people with obesity, it seems most appropriate to use an open-ended approach to investigate the issues of interest. A qualitative approach has therefore been selected as the main method of investigation in this study. No specific hypotheses have therefore been made.

6. Recruitment of participants

Approximately eight participants will be required. They will be recruited from the community Participant Panel run by the School of Psychology, University of Wales, Bangor. There are currently 266 adult females registered on the Community Participant Panel. Data about the height and weight of the people listed on the panel is not kept. However, assuming that the people registered on the panel are representative of the general population in terms of their body size, it would be predicted that around 20% would fall into the obese category (i.e. that there will be approximately 50 women with obesity registered on the panel).

Women registered on the Participant Panel will be contacted by telephone, email or letter (depending on their contact information available). Appendix A gives an outline of the explanation that will be given either by telephone, email or letter. This specifies that the study is looking for people who are overweight to take part. Those who are interested in taking part will be sent the following information by post: a Covering Letter, Information Sheet, Consent Form and Screening Questionnaire (see Appendices B, C, D & E). They will be asked to return the Consent Form and Screening Questionnaire by post (in a prepaid envelope addressed to the investigator at N.W.C.P.C.). They will then be contacted by the researcher and informed as to whether or not they will be invited to participate in the study. If they are suitable for inclusion in the study they will be invited to an interview and arrangements will be made for this. If they are not suitable they will be debriefed and given the opportunity to ask questions related to the study.

Criteria for inclusion in the study

In order to increase the homogeneity of the sample only adult women (aged between 18 and 65 years) will be included in the study. Women will be included in the study provided that the are obese according to the UK definition i.e. they have a Body Mass Index (B.M.I.) of greater than 30kg/m^2. This will at this stage be calculated from the person's self-reported height and weight requested on the screening questionnaire. It is the intention of this study to investigate the views of people who are not currently undergoing treatment for major health problems related to their weight or mental health problems. Hence only those who report on Item 1 of the Screening Questionnaire that their health is average or good will be suitable for inclusion. Similarly only respondents who answer 'no' to Items 2, 3, and 4 will be deemed suitable for inclusion in the study. Those participants who are judged to be suitable for invitation to take part in the study according to the above criteria, and who decide to take part, will be weighed and measured by the researcher when they attend for the study. Bathroom scales will be used for weighing and a height rule will be used for measuring. This will ensure that their B.M.I. falls above the UK threshold for classification as obese.

7. Study design

The study will investigate the experiences of a non-clinical population of women with obesity using qualitative and quantitative methods.

8. Procedures employed

Participants will be interviewed according to a semi-structured interview schedule. This interview will be audio tape-recorded. Participants will then be asked to complete a number of questionnaires in the presence of the researcher.

9. Measures employed

Semi-structured interview

The semi-structured interview schedule (shown in Appendix F) will be used as a basis for the interviews. This schedule was drawn up according to the guidelines described by Smith, 1995. The interviewer will attempt to facilitate and guide the participant in the discussion rather than dictate exactly what will happen. Initially very-open ended questions will be asked and these will ideally be sufficient to enable the respondent to talk about the subject. It is anticipated that many of the topics of interest will be covered in this way. However, if a participant has difficulties with a topic of interest or does not mention aspects of the topics thought by the researcher to be important, the researcher will prompt them with a more specific question. Additional non-directive prompts will also be used to encourage the participant to expand on a topic. e.g. 'Can you tell me more about that?'. More specific probes may also be used to investigate an issue more fully, such as 'What do you think about that?' or 'How did that make you feel?' It is not necessary that the schedule be followed exactly, and, if the participant directs the conversation in a novel route which is related to the topic in question, there will be the flexibility to allow this to happen to some extent. Participants will not be pushed into talking about issues with which they are not comfortable. If a participant appears uncomfortable with a particular line of questioning this will be discontinued.

It is anticipated that this interview will last for approximately one hour, although this will vary according to the participant, and may be shorter or longer than an hour.

Shape- and Weight-Based Self-Esteem Inventory (S.A.W.B.S., Geller, Johnston & Madsen, 1997; Appendix G)

Shape- and weight-based self-esteem has been identified as a "central cognitive substrate" of the eating disorders (Cooper & Fairburn, 1993). The S.A.W.B.S. is a relatively new tool designed to assess the contribution of shape and weight attributes to a person's overall self-esteem. The psychometric properties of this questionnaire have been established in non-clinical and clinical (eating disordered and psychiatric) adult populations (Geller, Johnson & Madsen, 1997; Geller et al., 1998). The S.A.W.B.S. scores were found to be stable over time, correlate strongly with measures of body dissatisfaction and eating disorder symptomatology, and to discriminate individuals with eating disorder from psychiatric and non-psychiatric controls.

Although the development of the S.A.W.B.S. has been based within the eating disorder literature, the concept of the relative contribution of shape- and weight-based self-esteem is relevant to people with obesity. Within the eating disorder literature, the higher the portion of self-esteem assigned to shape and weight, the higher the eating disorder symptomatology and psychological distress. It could be hypothesised that women with obesity who derive a low proportion of their self-esteem from their body shape and weight would show lower levels of psychological distress and higher global self-esteem than those who derive a high proportion of their self-esteem from their body shape and weight. Alternatively, ranking one's body shape and weight as relatively

unimportant in one's self-esteem may be seen as a coping strategy for people with obesity. Hence, the relative proportions of self-esteem apportioned to body shape and weight by the participants will be of interest in themselves. Norms for the S.A.W.B.S. have not yet been established for people with obesity. Due to this, and the fact that this study will look at low numbers of individuals, the S.A.W.B.S. scores for each individual will be viewed in conjunction with the qualitative data obtained. For example, in the semi-structured interview a participant may make statements about their view of themselves and these statements can be compared with their S.A.W.B.S. score. It may also be appropriate to consider the S.A.W.B.S. scores of the whole group in relation to established norms for clinical and non-clinical groups of women.

The S.A.W.B.S. inventory requires individuals to select from a number of personal attributes those that are important to how they have felt about themselves in the past 4 weeks. The list of personal attributes was generated from previous measures that have identified specific dimensions of self-esteem and comprises: intimate and romantic relationships, body shape and weight, competence at school/work, personality, friendships, face, personal development, competence at activities other than school/work and other (individuals are asked to list an attribute if it is not covered in the preceding list). After selecting the personal attributes that are important to how they feel about themselves, individuals rank order the attributes in terms of how much their opinion of themselves is based on each. They are then required to divide a circle into pieces such that the size of each piece reflects the extent to which their self-opinion is based on each of the ranked attributes. The S.A.W.B.S. score is calculated by measuring the angle of the shape and weight piece of the circle. It gives an indication

of the relative contribution of shape and weight to overall self-esteem: the higher the S.A.W.B.S. score, the greater the importance attached to body shape and weight by the individual.

Modification of administration of S.A.W.B.S. (Appendix H)

However, it was felt that it would be difficult for participants to use a circle to assign portions to each attribute, as it necessitates having a mental picture of how much of the circle should be left for all the attributes. In other words, it would be difficult to assign a portion of the circle to each attribute and leave the correct amount of space for the last attributes. Therefore the practical procedure for using this measure has been altered to make it easier for the participant to use. As with the S.A.W.B.S., the participant selects from the list of personal attributes and assigns them a rank order. Then, rather than dividing up a circle on a piece of paper, the participant uses an instrument designed to allow them to portion up the circle. Different coloured card represents each attribute and the participant is able to alter the size of all the angles easily until they are satisfied that each one is correct. The angles assigned to the personal attributes can then be used in the same way as with the S.A.W.B.S. It is anticipated that it will take up to fifteen minutes to complete this measure.

Rosenberg Self-Esteem Scale (RSES, Rosenberg, 1979; Appendix I)

This is a widely used, standardised self-report questionnaire comprising of 10 items to assess attitudes of general self-worth and self-esteem. Respondents are required to rate the extent to which the statements are descriptive of them on 5-point Likert scales ranging from "not at all descriptive of me" to "very descriptive of me". The RSES has

been shown to have strong construct, convergent and discriminant validity (Rosenberg, 1979) and correlates with other measures of self-esteem and peer ratings (Demo, 1985). Scores on the RSES range from 10-50. It is anticipated that it will take up to five minutes to complete this measure.

Symptom Checklist-90 (SCL-90-R, Derogatis, 1977; Appendix J)

The SCL-90-R is a widely used, self-report screening instrument designed to provide a profile of current psychopathology. It consists of ninety questions designed to measure nine dimensions of psychopathology as determined by factor analysis: somatization (such as "trouble in getting your breath"), obsessive compulsive difficulties, interpersonal sensitivity (such as "feeling inferior to others"), depression, anxiety, anger-hostility, phobic anxiety, paranoid ideation, and psychoticism (such as "having thoughts that are not your own". There are also several questions about miscellaneous problems such as "trouble in falling asleep". For each question the respondent responds by selecting one of five alternatives from "not at all" to "extremely" in answer to the question "How much are you bothered by…". It is anticipated that it will take up to ten minutes to complete this measure.

10. Qualifications of the investigators to use the measures

Trainee Clinical Psychologist

11. Venue for investigation

The study will be carried out in the Seminar Room of the N.W.C.P.C., University of Wales, Bangor. In some cases it may not be possible for the participant to travel to the University. In such cases the study will be carried out at a health centre or clinic which

is convenient for the participant. Consent from the health centre or clinic to use their premises will be sought as necessary.

12. The duration of the study

It is anticipated that it will take up to an hour and a half to complete the study. Participants will be offered the opportunity to take a break after the interview, before commencing completing the questionnaires. The study will be carried out from Summer 2000 to Spring 2001.

13. Data analysis

Interview data

The data from the interviews will be transcribed and analysed using qualitative techniques, predominantly Interpretative Phenomenological Analysis (I.P.A.). I.P.A. is thought to be the most appropriate type of analysis for this study as it aims to explore the participant's view of the topic under investigation. Thus, the approach is phenomenological in that it is concerned with the individual's personal perception or account of the topic rather than attempting to produce objective statements about the topic. However, I.P.A. also recognises the dynamic nature of the research process. Whilst one is attempting to get a view into the world of the participant, access depends on, and is complicated by, the researcher's own conceptions; indeed these are required in order to make sense of the participant's personal world through a process of interpretative activity (Smith, Jarman & Osborn, 1999). I.P.A. involves careful examination of the transcript and extraction of the main themes brought up by the

participant. The list of themes is then further scrutinised to identify connections and possible superordinate concepts in the participants' account.

It may also be appropriate to consider the causal statements made by the participants about weight. The Leeds Attributional Coding System (Stratton, 1997) provides a framework by which to do this. Initially statements about causality are extracted from the text. These are then coded according to whether they are stable/unstable (i.e. the cause will apply in the future), global/specific (the cause has a significant range of consequences), internal/external; (did the cause originate in the person or due to external circumstances), personal/universal (i.e. would the event have happened to anyone or just to that person?), and controllable/uncontrollable (i.e. could the individual have exerted a significant amount of control over the outcome). For example, the statement 'I think the main reason I am fat is because being fat runs in my family genes' might be rated as stable (their genes will not change in the future), specific (it only effects their degree of fatness), external (it is the family genes that are responsible), universal (anybody with their genes would be fat), uncontrollable (there's not a lot the individual can do about their genes). In this way it will be possible to look systematically at the way the participants think about body weight. This may shed light on possible psychological barriers to weight loss. For example, a person showing the attributional style in the above example may believe that attempts to lose weight are futile.

Data from the interviews will be transcribed within two weeks of the interview. During that period appropriate care will be taken of the tapes and following transcription the

recordings will be destroyed. The transcripts will be free from all identifying features and will be coded according to a pseudonym so that only the interviewer will be able to identify the participants.

Questionnaire data

Due to the low numbers of participants in this study the data obtained will be viewed together with the qualitative data. It may be appropriate to compare the self-esteem and SCL-90-R scores of the participants with existing norms.

As with the tape transcripts questionnaires will be coded with a pseudonym so that it will not be possible to identify the participants who completed the questionnaires.

14. Potential hazards to participants / investigators

It is possible that participating in the study may increase the participants' level of attention to their body weight. It may increase the participants' attention to negative aspects of their weight that they had not previously considered. In an attempt to assess this, participants will be debriefed about any effects that participating in the study may have had on them. They will be given a list of organisations that they can contact if they have any concerns about issues raised during the study (see Appendix K).

No potential hazards to the investigator are anticipated.

15. Potential offence / distress to participants

As already mentioned obesity is a stigmatised condition in western culture. Because this study is focussing on obesity and is of a personal nature some people may find it offensive or distressing. However, every effort will be made to avoid causing offence or distress during the selection and participation procedures of the study in the following ways:

Selection procedures:

- Initially it will be made clear to people contacted on the Participant Panel that they are being approached to participate in the study because they have registered themselves on the Participant Panel. It will be stressed that we have no information about their weight and height and therefore we are not approaching them because of their body weight. This will avoid any misunderstandings as to why they have been approached to participate in a study about overweight.
- The nature of the study will be made clear to the people contacted on the Participant Panel from the outset. It will also be made clear that participation is entirely voluntary. They will thus have the opportunity, knowing the nature of the study, to opt not to take part. It is anticipated that people who are likely to find the nature of the study offensive or distressing will not opt to take part.

During the study procedures:

- It will be made clear to participants that they may withdraw from the study at any point during data collection without having to give a reason or without any detrimental effect to themselves. Hence participants who feel uncomfortable with the nature of the study are free to withdraw.

- The term 'obesity' will not be used during the running of the study as it is felt that it is not an everyday term and has negative connotations. The term 'overweight' will be used instead.
- The interview component of the study has been designed to be as open-ended and value-free as possible, whilst covering the topics of interest. Every attempt will be made to allow the participant to talk about their own views rather than the researcher imposing her own views of the subject. In this way the interview should involve the participant exploring their existing views on the topics.
- During the interview if a participant appears to be uncomfortable with a particular line of conversation this will not be pursued.
- The questionnaires that have been chosen are published questionnaires and it is not anticipated that they will cause offence or distress.

16. How consent is to be obtained

Written consent will be obtained by the participants returning a Consent Form (see Appendix D) together with the Screening Questionnaires by post. These will be reviewed at the beginning of the interview with the participant and signed by the investigator.

17. Information for participants

Information about the study will be given to participants in the form of an Information Sheet (see Appendix C). In addition, participants will be given the opportunity to ask questions throughout the study process.

18. Approval of relevant professionals

Not Applicable. No other professionals will be involved in this study.

19. Payments

Participants' travel costs will be reimbursed at public transport rates. People registered on the Community Participant Panel are normally paid a small amount of money when they participate in a study. Those who complete this study will be paid in accordance with the guidelines for payments of participants of the School. There will be no payment to investigators, departments or institutions in relation to the study.

20. Equipment required and its availability

A boundary microphone and tape recorder will be required to record the interviews. A transcribing machine will be required to transcribe the interviews. This equipment is available and will be provided by the N.W.C.P.C.. A set of bathroom scales and a height rule are available for measuring participants' weight and height.

21. Feedback to participants

Participants will be asked at the end of their participation in the study whether they would like to receive feedback on the results of the study. Following completion of the analysis of the study a brief participant feedback sheet will be prepared. This will give a brief general summary of the findings of the study and their relevance to the understanding of overweight. This will be circulated to all participants who expressed a wish to see the study findings.

22. B.P.S. Guidelines on ethical standards in research

It is the author's understanding that this proposal conforms to B.P.S .Guidelines on Ethical Standards in Research.

References

Cooper Z. & Fairburn, C. (1993). Confusion over the core psychopathology of bulimia nervosa. *International Journal of Eating Disorders, 13*, 385-389.

Demo, D.H. (1985). The measurement of self-esteem: refining our methods. *Journal of Personality and Social Psychology, 48*, 1490-1502.

Derogatis, L.R. (1977). *SCL-R-90: Administration, scoring and procedure manual.* Baltimore: Clinical Psychometrics Research.

Geller, J., Johnston, C. & Madsen, K. (1997). A new measure of the role of shape and weight in self-concept: the shape and weight based self-esteem inventory. *Cognitive Therapy and Research, 21,* 5-24.

Geller, J., Johnston, C., Madsen, K., Goldner, E., Remick, R. & Laird Birmingham, C. (1998). Shape and weight based self-esteem and the eating disorders. *International Journal of Eating Disorders, 24,* 285-298.

Rosenberg, M. (1979). *Conceiving the self.* New York: Basic.

Smith, J.A. (1995). Semi-structured interviewing and qualitative analysis. In J.A. Smith, R. Harre, R. and L. Langenhove (Eds.) *Rethinking Methods in Psychology*, London: Sage, *99,* 9-26.

Smith, J.A., Jarman, M. & Osborn, M. (1999). Doing Interpretative Phenomenological Analysis. In: *Qualitative Health Psychology,* (pp219-240). Sage, London.

Stratton, P. (1997). Attributional coding of interview data: meeting the needs of long-haul passengers. In: N. Hayes (Ed.) *Doing Qualitative Analysis in Psychology.* Psychology Press, UK.

Appendix A

Participant Recruitment Explanation
(delivered by letter, email or telephone)

(N.W.C.P.C. headed notepaper)
North Wales Clinical Psychology Course
School of Psychology
43 College Road
University of Wales, Bangor
Tel: 01248 388365

Dear *(name)*

I am writing to/ringing you because we are currently recruiting women to take part in a research study. I obtained your name and address from the community participant panel run by the School of Psychology, University of Wales, Bangor. I understand that you have registered your interest in taking part in research *(check this is still the case)*.

We have no information about panellists' height or weight. The study that we are currently recruiting for is looking for overweight people to take part. As we have no information about your height and weight we have contacted you with no idea about your size at all.

The research aims to gather information about the views and feelings of overweight women about overweight in general, about being overweight themselves, and about how they feel about themselves. It would involve an interview and filling in some questionnaires.

If you think you would be classified as overweight and might like to take part…

- *(if contacted by letter)* ...please send off for further information about the research by returning the slip below in the prepaid envelope enclosed
- *(if contacted by phone)* ...I will send you further information about the research
- *(if contacted by email)* ...please state your interest in a reply to this email and I will send you further information about the research.

Thankyou.

Yours sincerely

Dr. Helen Delargy
Trainee Clinical Psychologist

Please send me further details about the study on what people who are overweight think and feel about being overweight.
Please print clearly below:
Name: _____
Address: _____
Telephone number: _____

Please detach and return to: Dr. Helen Delargy, N.W.C.P.C., School of Psychology, 43 College Road, University of Wales, Bangor.

Appendix B

Participant Covering Letter

(N.W.C.P.C. headed notepaper)
North Wales Clinical Psychology Course
School of Psychology
43 College Road
University of Wales, Bangor

Tel: 01248 388365
email: Helendelargy@Yahoo.com

Dear *(name)*

Thankyou for requesting further information about our study which is enclosed. If you decide that you would like to take part in the study please sign at the bottom of the Consent Form to consent to taking part. Please also complete the enclosed Questionnaire . Please return both the Consent Form and Questionnaire in the prepaid envelope enclosed but keep the Information Sheet for your information.

If you have any queries please do not hesitate to contact me. Thankyou.

Yours sincerely

Dr. Helen Delargy
Trainee Clinical Psychologist

Appendix C

Participant Information Sheet

Information sheet

Investigation of the experiences of women who are overweight

Title of research: Investigation of the views of women who are overweight

Investigators: Dr. Helen Delargy (Trainee Clinical Psychologist) and Dr. Isabel Hargreaves (Clinical Psychology Course Director)

You are being invited to take part in a research study. Before you decide to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Ask us if there is anything that is not clear or if you would like further information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?
The views of people who are overweight may give valuable insight into the condition and what it is like to be overweight. This research aims to gather information about the views and feelings of overweight women about overweight in general, about being overweight themselves and about how they feel about themselves.

Who has been invited to take part?
Women who were registered on the community participant panel of the School of Psychology, University of Wales, Bangor were contacted. As we had no information about panellists' height and weight, the women who were first contacted to take part were not selected according to their body weight or size. Those people who then expressed an interest in the study were sent an information pack and questionnaire. Participants will be selected from those people who fill in and return the questionnaire and whose answers fit the study criteria. Those people who fill in and return the questionnaire but do not fit the criteria for inclusion in the study will be debriefed about the study.

What does taking part involve?
Participation in the research will involve being interviewed and filling in three questionnaires. Initially you will be asked to take part in an interview with Dr. Helen Delargy about your views on overweight generally, about your own weight and how you feel about yourself. Following this you will be asked to fill in questionnaires about yourself, including questionnaires about the way you feel at the moment and how you feel about yourself generally. It is anticipated that the interview will last for up to an hour. It will take approximately half an hour to fill in the questionnaires. Therefore in total the study will take up to one-and-a-half hours with a break if you wish. The interviews will be conducted in English and the questionnaires will be in English.

What are the possible benefits and harms of taking part?
This research will provide the opportunity for women who are overweight to voice their views about overweight and to contribute to the understanding of being overweight. It is possible that taking part in the study will focus participants' thoughts on negative

aspects of their weight that they had not considered before. However, the interview will be open-ended and seeks to establish the participant's own point of view.

Where will the research take place?
The research will take place at the School of Psychology, University of Wales, Bangor or, if this is not convenient, at a health centre or clinic convenient for you. Travel costs will be reimbursed at public transport rate when you attend for the study. At the time of participation, the participants will be asked if they would like to know the findings of the research. Those participants who requested this information will be sent a summary of the research findings but will not be given feedback on their own results.

Will my taking part in this study by kept confidential
Yes, all information will be anonymous and confidential. The interview will be tape-recorded so that the researcher can transcribe (type out) the information that you give. Once the transcription is completed (within 2 weeks of the interview) the tape-recording will be destroyed. The transcription (stored on computer and printed out) will not have the participant's name or identifying details on it. The transcription will be coded with a number so that only Dr. Helen Delargy will be able to identify who was interviewed. Similarly, the questionnaires will not have any identifying information on them apart from a code number so that only Dr. Helen Delargy will be able to identify who filled them in. This information will be treated in the strictest confidence. Information from the content of the interview or questionnaires used in reporting and publishing the results of the research will be selected so that it does not allow the identification of the participant. However, if, during the study, you give me information that causes me concern about your welfare or the welfare of another person I will be obliged to contact you G.P.

Is participation voluntary?
Yes, participation in this study is entirely voluntary. You have the right to refuse to take part or withdraw from the study at any time without any penalty. Even if at first you choose to take part you can still withdraw from the study at any stage during data collection without having to give a reason.

If you have any concerns, questions or comments about the research procedure or any other aspect of the study you can contact: Dr. Helen Delargy or Dr. Isabel Hargreaves at the School of Psychology, 43 College Road, University of Wales, Bangor, Gwynedd, LL57 2DG, Tel: 01248 382205.

Any complaints about any part of this study should be addressed to: Professor C. F. Lowe, Head of School of Psychology, University of Wales, Bangor, Gwynedd, LL57 2DG.

Appendix D

Participant Consent Form
(English version)

Investigation of the experiences of women who are overweight

Consent Form

- I confirm that I have read and understand the Information Sheet.
- I understand that participation in this study will involve me being interviewed and filling in some questionnaires about my views on overweight generally, about my own weight and how I feel about myself.
- I am aware that I can withdraw from this study at any time during data collection without having to give a reason.
- I have been given a copy of this Consent Form and the Information Sheet to keep.
- I agree to participate in this study.

Name of participant: _____

Signature: _____

Date: _____

Signature of investigator: _____

Date: _____

Appendix E

Participant Screening Questionnaire

Investigation of the experiences of women who are overweight

Questionnaire

Before you can be enrolled in the study we need some further information about you. Please complete the following questionnaire and return it in the prepaid envelope enclosed. All information that you give will be seen only by Dr. Helen Delargy, the principal researcher, and kept strictly confidential. If you have any questions or queries please contact Helen on the contact 'phone number given.

1. Personal details

Name: _____

Address: _____

Height: _____

Weight _____

Name and address of your doctor/G.P. _____

_____

2. How would you describe your general health at the moment?

Poor / average / good*

3. Are you at the moment, or have you recently been, receiving any treatment for any major health problems?

Yes / No*

4. Are you at the moment, or have you recently been, receiving any treatment for an eating disorder?

Yes / No*

5. Are you at the moment, or have you recently been, receiving any treatment for depression, anxiety or a mental health problem?

Yes / No*

Thankyou

** Please delete as applicable*

Appendix F

Semi-structured Interview Schedule

Interview

(Type in italics are notes for the interviewer. Type not in italics may be addressed to the participant.)

Introduction
This study aims to look at what people who are overweight think and feel about overweight. I'm going to go through what the study involves with you to make sure that you're happy with everything that is going to happen.
Give the participant a copy of their Consent Form and another Information Sheet
Go through the Information sheet and Consent Form with participant
Ask if any questions?
Check is it all OK?

In this study I am particularly interested in your point of view so I'm going to let you do most of the talking. If I don't say much its not because I'm not interested in what you're saying but because I don't want to put you off by commenting on what you say. From time to time I may write something down to remind me of something interesting you have said that I want to ask you about later. Remember that there are no right or wrong answers, it is your point of view that I'm interested in.

1. Can you tell me the brief history of your weight?
   Prompts: When did you first start to gain weight?
   Has your weight tended to go up or down or has it stayed the same since then? (gradual or sudden changes?)
   Do you see yourself as overweight now?

2. Could you describe, in your own words, what it is like being your weight?

3. Why do you think people become overweight?
   Prompts: What makes one person become overweight and not another?
   Do you think that lifestyle, genetics or other factors play a part?
   (diet, activity level, genetics, things to do with the person or circumstances)

4. *If not discussed above:* Why do you think you have gained weight?

5. Do you think it is possible for people to control or change their weight?
   If not discussed above: Do you think you could control or change your weight?

6. *If do believe weight control is possible:* How can people control their weight?
   Prompt: What are the best ways to lose weight?
   Prompts if not discussed above: What do you think about dieting? Do you think it works? For other people? For you? What do you think about exercising as a means of controlling your weight? Do you think it works? For other people? For you?

7. What things do you think stop people from being the weight they want to be?

8. Have you ever wanted to lose weight?
   Prompts: If so: Have you ever tried to lose weight?
   If so: How have you tried to lose weight?

9. How would you describe yourself as a person?
   Prompts: what sort of person are you? Most important characteristic?

10. Do you think that being your weight makes a difference to how you see yourself?
   Prompts: If so In what ways?

11. What about the way other people see you, is this affected by your weight?
   Prompts: members of your family, friends, strangers, society generally
   If so In what ways?

12. Thinking about all the different aspects of your life, how important is your weight or body size?
   Prompts: If someone asked you to describe yourself, would you mention your weight/size? Do you see being your weight as a problem? *(for others, self)*

13. How much do you think about your weight?
   Prompts: is it something you think about much?

14. Do you think that your weight has had any effects on your life as a whole?
   Prompts: do you think you'd be doing different things now, if you were lighter/smaller? (e.g. work, home)

15. On a day-to-day level, do you think things would be different if you were lighter?
   Prompts: would some things be easier or harder?

16. Do you have any ways of dealing with any problems related to your weight *(if participant has mentioned problems)*?
   Prompts: Have you had any negative experiences related to your weight recently? What about any positive aspects? Any ways of coping (practical, mental)?

Appendix G

Shape- and Weight-based Self-esteem Inventory (S.A.W.B.S.)

DIMENSIONS OF SELF-ESTEEM INVENTORY

OUR OPINION OF OURSELVES IS BASED ON HOW WE FEEL ABOUT OUR DIFFERENT PERSONAL ATTRIBUTES.

STEP 1: Please read through the list below and **PLACE AN "X" on the line next to each attribute that is important to how you have felt about yourself in the last four weeks.**

STEP 2: Now, look over the attributes you have selected, and **RANK ORDER them in terms of how much your opinion of yourself in the last four weeks has been based on each attribute.** The numbers should not necessarily reflect how satisfied you have been with the attribute, but rather how important the attribute has been to how you feel about yourself.

STEP 3: Using the attributes you selected, **DIVIDE THE CIRCLE** below so that the size of each section is a reflection of **how much your opinion of yourself in the last four weeks has been based on that attribute** (larger pieces should indicate that a greater part of your opinion of yourself has been based on that attribute, for example). Place the letters corresponding to the attributes inside the pieces of the circle.

☐ _____ **A: Your intimate or romantic relationships**
e.g., as reflected in the level of closeness you feel in close relationships

☐ _____ **B: Your body shape and weight**
e.g., your actual current shape or weight

☐ _____ **C: Your competence at School/Work**
e.g., as reflected by grades or work evaluation

☐ _____ **D: Your Personality**
e.g., warmth, level-headedness, openness, self-control

☐ _____ **E: Your Friendships**
e.g., as reflected by the number or quality of friendships

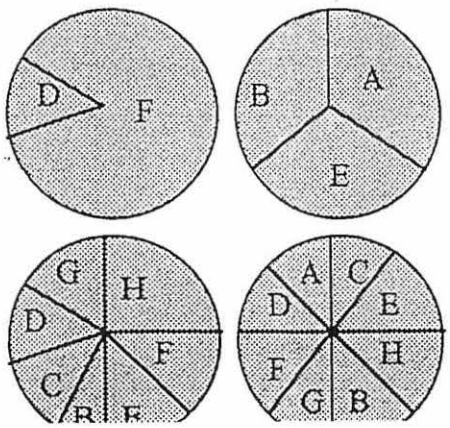
☐ _____ **F: Your Face**
e.g., how "good looking" you are

☐ _____ **G: Your Personal Development**
e.g., your sense of morality, ethics, or spirituality

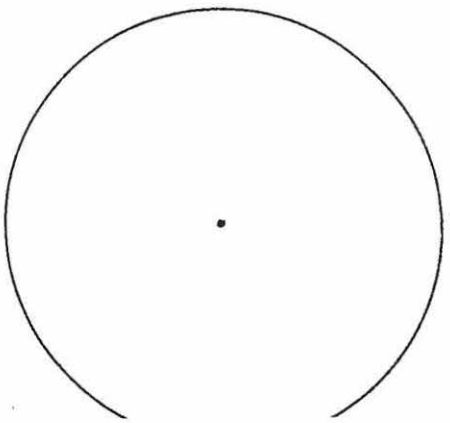
☐ _____ **H: Your competence at activities other than school/work**
e.g., your competence in music, sports, hobbies

☐ _____ **I: Other**
Please describe:_____

EXAMPLES:



YOUR CIRCLE:



Appendix H

Instrument designed for modified administration of the S.A.W.B.S.

Dimensions of self-esteem inventory

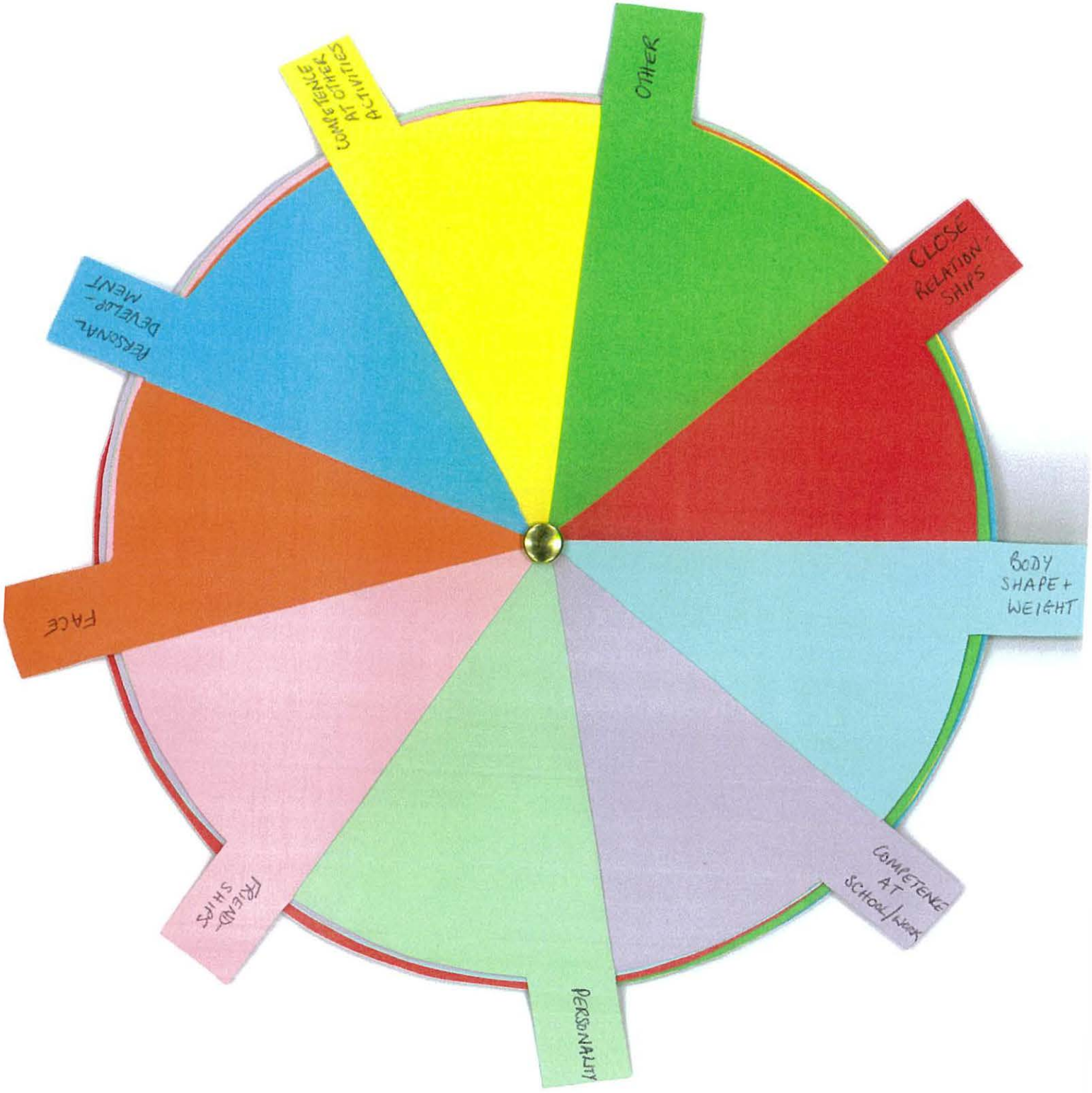
Our opinion of ourselves in based on how we feel about our different personal attributes.

Step 1: Please read through the list below and **place an 'X' on the line next to each attribute that is important to how you have felt about yourself in the last four weeks.**

☐	____	**A: Your intimate or romantic relationships** e.g. as reflected in the level of closeness you feel in close relationships	
☐	____	**B: Your body shape and weight** e.g. your actual current shape or weight	
☐	____	**C: Your competence at school / work** e.g. as reflected by grades or work evaluation	
☐	____	**D: Your personality** e.g. warmth, level-headedness, openness, self-control	
☐	____	**E: Your friendships** e.g. as reflected by the number or quality of friendships	
☐	____	**F: Your face** e.g. how "good looking" you are	
☐	____	**G: Your personal development** e.g. your sense of morality, ethics or spirituality	
☐	____	**H: Your competence at activities other than school / work** e.g. your competence in music, sports, hobbies	
☐	____	**I: Other** Please describe: _____	

Step 2: Now look over the attributes you have selected above. In the boxes on the left-hand side **rank order them in terms of how much your opinion of yourself in the last four weeks has been based on each attribute.** The numbers should not necessarily reflect how satisfied you have been with the attribute, but rather **how important the attribute has been to how you feel about yourself.**

Step 3: Using the attributes you have selected, **divide the cardboard circle** so that the size of each section is a reflection of **how much your opinion of yourself in the last four weeks has been based on that attribute** (for example, larger pieces should indicated that a greater part of your opinion of yourself has been based on that attribute).


COMPETENCE AT OTHER ACTIVITIES
OTHER
CLOSE RELATION-SHIPS
BODY SHAPE + WEIGHT
COMPETENCE AT SCHOOL/WORK
PERSONALITY
FRIEND-SHIPS
FACE
PERSONAL DEVELOP-MENT

Appendix I

Rosenberg Self-esteem Scale

Please read each statement carefully and decide the degree to which it is characteristic or true of you. Then circle a number between "1" and "4" according to the following scale:

1 = STRONGLY AGREE
2 = AGREE
3 = DISAGREE
4 = STRONGLY DISAGREE

Please be sure to complete all the statements.

		Strongly Agree			Strongly Disagree
1.	On the whole, I am satisfied with myself.	1	2	3	4
2.	At times I think I am no good at all.	1	2	3	4
3.	I feel that I have a number of good qualities.	1	2	3	4
4.	I am able to do things as well as most other people.	1	2	3	4
5.	I feel I do not have much to be proud of.	1	2	3	4
6.	I certainly feel useless at times.	1	2	3	4
7.	I feel that I am a person of worth, at least on an equal plane with others.	1	2	3	4
8.	I wish I could have more respect for myself.	1	2	3	4
9.	All in all, I am inclined to feel that I am a failure.	1	2	3	4
10.	I take a positive attitude toward myself.	1	2	3	4

Appendix J

Symptom Checklist 90-R

SCL-90-R®

Symptom Checklist-90-R

Leonard R. Derogatis, PhD

_____
MI

Age Gender Test Date

DIRECTIONS:

1. ~~Print your name, identification number, age, gender, and testing date in the area on the left side of this page.~~
2. Use a lead pencil only and make a dark mark when responding to the items on pages 2 and 3.
3. If you want to change an answer, erase it carefully and then fill in your new choice.
4. Do not make any marks outside the circles.

DO NOT SEND TO NATIONAL COMPUTER SYSTEMS
USE ONLY FOR HAND SCORING

Product Number
05618

INSTRUCTIONS:

Below is a list of problems people sometimes have. Please read each one carefully, and blacken the circle that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Blacken the circle for only one number for each problem and do not skip any items. If you change your mind, erase your first mark carefully. Read the example before beginning, and if you have any questions please ask them now.

	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY	EXAMPLE HOW MUCH WERE YOU DISTRESSED BY:
1	⓪	①	②	●	④	Bodyaches

	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY	HOW MUCH WERE YOU DISTRESSED BY:
1	⓪	①	②	③	④	Headaches
2	⓪	①	②	③	④	Nervousness or shakiness inside
3	⓪	①	②	③	④	Repeated unpleasant thoughts that won't leave your mind
4	⓪	①	②	③	④	Faintness or dizziness
5	⓪	①	②	③	④	Loss of sexual interest or pleasure
6	⓪	①	②	③	④	Feeling critical of others
7	⓪	①	②	③	④	The idea that someone else can control your thoughts
8	⓪	①	②	③	④	Feeling others are to blame for most of your troubles
9	⓪	①	②	③	④	Trouble remembering things
10	⓪	①	②	③	④	Worried about sloppiness or carelessness
11	⓪	①	②	③	④	Feeling easily annoyed or irritated
12	⓪	①	②	③	④	Pains in heart or chest
13	⓪	①	②	③	④	Feeling afraid in open spaces or on the streets
14	⓪	①	②	③	④	Feeling low in energy or slowed down
15	⓪	①	②	③	④	Thoughts of ending your life
16	⓪	①	②	③	④	Hearing voices that other people do not hear
17	⓪	①	②	③	④	Trembling
18	⓪	①	②	③	④	Feeling that most people cannot be trusted
19	⓪	①	②	③	④	Poor appetite
20	⓪	①	②	③	④	Crying easily
21	⓪	①	②	③	④	Feeling shy or uneasy with the opposite sex
22	⓪	①	②	③	④	Feelings of being trapped or caught
23	⓪	①	②	③	④	Suddenly scared for no reason
24	⓪	①	②	③	④	Temper outbursts that you could not control
25	⓪	①	②	③	④	Feeling afraid to go out of your house alone
26	⓪	①	②	③	④	Blaming yourself for things
27	⓪	①	②	③	④	Pains in lower back
28	⓪	①	②	③	④	Feeling blocked in getting things done
29	⓪	①	②	③	④	Feeling lonely
30	⓪	①	②	③	④	Feeling blue
31	⓪	①	②	③	④	Worrying too much about things
32	⓪	①	②	③	④	Feeling no interest in things
33	⓪	①	②	③	④	Feeling fearful
34	⓪	①	②	③	④	Your feelings being easily hurt
35	⓪	①	②	③	④	Other people being aware of your private thoughts
36	⓪	①	②	③	④	Feeling others do not understand you or are unsympathetic
37	⓪	①	②	③	④	Feeling that people are unfriendly or dislike you

	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY	HOW MUCH WERE YOU DISTRESSED BY:
38	⓪	①	②	③	④	Having to do things very slowly to insure correctness
39	⓪	①	②	③	④	Heart pounding or racing
40	⓪	①	②	③	④	Nausea or upset stomach
41	⓪	①	②	③	④	Feeling inferior to others
42	⓪	①	②	③	④	Soreness of your muscles
43	⓪	①	②	③	④	Feeling that you are watched or talked about by others
44	⓪	①	②	③	④	Trouble falling asleep
45	⓪	①	②	③	④	Having to check and double-check what you do
46	⓪	①	②	③	④	Difficulty making decisions
47	⓪	①	②	③	④	Feeling afraid to travel on buses, subways, or trains
48	⓪	①	②	③	④	Trouble getting your breath
49	⓪	①	②	③	④	Hot or cold spells
50	⓪	①	②	③	④	Having to avoid certain things, places, or activities because they frighten you
51	⓪	①	②	③	④	Your mind going blank
52	⓪	①	②	③	④	Numbness or tingling in parts of your body
53	⓪	①	②	③	④	A lump in your throat
54	⓪	①	②	③	④	Feeling hopeless about the future
55	⓪	①	②	③	④	Trouble concentrating
56	⓪	①	②	③	④	Feeling weak in parts of your body
57	⓪	①	②	③	④	Feeling tense or keyed up
58	⓪	①	②	③	④	Heavy feelings in your arms or legs
59	⓪	①	②	③	④	Thoughts of death or dying
60	⓪	①	②	③	④	Overeating
61	⓪	①	②	③	④	Feeling uneasy when people are watching or talking about you
62	⓪	①	②	③	④	Having thoughts that are not your own
63	⓪	①	②	③	④	Having urges to beat, injure, or harm someone
64	⓪	①	②	③	④	Awakening in the early morning
65	⓪	①	②	③	④	Having to repeat the same actions such as touching, counting, or washing
66	⓪	①	②	③	④	Sleep that is restless or disturbed
67	⓪	①	②	③	④	Having urges to break or smash things
68	⓪	①	②	③	④	Having ideas or beliefs that others do not share
69	⓪	①	②	③	④	Feeling very self-conscious with others
70	⓪	①	②	③	④	Feeling uneasy in crowds, such as shopping or at a movie
71	⓪	①	②	③	④	Feeling everything is an effort
72	⓪	①	②	③	④	Spells of terror or panic
73	⓪	①	②	③	④	Feeling uncomfortable about eating or drinking in public
74	⓪	①	②	③	④	Getting into frequent arguments
75	⓪	①	②	③	④	Feeling nervous when you are left alone
76	⓪	①	②	③	④	Others not giving you proper credit for your achievements
77	⓪	①	②	③	④	Feeling lonely even when you are with people
78	⓪	①	②	③	④	Feeling so restless you couldn't sit still
79	⓪	①	②	③	④	Feelings of worthlessness
80	⓪	①	②	③	④	The feeling that something bad is going to happen to you
81	⓪	①	②	③	④	Shouting or throwing things
82	⓪	①	②	③	④	Feeling afraid you will faint in public
83	⓪	①	②	③	④	Feeling that people will take advantage of you if you let them
84	⓪	①	②	③	④	Having thoughts about sex that bother you a lot
85	⓪	①	②	③	④	The idea that you should be punished for your sins
86	⓪	①	②	③	④	Thoughts and images of a frightening nature
87	⓪	①	②	③	④	The idea that something serious is wrong with your body
88	⓪	①	②	③	④	Never feeling close to another person
89	⓪	①	②	③	④	Feelings of guilt
90	⓪	①	②	③	④	The idea that something is wrong with your mind

Appendix K

List of Support Agencies

Investigation of the experiences of women who are overweight

Contacts

If you have any questions or queries about your participation in this study please contact Dr Helen Delargy or Dr. Isabel Hargreaves at the North Wales, Clinical Psychology Course, School of Psychology, 43 College Road, University of Wales Bangor. Telephone:

If you are concerned about any of the issues raised whilst taking part in the study you could contact and discuss it with the following people or organisations:

1. Your own doctor (G.P.). If appropriate your doctor may refer you to your local Community Mental Health Team.

2. The Samaritans
Bangor: 5 Abbey Road, Bangor. Tel: (01248) 354646
Rhyl: 23 Bedford Street, Rhyl (01745) 354545

3. MIND (National Association for Mental Health)
Abbey Road Day Centre, 9 Abbey Road, Bangor. Tel: (01248) 354888

Letter of approval from Research Ethics Committee

c.c. Dr. Isabel Hargreaves

Ysgol Seicolog
Prifysgol Cymru Bangor
Bangor, Gwynedd LL57 2DG
Ffôn: Bangor (01248) 382211
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e-mail: pss029@bangor.ac.uk.
http://www.psych.bangor.ac.uk/

October 10, 2000

Dr. Helen Delargy
Trainee Clinical Psychologist
NWCPC
School of Psychology
University of Wales
Bangor

Dear Colleague

Investigation of the experiences of people with obesity

Your research proposal (referred to above and on the attached sheet) has been reviewed by the School of Psychology Research Ethics Committee and they are satisfied that the research proposed accords with the relevant ethical guidelines.

If you wish to make any substantial modifications to the research project, please inform the committee in writing before proceeding. Please also inform the committee as soon as possible if participants experience any unanticipated harm as a result of taking part in your research, or if any adverse reactions are reported in subsequent literature using the same technique elsewhere.

.

Good luck with your research.

Kath Chitty
Coordinator -School of Psychology Research Ethics Committee

Letter requesting Research Ethics Committee's consideration of changes to the research proposal

Cwrs Seicoleg Clinigol Gogledd Cymru

North Wales Clinical Psychology Course

Prifysgol Cymru · University of Wales
BANGOR

Ysgol Seicoleg,
Prifysgol Cymru, Bangor,
Bangor,
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Ffacs: 01248 383718

School of Psychology,
University of Wales, Bangor
Bangor,
Gwynedd LL57 2DG.
Tel: 01248 382205
Fax: 01248 383718

22.11.00

Dear Research Ethics Committee,

Re: Proposal number 345: Investigation of the experiences of people with obesity

I wish to make a number of changes to the above research project.

1. As a way by which to check the credibility of the analysis that I conduct on the interview data, I wish to carry out "member checking" with at least some of the participants. This will involve discussing my interpretation of each participant's transcripts with them after I have completed the initial analysis to ensure that I have understood and summarised what they have said accurately. This will be conducted by meeting with the participants for a second time. This part of the study will conform to the same ethical standards as in the original proposal in terms of procedure (the interviews will be tape-recorded and transcribed), confidentiality and payment. It is anticipated that this part of the study will last for up to half an hour. The relevant paragraph of the Information Sheet has been altered accordingly (see Appendix A). NOW APPENDIX L

2. It may be useful to directly quote substantial parts of participants' transcripts or even include an entire transcript in the write-up of the research. However, quotes from the participants will only be used with the consent of the participants. If it is necessary to include an entire transcript this will be bound separately from the thesis and will not be available to the public. Furthermore all quotes and transcripts will be carefully scrutinised and edited to remove any identifying features. The consent form (both English and Welsh versions) has been modified to include these possibilities see Appendix B). NOW APPENDIX M

I would be grateful if you could let me know whether these changes are acceptable. Thankyou.

Yours sincerely

H Delargy

Dr. Helen Delargy
Trainee Clinical Psychologist

Appendix L

Revised Participant Information Sheet

Information Sheet

Investigation of the experiences of women who are overweight

Title of research: Investigation of the views of women who are overweight

Investigators: Dr. Helen Delargy (Trainee Clinical Psychologist) and Dr. Isabel Hargreaves (Clinical Psychology Course Director)

You are being invited to take part in a research study. Before you decide to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Ask us if there is anything that is not clear or if you would like further information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?
The views of people who are overweight may give valuable insight into the condition and what it is like to be overweight. This research aims to gather information about the views and feelings of overweight women about overweight in general, about being overweight themselves and about how they feel about themselves.

Who has been invited to take part?
Women who were registered on the community participant panel of the School of Psychology, University of Wales, Bangor were contacted. As we had no information about panellists' height and weight, the women who were first contacted to take part were not selected according to their body weight or size. Those people who then expressed an interest in the study were sent an information pack and questionnaire. Participants will be selected from those people who fill in and return the questionnaire and whose answers fit the study criteria. Those people who fill in and return the questionnaire but do not fit the criteria for inclusion in the study will be debriefed about the study.

What does taking part involve?
Participation in the research will involve being interviewed and filling in three questionnaires. Initially you will be asked to take part in an interview with Dr. Helen Delargy about your views on overweight generally, about your own weight and how you feel about yourself. Following this you will be asked to fill in questionnaires about yourself, including questionnaires about the way you feel at the moment and how you feel about yourself generally. It is anticipated that the interview will last for up to an hour. It will take approximately half an hour to fill in the questionnaires. Therefore, in total, this part of the study will take up to one-and-a-half hours with a break if you wish. The researcher may contact you on second occasion to review what you said during the interview to check that she has understood what you were saying accurately. It is anticipated that this part of the study will take up to half and hour. The interviews will be conducted in English and the questionnaires will be in English.

What are the possible benefits and harms of taking part?
This research will provide the opportunity for women who are overweight to voice their views about overweight and to contribute to the understanding of being overweight. It is possible that taking part in the study will focus participants' thoughts on negative aspects of their weight that they had not considered before. However, the interview will be open-ended and seeks to establish the participant's own point of view.

Where will the research take place?
The research will take place at the School of Psychology, University of Wales, Bangor or, if this is not convenient, at a health centre or clinic convenient for you. Travel costs will be reimbursed at public transport rate when you attend for the study. At the time of participation, the participants will be asked if they would like to know the findings of the research. Those participants who requested this information will be sent a summary of the research findings but will not be given feedback on their own results.

Will my taking part in this study by kept confidential
Yes, all information will be anonymous and confidential. The interview will be tape-recorded so that the researcher can transcribe (type out) the information that you give. Once the transcription is completed (within 2 weeks of the interview) the tape-recording will be destroyed. The transcription (stored on computer and printed out) will not have the participant's name or identifying details on it. The transcription will be coded with a number so that only Dr. Helen Delargy will be able to identify who was interviewed. Similarly, the questionnaires will not have any identifying information on them apart from a code number so that only Dr. Helen Delargy will be able to identify who filled them in. This information will be treated in the strictest confidence. Information from the content of the interview or questionnaires used in reporting and publishing the results of the research will be selected so that it does not allow the identification of the participant. However, if, during the study, you give me information that causes me concern about your welfare or the welfare of another person I will be obliged to contact you G.P.

Is participation voluntary?
Yes, participation in this study is entirely voluntary. You have the right to refuse to take part or withdraw from the study at any time without any penalty. Even if at first you choose to take part you can still withdraw from the study at any stage during data collection without having to give a reason.

If you have any concerns, questions or comments about the research procedure or any other aspect of the study you can contact: Dr. Helen Delargy or Dr. Isabel Hargreaves at the School of Psychology, 43 College Road, University of Wales, Bangor, Gwynedd, LL57 2DG, Tel: 01248 382205.

Any complaints about any part of this study should be addressed to: Professor C. F. Lowe, Head of School of Psychology, University of Wales, Bangor, Gwynedd, LL57 2DG.

Appendix M

Revised Participant Consent Form

Investigation of the experiences of women who are overweight

Consent Form

- I confirm that I have read and understand the Information Sheet.
- I understand that participation in this study will involve me being interviewed and filling in some questionnaires about my views on overweight generally, about my own weight and how I feel about myself.
- I understand that what I say in the interviews will be transcribed and some or even all of it may be quoted directly in the write-up or publication of this research but that information that could identify me will be removed.
- I am aware that I can withdraw from this study at any time during data collection without having to give a reason.
- I have been given a copy of this Consent Form and the Information Sheet to keep.
- I agree to participate in this study.

Name of participant: _____

Signature: _____

Date: _____

Signature of investigator: _____

Date: _____

Letter of Approval from Research Ethics Committee for Changes to Research Proposal

Prifysgol Cymru · University of Wales
BANGOR

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1 December 2000

Dr. Helen Delargy
Trainee Clinical Psychologist
NWCPC
School of Psychology
University of Wles
Bangor

Dear Colleague

Investigation of the experiences of people with obesity

Thank you for your letter of November 22nd setting out proposed amendments to the above-mentioned study already granted approval on behalf of the School of Psychology Research Ethics Committee.

These changes have now been scrutinised on behalf of the committee and I confirm further approval to cover them.

Yours sincerely

Kath Chitty

Kath Chitty
Coordinator - School of Psychology Research Ethics Committee

Email Requesting Research Ethics Committee's Consideration of Additional Method of Participant Recruitment

Email to Kath Chitty, Coordinator, School of Psychology Research Ethics Committee

Date: 13.12.00

Dear Kath

Re: DClinPsy study on the experiences of people with obesity

I have as yet been unable to recruit enough people for my study using the community participant panel and thought about trying a poster put up around the university and local community. I wondered if this would be agreed by the ethics committee? I have attached a draft of the poster to this email. I would be grateful if you could get back to me about this as soon as possible. Thanks. Helen

Appendix N

Recruitment Poster (English version)

Overweight and interested in sharing your views about it?

I am currently looking for overweight women to take part in a research study to investigate the views of overweight women.

The study would involve taking part in a one-to-one interview about your views of being overweight and filling in some questionnaires.

If you would like further information please contact me, Helen Delargy, either by leaving a message on 01248 388365 or by email: HelenDelargy@yahoo.com, or by writing to me at the School of Psychology, 43 College Road, University of Wales, Bangor.

Email of Approval from Research Ethics Committee's for Additional Method of Participant Recruitment

Email received from Kath Chitty, Coordinator, School of Psychology Research Ethics Committee

Date: 14.12.00

Dear Helen
INVESTIGATION OF THE EXPERIENCES OF PEOPLE WITH OBESITY
Thankyou for your email, details of which have been forward to our reviewer who has given this consideration and confirms approval of this method of recruitment.
However, it has been suggested that providing a Welsh version of the poster would be adviseable. Also, if you were planning to advertise in the local press, we would require copies of both versions.
Kath

cc. i.hargreaves@bangor.ac.uk

Kath Chitty, Admissions Secretary Tel: +44 (0) 1248 382629
Email:k.chitty@bangor.ac.uk School of Psychology http://www.psych.bangor.ac.uk
University of Wales Bangor Tel +44 (0) 1248 382211 Bangor, Gwynedd LL57 2DG
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Literature Review

Psychological aspects of obesity: can qualitative approaches to research increase understanding and inform practice?

Helen Delargy

Child Development Centre, Holyhead Road, Bangor, North Wales, UK.

Proposed additional author: Isabel Hargreaves

North Wales Clinical Psychology Course, School of Psychology, University of Wales Bangor, Bangor, North Wales, UK.

To be submitted to the British Journal of Health Psychology

Psychological aspects of obesity: can qualitative approaches to research increase understanding and inform practice?

Objectives. Despite well-established health and social costs of obesity, its prevalence has continued to increase rapidly, indicating a need for improved approaches to prevention and treatment. Clinical psychology has offered useful contributions to many areas of physical health but obesity has not traditionally received much attention. With reference to the literature this paper aimed to consider the relevance of psychological processes in the development and treatment of obesity, and highlight the ways that clinical psychology can contribute to obesity management.

Conclusions. The review of the literature highlighted some psychological processes that may serve to maintain poor weight control. The application of models developed within health psychology to obesity also highlighted psychological processes that may be involved in the maintenance of obesity. Incorporating psychological models and strategies into treatment approaches offers the potential to improve practice. However, this review revealed that there has been relatively little research into the psychological processes (cognitions, behaviours and emotions) involved in weight control, and argues that a deeper understanding of the experience of obesity will better inform clinical practice. Finally the paper suggests that qualitative approaches to investigation may be particularly valuable at this stage of research into the experience of obesity.

Keywords: Obesity, clinical psychology, cognitions, treatment, qualitative

The prevalence of obesity has increased considerably in recent years despite government targets to reduce the levels. By 1996 prevalence in the UK was more than double that in 1980, having increased to 16% in men and 18% in women (British Nutrition Foundation, 1999). Obesity is characterised by the excessive storage of energy as fat and is defined as having a Body Mass Index (B.M.I.) of greater than $30kg/m^2$ (World Health Organisation, 1997). Obesity arises when energy intake exceeds energy expenditure and reasons for this imbalance are emerging. Appetite and eating behaviour are governed by a complex bio-psychological system which incorporates biological, psychological, and environmental factors (Blundell, 1990). The fact that human genetics and biology have remained stable over the last few decades whilst the prevalence of obesity has increased implicates lifestyle and environmental factors in its development (Prentice & Jebb, 1995). The present environment, with the wide range of highly palatable, readily available food, and which encourages sedentary lifestyles undermines the biological regulatory mechanisms of the appetite control system, making it difficult for people to keep their food consumption down to a level that matches their energy requirements (Blundell, 2001). When negative energy balance occurs physiological and psychological mechanisms will act to restore the balance although similar adjustments do not happen when positive energy balance occurs.

There are well-established links between obesity and increased morbidity and mortality, and effects on health are severe with morbid obesity (B.M.I. > $40kg/m^2$). Health complications include increased risk of diabetes, coronary heart disease, certain cancers, osteoarthritis, gallstones, sleep apnoea and reproductive disorders (British Nutrition

Foundation, 1999). Obesity, as a chronic, non-fatal condition, also has considerable economic costs, comprising direct costs associated with treating obesity and obesity-related diseases and costs to the individual such as lost earnings due to mortality and morbidity (estimated at £9.5million, £470million and £1.3billion respectively in England in 1998, Morris, 2001).

Obesity may also carry psychological costs for several reasons. Quality of life may be adversely affected by excess body weight making mobility and daily living more difficult (Kolotkin, Head, Hamilton & Tse, 1995). Increased risk to physical health itself may increase vulnerability to psychological problems through distress about health. However, likely to be of greater significance in the aetiology of psychological sequelae of obesity are cultural attitudes towards obesity. Although in western culture slimness is becoming harder to achieve and rarer, a body shape that is not realistically attainable for the majority is idealised, and obesity is highly stigmatised. Common stereotypes of obese people include the views that they are ugly, morally and emotionally impaired, asexual, discontented, weak-willed and unlikeable (Crandall, 1994.). Such attitudes result in frequent and distressing stigmatising experiences (Myers & Rosen, 1999) and discrimination in many domains of life, such as in the workplace (Rand & MacGregor, 1990). Stigmatisation due to obesity may be the most debilitating of all conditions (Allon, 1982) as it is immediately visible to others and therefore likely to affect most social interactions (Crocker, Cornwell & Major, 1993). Furthermore, although people with many stigmatising conditions are not usually held to be responsible for their condition, people with obesity are frequently blamed for their condition because weight is culturally viewed as essentially under the individual's

control (Rodin, Price, Sanchez & McElligot, 1989). This view does not acknowledge that weight control is actually very difficult for many people in the present environment. The internalisation of this cultural view (the individual blames themselves for failure to control their weight) is thought to generate psychological distress (Jeffery, French & Schmid, 1990), although little is known about the extent to which obese people do internalise this view.

Treatment and prognosis

Efforts to reduce the prevalence of obesity at the population level have focussed on educating the public about healthy lifestyle choices. However, conventional programmes, such as that launched in the UK following the publication of the *Health of the Nation* (Department of Health, 1992) "*met with a resounding lack of success. The public received and understood the message, but the prevalence of obesity continued to increase*" (British Nutrition Foundation, 1999, pp. 141). This suggests that people know what they should be doing in terms of selecting healthy foods and keeping physically active but, despite the health costs and stigmatisation of obesity, they do not do it. The reasons for this apparent lack of action are critical to attempts to tackle the problem of obesity but are not well understood.

The main evidence-based approaches to obesity treatment at the individual level have recently been reviewed by Cooper and Fairburn (2001). For morbidly obese individuals surgery may be recommended to alter the size or absorptive capacity of the stomach. Although invasive, surgery usually results in substantial weight loss (20-45% of pre-operative weight) over the first year after treatment and this is generally well-

maintained (Kral, 1998). Pharmacotherapy with appetite-suppressing drugs such as fenfluramine results in 5-10% initial weight loss (Bray, 1998), with weight levelling off after six months. Behavioural treatments result in a weight loss of approximately 10% of initial body weight among those that complete programmes (Wing, 1998). However, with both pharmacotherapy and behavioural approaches there is almost invariably weight regain. Thus, the two-non-surgical treatments for obesity produce relatively modest reductions in weight and the weight lost is almost invariably regained once treatment is stopped.

The lack of success of treatment strategies has led some to question whether obesity should be treated at all (Brownell, 1993). However, it has recently become apparent that even modest weight loss is associated with significant health benefits. Clinically important improvements in important health indices have been found to accompany a 5-10% reduction in weight (e.g. Tremblay et al., 1999). Furthermore, if the lost weight is not regained, these benefits are sustained (Wing & Jeffery, 1995). Recommendations for treatment programmes reflect this finding. For example, the UK Royal College of Physicians (1998) stated that the primary goal of treatment should be a 10% reduction in initial weight, and defined successful weight loss as a loss of more than 5% of initial weight. Thus, modest weight loss such as that achieved by pharmacological and behavioural treatments can bring about clinically important improvements in health indices. However, since both approaches have poor prognosis in terms of weight loss maintenance, improving weight oss maintenance remains an important challenge (Cooper & Fairburn, 2001).

Clinical psychology and obesity

Clinical psychology has made significant contributions in many areas of physical health, such as pain management, but obesity has not traditionally received much attention. However, the importance of individual psychological factors in the development and treatment of obesity has been increasingly recognised (e.g. Jebb, 1999; British Nutrition Foundation, 1999). The discussion above introduces two core issues in weight control which indicate that clinical psychology, with its roots in understanding human behaviour and experience, is well placed to tackle this problem. Firstly, due to its disabling and stigmatising nature, obesity may carry psychological costs for some individuals. Not only are these distressing in themselves, but they are likely to have detrimental effects on individuals' weight control efforts. In turn, failed efforts to control weight are distressing. In such a way there is likely to be a vicious circle between negative psychological states and poor weight control (Hill, 2001). There is considerable evidence of this relationship in studies of dieting and bingeing. Low mood is often reported to precede 'breaking' a diet or bingeing, and these activities are reported to lead to further low mood and self-reproach (Cooper, 1997). Secondly, weight control requires behaviour change and change maintenance, which many people apparently fail to achieve. Working with people to change unhelpful cognitions and behaviours and cope with difficult emotions falls within psychologists' domain of expertise.

Although apparently well-suited to treating obesity, psychological approaches have had limited success. Although 10% of initial weight is typically achieved through behavioural programmes, weight loss maintenance is poor. Historically psychological

approaches first described and reported in the 1960s have comprised behavioural techniques, teaching self-control procedures such as minimising exposure to discriminating stimuli for eating, rewarding moderate and appropriate eating, and reducing the reinforcement value of eating. Subsequently programmes have developed to include cognitive procedures and this has sometimes led to the re-labelling of the treatments as "cognitive-behavioural" (e.g. Foreyt & Poston, 1998). Some treatments have aimed at "modifying cognitions", though there is no consensus on what kind of cognitions are suitable targets for treatment (Wardle, 1994), and Cooper and Fairburn (2001) have argued that these programmes bear little resemblance to cognitive-behaviour therapy in terms of their theoretical basis, aims and procedures. They identified a need for the development and evaluation of a specific cognitive-behavioural theory of obesity. Clearly, an understanding of the psychological processes involved in weight gain and successful weight loss and maintenance will be important in informing clinical practice. Literature concerning such psychological processes is briefly reviewed below.

Obesity and negative psychological processes

Given the stigmatisation of obesity levels of psychological distress and psychopathology might to predicted to be elevated among obese people (Cocker & Major, 1989). However research has not consistently supported this. Whilst some early studies suggested that obese people show no higher levels of psychopathology than normal weight people (reviewed by Wadden & Stunkard, 1987; Stunkard and Wadden, 1992), others have suggested much higher levels of affective disorder and anxiety amongst obese people (Goldsmith et al., 1992; Sullivan et al., 1993). In a timely review

of the literature Friedman and Brownell (1995) suggested that future research should address the methodological weaknesses of earlier studies, such as an over-representation of clinical samples, and identify individual features, including thought-related factors (e.g. self-concept, body image disturbance, cognitive style) and behavioural factors (e.g. dieting, binge eating, weight cycling) that make people more vulnerable to suffering psychologically from their obesity. They noted a need to gain understanding of social and psychological causal pathways linking obesity with specific psychological distress. Their paper provided a useful framework in which to consider subsequent research, and recent work has begun to investigate these areas, some using population samples rather than clinical samples. This work has been reviewed elsewhere and suggests that risk factors for psychological health problems are being severely obese, female and having co-occurring chronic illnesses (Hill, 2001). Other factors emerging are roles for self-esteem and social support in mediating vulnerability to psychological distress. Miller & Downey (1999) meta-analysed studies of the relationship between body weight and self-esteem and found lower self-esteem was associated with heavier weight. Throwing more light on the nature of the relationship Hill & Williams (1998) investigated the relationship between obesity and psychological health, concluding that poor mental health is not the inevitable consequence of even the most extreme obesity. However, poor mental health was related to low self-esteem and poor peer relationships, and these may mediate between obesity and mental health.

Another possible mediator between body weight and negative psychological consequences is beliefs about the causes of overweight (i.e. who is 'to blame' for a person's weight problem). Studies suggest that lower self-esteem and higher levels of

depression are found amongst people who attribute negative life events to internal rather than external factors (e.g. Abramson, Metalsky & Alloy, 1989). Walsh Pierce and Wardle (1997) investigated how children's attribution of cause of their body weight affected self-esteem. Whilst there was some support for the view that overweight children are generally more vulnerable to low self-esteem, lower self-esteem was found in the children who believed that they were responsible for their overweight (overeating, lack of exercise) than those who attributed their overweight to more external causes (genetic predisposition, medical cause). In a study of attributions for dietary failure Jeffery, French and Schmid (1990) found that people on low sodium and high potassium diets displayed the typical self-serving attributional style, viewing their dietary failures as due to causes external to and uncontrollable by themselves. (This attributional style has been hypothesised to allow people to preserve their self-esteem in the face of failure (deJong, Koomen & Mellenberg, 1988)). However, those on diets that included weight loss were more likely to view their problems as attributable to themselves. These studies suggest that attributions of cause and controllability of weight may impact on a person's ability to cope with being obese, although no other research to date has investigated these issues.

Psychological issues in the management of obesity itself

Obesity arises as a result of behaviours (eating, food choice, activity) within a set of environmental circumstances. It follows that prevention and treatment necessitate behaviour change. The failure of public health education campaigns suggests a need to embrace the process of behaviour change and the social and psychological factors which motivate and sustain behaviour change more fully. There has been relatively

little research into this area, but a number of psychological concepts and models developed in health psychology can usefully be applied to weight control.

The transtheoretical model of behaviour change, first developed by Prochaska, DiClemente and Norcross (1992) with reference to smoking cessation, proposed that behaviour change occurs in stages: the precontemplative, contemplative, preparation, action and maintenance of change stages. This process is viewed as a continuum, with individuals leaving and re-entering at different points. A further stage included by others is relapse, in which maintenance ends and there may be recycling among the earlier stages (Brownell, Marlatt, Lichtenstain & Wilson, 1986). One study used this model to examine weight control behaviours and showed that, as well as those actually taking action to lose weight, many individual's were trying to maintain their weight and many were contemplating action (O'Connell & Velicer, 1988). A key theoretical construct within the transtheoretical model is self-efficacy theory, which proposes that confidence in the ability to perform a particular behaviour is strongly associated with the actual ability to perform that behaviour (Bandura, 1977). Research typically reveals a strong relationship between perceptions of self-efficacy and initial health behaviour change as well as longer-term maintenance of that change. In relation to weight control one study found that self-efficacy was lower amongst obese women seeking treatment for their obesity than controls but increased to 'normal' levels with weight loss (Richman et al., 2001). Further investigation of the role of self-efficacy in weight control is needed.

Kirschenbaum et al. (1992) developed this model based on clinical observations of the stages of change during the process of long-term weight control in an attempt to provide information about the emotional, cognitive and behavioural experiences and difficulties likely to be encountered during weight loss. Three primary stages were identified, each characterised by a specific set of thoughts, feelings and behaviours: the 'Honeymoon' phase is characterised by enthusiastic efforts and concomitant success; the 'Frustration' phase occurs when the harsh realities of the required changes become apparent, and finally the 'Tentative Acceptance' stage may be reached when there is less emotionality and the individual becomes more able to incorporate the changes into their lifestyle. They argue that in order to "*develop and sustain the 'obsessive-compulsive self-regulation' necessary for successful weight control*" (pp. 624), patients experience cognitive, emotional and behavioural changes and it will helpful to educate them about what to expect at each stage. This approach provides a framework by which to educate patients and allows for the identification of the therapeutic approaches that are likely to be most useful at each stage.

Matching the stage that a person is at in terms of readiness to change with the treatment and support offered is likely to be crucial to the success of weight control attempts. Primary healthcare providers are well-placed to identify patient's readiness to change and recommend the most effective strategy for that individual, whether it be to encourage self-directed attempts at weight loss or refer to a professional weight control program. Psychologists may be able to offer education and support in motivational interviewing and moving patients towards a state of readiness to change (Kirschenbaum, 1996). Kirschenbaum noted that the Frustration phase may also apply

to those caring for obese patients due to the notoriously refractory nature of obesity. This often leads to ineffective and guilt-inducing communication that may decrease the probability of positive change. Improved communication may increase the likelihood of positive change (Sweet, Rozensky & Tovian, 1991) and psychologists can offer support with this.

The relapse-prevention model, (devised by Marlatt and George, 1984, with reference to addictive behaviours) was applied to weight control by Sternberg (1985) based on a cognitive-behavioural analysis of the relapse and maintenance processes occurring during weight loss. It is assumed that a dieter, whilst following a set of rules governing their eating and exercise behaviour, experiences a sense of personal control (self-efficacy) over them. This perception continues until the dieter experiences a situation which threatens their sense of control (e.g. boredom, depression) and the likelihood of a 'slip' (i.e. overeating) will depend on their ability to engage in adequate coping behaviour. If they maintain their control their sense of self-efficacy will increase. People often draw inferences about their internal states through observation of their own behaviour (Bem, 1972). If a slip occurs the dieter is likely to respond with cognitive dissonance (they are likely to attribute the cause of overeating to lack of will-power and other internalised constructs rather than to lack of coping strategies). The cognitive dissonance between self as a controlled eater 'v' overeating will be reduced by continuing overeating and changing their cognitions to match the new uncontrolled eating pattern: "*I am not the sort of person who can control my weight, I'm destined to be fat all my life. I might as well eat what I want.*" This model was tested through comparing groups of participants receiving a standard behavioural programme and

those receiving this plus a cognitive element based on the relapse-prevention model (e.g. analysis of high-risk situations and developing skills for avoiding slips or minimising their impact). There were some apparent benefits of this aspect of the programme on weight loss maintenance subsequent to treatment termination.

Implications for future work

The discussion above highlights several ways in which clinical psychology might usefully offer input. These include offering individual therapy to those suffering psychologically from their obesity, offering education and support to healthcare professionals about stages in weight control and how best to treat and support patients at each stage, and directing professional weight control programmes which address behavioural, cognitive and emotional aspects (also identified by Kirschenbaum, 1996). The discussion also highlighted some of the psychological processes that might be targets for intervention, such as low self-esteem and relationship-building, eliciting social support, and addressing attributions of responsibility for weight and weight control failure. The application of the health psychology models demonstrates possible directions for improvements to weight control programmes, such as educating patients and healthcare providers about the weight loss process, engendering realistic expectations, improving appropriate coping strategies and challenging unhelpful attributions for failure. The literature on obesity and psychological health also raised the question of the mechanisms through which some obese people apparently maintain good psychological health. Identification of processes that appear to be protective could inform psychological treatment of those who suffer psychologically from their obesity. Even those people who manage to achieve moderate weight loss with health benefits

may never be slim, and treatment may include teaching cognitive strategies to help them to maintain good psychological health as an overweight person. However, the discussion also highlighted that there has been relatively little research into these psychological processes and related interventions. Specifically there is a need to learn more about the role of attribution of cause and controllability of overweight and self-efficacy, and factors that may protect against psychological suffering.

Can qualitative approaches to investigation contribute to understanding obesity?

It is clear that there remains a lot to learn about the way obese people think and feel about their condition, and it is likely that eventually a variety of approaches to investigation will provide information about this. However in situations in which relatively little is known about a topic, qualitative approaches can be valuable in enriching the way psychology conceives the individual's experience of their health status (Smith, Flowers & Osborn, 1997). Approaches to investigating psychological processes in obesity have generally concentrated on measuring outcomes associated with obesity or assessing the relationship between individual differences such as attributional style and coping. Much research to date has involved the use of tight quantitative methods that necessarily limit the information yielded and only allow further investigation of predetermined constructs. Furthermore, there have been very few attempts to understand the individuals' representations of their condition. Qualitative methods can be used to obtain intricate details about phenomena such as thought processes and emotions that may be difficult to access through more conventional research approaches (Strauss & Corbin, 1998). Such insights may be particularly valuable in designing psychological treatment approaches. These

approaches also offer the possibility that insight will be gained into new areas of the topic that will generate new theory and research (Good & Watts, 1996).

In the area of health and illness it may be especially important to incorporate attempts to understand the individual's perspective, since the degree to which individuals consider their bodily state to be important is a central element. When something goes wrong with the body people often consider their sense of identity threatened, and may spend considerable time reflecting on what is happening to them and why (Smith, Flowers & Osborn, 1997). The outcome of these reflections may have important implications for the person's behaviour in relation to their illness and the psychological impact of the illness, and affect their chances of recovery or successfully coping with the illness. In some areas of health psychology qualitative methods have produced important findings. For example, in the field of HIV prevention there have been reports of increases in unprotected anal sex among gay men despite the risk of HIV infection. One qualitative study investigated the way gay men thought about sex and relationships and revealed that in the context of romantic relationships men often prioritised the expression of commitment, trust and love over their own health (Flowers, Smith, Sheeran & Beail, 1997). This suggests that HIV prevention approaches may need to address more than the simple 'condom use' approach and consider the meanings of unprotected sex within the gay relationship. This illustrates how detailed consideration of the person's perspective can enrich understanding of important issues such as why individuals engage in health risk behaviours or fail to engage in health enhancing behaviours.

It is perhaps surprising therefore that there have been few attempts to use qualitative methods to gain insight into the experience of obesity. One paper in particular, based on clinical observations made whilst interviewing people entering an obesity treatment study (Cooper & Fairburn, 2001), illustrates the potential utility of this approach. The authors suggested that cognitive factors are likely to contribute to understanding why some people engage in the behaviours necessary for weight loss maintenance while others do not. They offered a cognitive-behavioural analysis of this phenomenon which provided information about patients' beliefs about weight loss and their ability to lose weight, their (often unrealistic) expectations about the broader effects of achieving their target weight will have on their lives, what motivated them to lose weight and to continue trying, the difficulties encountered, stages in treatment and associated cognitions which were likely to cause patients to give up, the effects of failure on patients' views of themselves and their situation, and how this impacted on further weight control efforts. This analysis represents the authors' organisation of their interpretations of clinical observations of their patients' views of their situation, a stance commensurate with the ideology of some qualitative approaches. Their analysis illustrates the richness of the data obtained and how examination of cognitions held by obese people can shed light on barriers to weight maintenance and would inform strategies for overcoming such problems. A cognitive-behavioural treatment programme was developed from this analysis (in progress, Cooper, personal communication), and the outcomes of this programme will provide information as to the usefulness of this account of obesity.

Two 'semi-qualitative' studies have investigated characteristics of weight loss maintainers. In the first a descriptive analysis of people who lost significant weight and were successful at maintaining the loss was carried out (Colvin & Olson, 1983). Participants were encouraged to develop their own stories through semi-structured interviews. They presented descriptions of how they had come to be overweight, their motivations for trying to lose weight and the strategies they used. For women, weight gain was seen to be a product of environmental factors (in terms of their life situation), lack of exercise and lack of nutritional knowledge. They did not experience a critical incident to initiate weight loss efforts. They used dieting alone to achieve weight loss as they believed exercise to be futile due to exercise increasing appetite. Their lifestyles had changed significantly in terms of daily occupation and activity levels and their diet plans were highly individualised and had come to be preferred over their old habits. Perhaps the most interesting part of the analysis was the authors' interpretation of a key change in the women's experiences with respect to control over their weight: they felt that the women had *"recognised their own responsibility for their body size... felt a strong need to take charge of their own weight loss plan."* (pp. 294). In another study, open-ended techniques were used to generate hypotheses for the development of a questionnaire to investigate weight loss maintenance (Kayman, Bruvold & Stern, 1990). Weight loss maintainers were found to have initiated and devised their highly individualised weight loss plans themselves rather than having received input from health professionals. They reported being patient, setting small, achievable goals and sticking to their plans, although they were flexible in their approach to avoid feelings of deprivation. This was contrary to the relapsers (i.e. those who regained their lost weight), who tended to lose weight through taking appetite suppressants, fasting or

rigid, restrictive diets. Diet foods were perceived to be 'special' and preparing a special diet could not be maintained in the face of negative life events.

These studies set out to examine the characteristics of weight loss maintainers and they achieved this to some extent. However, they treated the interview data in a rather quantitative way, tending to quantify the proportion of women falling into each category. They also reported on fairly straightforward, tangible issues, such as what methods people had used to lose weight, not taking the opportunity to investigate more intricate experiences such as thought processes and emotions. Two studies have adopted a more truly qualitative approach. The first adopted a grounded theory approach to examine the experience of women in a weight loss programme (Adams, 1998). Semi-structured interviews with fourteen post-menopausal obese women were subjected to constant comparative analysis. A social psychological process named 'Taking Charge of One's Life' emerged and comprised three phases. 'Engaging' involved recognising that one's health was declining and/or that one was not meeting societal expectation of thinness and searching for help. 'Internalising' was identified as a cognitive process in which self-efficacy and outcome beliefs were incorporated within the self through learning or socialisation, and was seen to enable women to make the commitment to weight management success. The third phase, 'Keeping One's Commitment', involved using strategies such as acquiring knowledge, negotiating support, overcoming temptation, protecting oneself and evaluating progress to incorporate major changes in lifestyle. The findings were interpreted to suggest that future interventions should be more individually based, taking account of women's perspectives, motivations for weight loss, and subjective definitions of success. In the

second study (Blackburn, 1996) the accounts of nine obese women were subject to qualitative analysis in order to explore the applications of relapse prevention theory to obesity. Predominant emergent themes included shame and low self-esteem, childhood trauma, environment and childbearing practices, health concerns, beliefs about biology and genetics and relationship to the body. Feelings and beliefs consistent with learned helplessness (Seligman, 1975) were common, and repeated experiences of relapse reinforced beliefs that efforts to maintain a desirable weight had no impact on the actual outcome. Perceptions of self-efficacy were extremely low; whilst participants were judged to be knowledgeable about the behaviours associated with successful maintenance, they did not feel that they had the necessary skills to achieve it. Whilst they agreed that it was possible to learn from previous relapses, they were unable to identify the factors that precipitated their relapses.

These studies provided more in-depth information about psychological processes that obese women may experience, such as beliefs about themselves and their situation, the emotional impact of being in their situation, and likely effects of this on future weight loss attempts. Potential barriers to weight loss and maintenance were identified, such as feelings of low self-efficacy, which may shed light on why so many obese people are currently relapsed or precontemplative of weight loss. Further qualitative work would offer the possibility of learning more about the psychological processes involved in weight control which could inform future clinical and research work.

Summary

Despite the health and social costs of obesity, many people do not apparently consistently engage in the behaviours necessary for weight control. Understanding the reasons for this will be key to tackling the problem of obesity. A review of the literature suggests that several psychological processes may be involved in maintaining obesity. For example, repeated failure at weight control, coupled with the cultural stigmatisation of obesity, are likely to give rise to emotions and cognitions about the self, which in turn are likely to have a detrimental effect on weight control behaviours, leading to further weight control failure. Cognitions such as beliefs and attributions of cause (or blame) and controllability of weight and perceptions of low self-efficacy are implicated. Although obesity has not traditionally received much input from clinical psychology, a number of ways that clinical psychologists could contribute to managing the problem have been identified. However, there has been a dearth of research investigating the psychological processes involved in weight control, and better insights into this will inform clinical practice. Qualitative approaches to investigation may be particularly valuable at this stage of research into the experience of obesity.

References

Abramson, L.Y., Metalsky, G.I. & Alloy, L.B. (1989). Hopelessness depression: a theory-based subtype of depression. *Psychological Review, 96,* 358-372.

Adams, P.M. (1998). Taking charge of one's life: a theoretical model for weight management success. *Dissertation Abstracts International: section B: The Sciences & Engineering, 58(12-B),* 6483. Univ. Microfilms International, US.

Allon, N. (1982). The stigma of overweight in everyday life. In B.B.Woldman (Ed.), *Psychological Aspects of Obesity* (pp. 130-174). New York: Van Nostrand Reinhold.

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

Bem, D.J. (1972). Self-perception theory. In L. Berkowitz (Ed.), *Advances in experimental social psychology, (Vol 6).* New York: Academic Press.

Blackburn, A.L. (1996). Self-efficacy and learned helplessness as determinants of relapse in the obese population. *Dissertation Abstracts International: section B: The Sciences & Engineering, 57(5-B),* 3401. Univ. Microfilms International, US.

Blundell, J.E. (1990). Appetite disturbance and the problems of overweight. *Drugs, 39(3),* 1-19.

Blundell, J.E. (2001). Obesity: adaptation failure in a technological world – appetite control. *Meeting of the Association for the Study of Obesity 'Tackling obesity in tomorrow's world'*, London 17th July.

British Nutrition Foundation (1999). *Obesity: Report of the British Nutrition Foundation Task Force.* Blackwell Science Ltd., London.

Brownell, K.D. (1993). Whether Obesity should be treated (editorial). *Health Psychology, 12,* 339-341.

Brownell, K.D., Marlatt, G.A., Lichtenstein, E. & Wilson, G.T. (1986). Understanding and preventing relapse. *American Psychologist, 41,* 765-782.

Colvin, R.H. & Olsen, S.B. (1983). A descriptive analysis of men and women who have lost significant weight and are highly successful at maintaining the loss. *Addicitve Behaviors, 8,* 287-295.

Cooper, M. (1997). Cognitive theory in anorexia nervosa and bulimia nervosa: a review. *Behavioural and Cognitive Psychotherapy. 25,* 113-145.

Cooper, Z. & Fairburn, C.G. (2001). A new cognitive behavioural approach to the treatment of obesity. *Behaviour Research and Therapy, 37(1),* 499-511.

Crandall, C.S. (1994). Prejudice against fat people: ideology and self-interest. *Journal of Personality and Social Psychology, 66,* 882-894.

Crocker, J. & Major, B. (1989). Social stigma and self-esteem: the self-protective properties of stigma. *Psychological Review, 96,* 608-630.

Crocker, J, Cornwell, B & Major, B. (1993). The stigma of overweight: affective consequences of attributional ambiguity. *Journal of Personality and Social Psychology, 64 (1),* 60-70.

deJong, P., Koomen, W. & Mellenbergh, G. (1988). Structure of causes for success and failure: a multidimensional scaling analysis of preference judgements. *Journal of Personality and Social Psychology, 55,* 718-725.

Department of Health (1992). *The Health of the Nation: a strategy for health in England.* HMSO, London.

Flowers, P. Smith, J.A., Sheeran, P. & Beail, N. (1997). "Coming out" and sexual debut: understanding the social context of HIV risk-related behaviour. *Journal of Community and Applied Social Psychology, 8,* 409-421.

Foreyt, J.P. & Poston, W.S.C. (1998). What is the role of cognitive behavioural therapy in patient management? *Obesity Research, 6(suppl 1)*, 18S-22S.

Friedman, M.A., & Brownell, K.D. (1995). Psychological correlates of obesity: moving to the next research generation. *Psychological Bulletin, 117:1*, 3-20.

Goldsmith, S.J., Anger-Friedfeld, K., Beren, S., Rudolph, D., Boeck, M. & Aronne, L. (1992). Psychiatric illness in patients presenting for obesity treatment. *International Journal of Eating Disorders, 12,* 63-71.

Good, D.A. & Watts, F.N. (1996). Qualitative Research. In G. Parry & F. Watts (Eds.). Behavioural and mental health research: a handbook of skills and methods. Second edition. Erlbaum (UK) Taylor Francis.

Hill, A.J. (2001). Psychological consequences of obesity. *Meeting of the Association for the Study of Obesity, UK,* London, 29th March.

Hill, A.J. & Williams, J (1998). Psychological Health in a non-clinical sample of obese women. *International Journal of Obesity, 22(6),* 578-83.

Jebb, S. (1999). The weight of the Nation: obesity in the UK. *A report commissioned by the Bread for Life Campaign*, The Flour Advisory Bureau, London.

Jeffery, R.W., French, S.A. & Schmid, T.L. (1990). Attributions for dietary failures: problems reported by participants in the hypertension Prevention Trial. *Health Psychology, 9(3),* 315-329.

Kayman, S., Bruvold, W. & Stern, J.S. (1990). Maintenance and relapse after weight loss in women: behavioral aspects. *American Journal of Clinical Nutrition, 52,* 800-807.

Kirschenbaum, D.S. (1996). Helping physicians make useful recommendations about losing weight. In R.J. Resnick & R.H. Rozensky (eds.), *Health Psychology Through the Lifespan: Practice and Research Opportunities.* American Psychological Association, Washington DC.

Kirschenbaum, D.S., Fitzgibbon, M.L., Martino, S., Conviser, J.H., Rosendahl, E.H. & Laatch, L. (1992). Stages of change in successful weight control: a clinically derived model. *Behavior Therapy, 23,* 623-635.

Kolotkin, R.L., Head, S., Hamilton, M. & Tse, C.K. (1995). Assessing impact of weight on quality of life. *Obesity Research, 3(1),* 49-56.

Kral, G.J. (1998). Surgical treatment of obesity. In: G.A. Bray, C. Bouchard & W.P.T. James (Eds.). *Handbook of Obesity* (pp. 977-993). New York: Marcel Dekker.

Marlatt, G.A. & George, W.H. (1984). Relapse prevention: introduction and overview of the model. *British Journal of Addictions, 79,* 261-273.

Miller, C.T. & Downey, K.T. (1999). A meta-analysis of heavyweight and self-esteem. *Personality and Social Psychology Review, 3(1),* 68-84.

Morris, S. (2001). Costs of treatment of obesity. *Meeting of the Association for the Study of Obesity, UK,* London, 29th March.

Myers, A. & Rosen, J.C. (1999). Obesity stigmatisation and coping: relation to mental health symptoms, body image, and self-esteem. *International Journal of Obesity, 23,* 221-230.

O'Connell, D. & Velicer, W.F. (1988). A decisional balance measure for the stages of change model for weight loss. *The International Journal of the Addictions, 23(7),* 729-750.

Prentice, A.M. & Jebb, S.A. (1995). Obesity in Britain. *British Medical Journal, 3111,* 1568-1569.

Prochaska, J.O., DiClemente, C.C. & Norcross, J.C. (1992). In search of how people change: applications to addictive behaviours. *American Psychologist, 47,* 1102-1114.

Rand, C.W. & MacGregor, A.M.C. (1990). Morbidly obese patients' perceptions of social discrimination before and after surgery for obesity. *Southern Medical Journal, 83,* 1391-1395.

Richman, R.M., Loughnan, G.T., Droulers, A.M., Steinbeck, K.S. & Caterson, I.D. (2001). Self-efficacy in relation to eating behaviour among obese and non-obese women. *International Journal of Obesity and Related Metabolic Disorders, 25(6),* 907-913.

Rodin, M. Price, J., Sanchez, F. & McElligot, S. (1989). Derogation, exclusion and unfair treatment of persons with social flaws: controllability of stigma and the attribution of prejudice. *Personality and Social Psychology Bulletin, 15,* 439-451.

Royal College of Physicians (1998). *Clinical Management of Overweight and Obese Patients*. London: The Royal College of Physicians of London.

Seligman, M.E.P. (1975). *Helplessness: on depression, development, and death.* New York: Freeman.

Smith, J.A., Flowers, P. & Osborn, M. (1997). Interpretative Phenomenological analysis and the psychology of health any illness. In: L. Yardley (Ed.), *Material Discourses of Health and Illness*. Routledge.

Sternberg, B. (1985). Relapse in weight control: definitions, processes, and prevention strategies. In G. A. Marlatt & J. R. Gordon (Eds.), *Relapse prevention: maintenance strategies in the treatment of addictive behaviors*. The Guildford Press, London.

Strauss, A. & Corbin, J. (1998). *Basics of qualitative research: techniques and procedures for developing grounded theory (second edition)*. Sage. London.

Stunkard, A.J. & Wadden, T.A. (1992). Psychological aspects of severe obesity. *American Journal of Clinical Nutrition, 55,* 524S-532S.

Sullivan, M., Karlsson, J., Sjostrom, L., Backman, L., Bengtsson, C., Bouchard, C., Dahlgren, S., Jonsson, E., Larsson, B., Lindstedt, S., Naslund, I., Olbe, W. & Wedel, H. (1993). Swedish Obese Subjects (SOS) – an intervention study of obesity: baseline evaluation of health in the first 1743 subjects examined. *International Journal of Obesity, 17,* 503-512.

Sweet, J. J., Rozensky, R. H. & Tovian, S. M. (Eds.) (1991). *Handbook of clinical psychology in medical settings.* New York: Plenum.

Tremblay, A, Doucet, E, Imbeault, P, Mauriege, P, Despres, J.-P. and Richard, D. (1999). Metabolic fitness in active reduced-obese individuals. *Obesity Research, 7,* 556-563.

Wadden, T.A.& Stunkard, A.J. (1987). Psychopathology and obesity. *Annals of the New York Academy of Science, 499,* 55-65.

Walsh Pierce, J. & Wardle, J. (1997). Cause and effect beliefs and self-esteem of overweight children. *Journal of Child Psychology and Psychiatry, 38(6),* 645-650.

Wardle, J. (1994). Disorders of eating and weight: treatment. In S. J. E. Lindsay & G.E. Powell (Eds.), *The handbook of clinical adult psychology (second edition).* Routledge: London.

Wing, R.R. (1998). Behavioral approaches to the treatment of obesity. In G.A. Bray, C. Bouchard, and W.P.T. James (Eds.) *Handbook of Obesity* (pp. 855-873). New York: Marcel Dekker.

Wing, R.R. & Jeffery, R.W. (1995). Effect of modest weight loss on changes in cardiovascular risk factors: are there differences between men and women or between weight loss and maintenance? *International Journal of Obesity, 19,* 67-73.

World Health Organisation (1997). *Obesity: preventing and managing the global epidemic*. Geneva: WHO.

Appendix A

A summary of a cognitive behavioural analysis of patients' approaches to obesity treatment (Cooper and Fairburn, 2001)

Cooper and Fairburn observed that an important factor in determining patients' weight loss goals (usually 20-30% of initial weight) is the belief that other personally salient objectives (termed "primary goals") cannot be achieved without the desired weight loss. These primary goals include a desire to change body shape, to improve appearance, to feel more attractive, to be able to wear more fashionable and flattering clothes and to improve self-confidence and self-respect. Patients do not usually appreciate that their primary goals are only loosely related to weight loss. Some primary goals require only modest weight loss (e.g. certain health goals), some are achieved only to a moderate extent by weight loss (e.g. modifying body shape) and some do not necessarily require any weight loss (e.g. improving self-confidence or interpersonal relationships). After about five to ten percent of initial weight is lost patients usually experience a demoralising decline in the weight loss rate. Concurrently they find that few of their primary goals being met by the weight loss. At this stage there is a tendency for patients to underestimate the significance of the weight lost and the associated positive changes (e.g. increased agility and fitness, reduction in clothes size) and to focus on the weight still to be lost. Some people then abandon their attempts at weight control because they believe their desired weight to be unattainable and further efforts and deprivation are not worthwhile. Others continue to believe that they can lose more weight and thereby achieve their primary goals but, because it is difficult to maintain high levels of dietary restraint, experience lapses. These are interpreted as lack of self-discipline and the person may come to doubt their ability to achieve their targets and give up weight control attempts. They undervalue what they have achieved and do not see their weight as controllable to any worthwhile extent. They therefore do not acquire weight maintenance skills and return to previous habits, regaining the lost weight.

Appendix B

Instructions to authors for submission to the British Journal of Health Psychology

NOTES FOR CONTRIBUTORS

1 The aim of the *British Journal of Health Psychology* is to provide a forum for high quality research relating to health and illness. The scope of the Journal includes all areas of health psychology across the life span, ranging from experimental and clinical research on aetiology and the management of acute and chronic illness, responses to ill-health, screening and medical procedures, to research on health behaviour and psychological aspects of prevention. Research carried out at the individual, group and community levels is welcome, and submissions concerning clinical applications and interventions are particularly encouraged.

The following types of paper are invited:

(a) Papers reporting original empirical investigations

(b) Theoretical papers which may be analyses or commentaries on established theories in health psychology, or presentations of theoretical innovations

(c) Review papers, which should aim to provide systematic overviews, evaluations and interpretations of research in a given field of health psychology

(d) Methodological papers dealing with methodological issues of particular relevance to health psychology.

2 The Journal is international in its authors and readers. Contributors should bear the international readership in mind, particularly when referring to specific health services.

3. Pressure on Journal space is considerable and brevity is requested. Papers should normally be no more than 5000 words.

4. Supplementary data too extensive for publication may also be deposited with the British Library Document Supply Centre. Such material should be submitted to the Editors together with the article for simultaneous refereeing. Further details of the scheme are given in the *Bulletin of the British Psychological Society*, 1977, **30**, February, p. 58.

5. This Journal operates a policy of blind peer review. Papers will normally be scrutinized and commented on by at least two independent expert referees as well as by an editor or associate editor. The referees will not be made aware of the identity of the author. All information about authorship, including personal acknowledgements and institutional affiliations should be confined to a removable front page (and the text should be free of such clues as identifiable self-citations ('In our earlier work...').) The paper's title should be repeated on the first page of text.

6. The editors will reject papers which evidence discriminatory, unethical or unprofessional practices.

7. Submission of a paper implies that it has neither been published elsewhere nor is under consideration by another journal.

8. In preparing material for submission authors should follow these guidelines:

(a) Contributions must be typed in double spacing with wide margins and on only one side of each sheet. Sheets must be numbered. Four good copies of the manuscript should be submitted and a copy should be retained by the author.

(b) Tables should be typed in double spacing, each on a separate sheet of paper. Each should have a self-explanatory title and be comprehensible without reference to the text.

(c) Figures are usually produced direct from authors' originals and should be presented as good black and white images preferably on high contrast glossy paper, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns or lines and shading should be avoided. Captions should be listed on a separate sheet.

(d) The Editors propose to adopt structured abstracts and all articles should be preceded by a structured abstract of between 100 and 250 words (less in the case of a short paper), giving a concise statement of the intention and results or conclusions of the article. Authors requiring further details on structured abstracts should contact the Journals Department (details on inside front cover).

(e) Bibliographic references in the text should quote the author's name and the date of publication thus: Hunt (1995). Multiple citations should be given alphabetically rather than chronologically: (Blackburn, 1996; Fortheringhame, 1994; Norman, 1995). If a work has two authors, cite both names in the text throughout: Choi and Salmon (1995). In the case of reference to five authors, use all the names on the first mention and *et al.* thereafter except in the reference list. For six or more, use *et al.* throughout.

(f) References cited in the text must appear in the list at the end of the article. The list should be typed double spaced in the following format:

Hunter, M. (1994). *Counselling in obstetrics and gynaecology*. Leicester: The British Psychological Society.

Pruitt, S.D., & Elliott, C.H. (1989). Paediatric procedures. In M. Johnstone & L. Wallace (Eds.), *Stress and medical procedures* (pp. 157–174). Oxford: Oxford University Press.

Ray, C., Phillips, L., & Weir, W.R.C. (1993). Quality of attention in chronic fatigue syndrome: Subjective reports of everyday attention and cognitive difficulty, and performance on tasks of focused attention. *British Journal of Clinical Psychology*, *32*, 357–364.

Note that journal titles are cited without abbreviation.

(h) Measurements should be in units of the International System.

(i) If the title of the article is longer than 80 characters, a short title should be provided for use as a running head.

(j) Footnotes are expensive to set and should be avoided.

(9) Proofs are sent to the corresponding author for correction of print but not for rewriting or the introduction of new material. Fifty complimentary copies of each paper are supplied to the corresponding author, but further copies may be ordered on a form supplied with the proofs.

(10) Authors should consult the Journal editor concerning prior publication in any form or in any language of all or part of their article.

(11) To protect authors and journals against unauthorized reproduction of articles, The British Psychological Society requires copyright to be assigned to itself as publisher, on the express condition that authors may use their own material at any time without permission. On acceptance of a paper submitted to the Journal, authors will be requested to sign an appropriate assignment of copyright form.

Research Paper

Women's experience of obesity: an interpretative phenomenological analysis.

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To be submitted to the British Journal of Health Psychology

Women's experience of obesity: an interpretative phenomenological analysis.

Objective. This study aimed to explore the experience of obesity through eliciting and analysing personal accounts of obese women.

Method. A community sample of seven women with obesity were interviewed about their experiences of obesity and beliefs about weight control. Transcripts of the accounts were subjected to qualitative analysis, specifically Interpretative Phenomenological Analysis, to elucidate the participants' perspectives through an interpretative process.

Results. Throughout their accounts participants presented their understanding of how they had come to be and remain in their situation. Overtly participants expressed the view, resonant of the cultural view, that weight is under the individual's control. However, more implicitly participants indicated that, for various reasons, weight control was not currently possible for themselves. Being big and beliefs about why they were big sometimes had very negative personal meanings for participants and was associated with emotional distress. Interestingly, participants described a number of processes that appeared to mediate between being big and its impact, including not thinking of themselves as big, viewing size as a relatively minor part of their lives, and drawing favourable comparisons between themselves with others and with previous selves.

Conclusions. This paper presented an analysis of the accounts of a group of obese women about the causes of their condition and the extent to which they could control it. It revealed some mechanisms by which the psychological impact of being big may be attenuated.

Keywords: Obesity, qualitative, Interpretative Phenomenological Analysis

There are well-established links between obesity and increased morbidity and mortality, which place considerable economic burden on the health service (costs of treatment of obesity and obesity-related diseases estimated at £480million in England in 1998; Morris, 2001). There may also be costs to the individual due to reduced quality of life (Kolotkin, Head, Hamilton & Tse, 1995). Furthermore, obesity is stigmatised in Western culture and obese people are likely to experience prejudice and discrimination (e.g. Rand & MacGregor, 1990). Obese people are seen as 'to blame' for their condition as weight is culturally viewed as under the individual's control (Rodin, Price, Sanchez & McElligot, 1989).

Despite these costs the prevalence of obesity has increased rapidly: between 1980 and 1996 it more than doubled, having risen to 16% in men and 18% in women (British Nutrition Foundation, 1999). Obesity arises when energy intake exceeds energy expenditure. It is widely agreed that energy imbalance occurs because the current environment facilitates overconsumption and sedentary behaviours which undermine the appetite control system (Blundell, 2001). Research suggests that the public understands the lifestyle changes necessary to controlling their weight (British Nutrition Foundation, 1999), but the increasing prevalence suggests that few people consistently engage in the necessary behaviour. Understanding this apparent failure is crucial to tackling the problem of obesity.

Evidence-based non-surgical treatments (pharmacotherapy and behavioural approaches) usually bring about modest weight loss in those who comply, and this has beneficial effects on health indices (e.g. Tremblay et al., 1999). However, weight is usually

regained after treatment and weight loss maintenance remains an important challenge. Although often approached as a predominantly medical issue, a greater application of psychological principles may be useful in improving treatment strategies (Kirschenbaum, 1996). A review of the literature (Delargy, 2002) highlighted some of the psychological processes that might be targets for intervention, but suggested that there has been relatively little research into these psychological processes and related interventions. Specifically, some areas that warrant further investigation are the role of cognitions such as attribution of cause and controllability of overweight, self-efficacy, and factors that may protect obese people against psychological suffering. Furthermore, although it has been acknowledged that individual psychological factors play an important role in the development and treatment of obesity (British Nutrition Foundation, 1999; Jebb, 1999), there have been few attempts to understand the individual's representation of their condition. In health psychology the degree to which individuals consider their bodily state to be important is a central premise, as individuals' reflections and beliefs about their situation may affect recovery or coping with their illness. A qualitative research approach can enrich the way mainstream psychology conceives the individual's experience of their health status (Strauss & Corbin, 1998).

The potential utility of applying qualitative approaches was illustrated by a paper which presented a cognitive-behavioural analysis of patients' experience of weight control (Cooper & Fairburn, 2001). This analysis represented the authors' organisation of their interpretations of clinical observations of their patients' views of their situation, a format commensurate with the ideology of some qualitative approaches. Rich

information emerged relating to patients' beliefs, motivators, emotions and cognitions related to weight loss and regain which was clearly relevant to designing future intervention strategies. Two other studies used semi-qualitative approaches and provided information about obese people's beliefs about how they had come to be overweight, about strategies that were helpful and suggested an important role for feelings of control over weight (Colvin & Olsen, 1983; Kayman, Bruvold & Stern, 1990). However, these studies treated the interview data quantitatively, limiting the richness of the information presented. Two further studies adopted more truly qualitative approaches (Adams, 1998; Blackburn, 1996), and provided more in-depth information about psychological processes experienced by obese women, such as beliefs about themselves and their situation, the emotional impact of their situation and the effects of these on weight loss attempts. Potential barriers to weight loss and maintenance were identified, such as feelings of low self-efficacy due to repeated relapse experiences, and there were implications for future intervention strategies.

A qualitative approach that lends itself particularly well to health psychology, is Interpretative Phenomenological Analysis (I.P.A.). This approach attempts to explore participants' views of the world, to get an 'insider's perspective', by allowing the person to tell their own story about the topic under investigation. It aims to discover meaning of the person's health condition to them rather than establish facts and is in this sense is phenomenological. However this approach also acknowledges that eliciting meaning from participant's accounts requires considerable interpretative work on the part of the researcher. Thus the finished analytic account can be said to represent the joint reflection of participant and researcher.

The present paper presents an interpretative phenomenological analysis of interviews with seven women with obesity. The study aimed to throw light upon the subjective experiences and beliefs of these women with respect to their size. Specifically it attempted to elicit the women's personal accounts of being their size and investigate their beliefs about weight control.

One methodological shortcoming highlighted in an important review of the literature on research into psychological issues in obesity (Friedman & Brownell, 1995) was an over-representation of clinical samples (i.e. obese people presenting for treatment). Only a minority of obese people seek treatment (Brownell, 1993) and those who seek treatment differ from those who do not (Fitzgibbon, Stolley & Kirschenbaum, 1993), and so are likely to be unrepresentative of the general obese population. Most obese people live with the condition without seeking treatment, and a shift toward community-based sampling has been advocated (Friedman & Brownell, 1995; Hill & Williams, 1998). A non-clinical sample was therefore recruited in the present study.

Method

Recruitment

Participants were recruited from communities in North Wales and England. In order to increase homogeneity of the sample only women were recruited. Numerous sex differences have been reported in relation to obesity, including on psychological outcomes (Carpenter et al., 2000) and reasons given for weight gain (Cachelin, Streigel-Moore & Brownell, 1998). Potential participants were recruited through one of two methods. A list (held by the School of Psychology at the University) of members of the local community who had previously registered an interest in taking part in research was used. In addition recruitment posters were displayed in public places around the communities. Women who expressed an interest in taking part were sent further details and a questionnaire to assess their suitability. Those women who met the following criteria were invited to participate: they were aged between 18 and 65 years; they were obese (Body Mass Index (B.M.I.) > $30kg/m^2$) according to self-reported weight and height; rated themselves to be in average or good health; and stated that they were not currently, or had not recently, been receiving treatment for a major health problem, an eating disorder or a mental health problem.

One-hundred-and-seventeen women from the community list were contacted either by telephone, e-mail or letter, and informed about the study. Nineteen women expressed an interest in taking part and were sent further details. Of those who returned questionnaires (sixteen) three met criteria for inclusion in the study (most of those who did not were not heavy enough). Eight women who saw recruitment posters contacted the researcher, and of these, four met inclusion criteria. All seven women who met

criteria were invited to take part and completed the study. This sample size was deemed sufficient as the analysis approach employed requires that the number of participants be small enough that the researcher can retain an overall mental picture of each individual case and the location of themes within them (1-10 cases is recommended, Smith, Jarman & Osborn, 1999).

Data collection

Participants were interviewed alone at a time and place convenient to themselves. A semi-structured interview was compiled according to the guidelines of Smith (1995) which aimed to facilitate participants in talking about their experiences using open-ended questioning, allowing some flexibility in the topics covered. However if participants did not mention a topic thought to be important by the researcher more specific questioning was used to encourage consideration of the topic. The interview consisted of questions relating to participants' weight history, eliciting their beliefs about weight control, and effects of their size on their personal and social experiences. The term 'overweight' was used throughout recruitment and data collection as it was felt that use of the stigmatised term 'obese' could distress participants. Participants' weights and heights were measured (using portable scales and measuring stick) prior to interview to ascertain their B.M.I.. Demographic details are outlined in Table 1.

Table1. Demographic details of participants

B.M.I.s ranged from 30.3 to 43.4kg/m^2 (Mean = 34kg/m^2, Median = 32kg/m^2): six participants' B.M.I.s fell within the World Health Organisation (1997) classification of Obese (30.0-39.9kg/m^2) and one within the classification of Morbidly Obese (>40kg/m^2). Three participants were currently at their highest weight, three had previously been slightly heavier and one had been substantially heavier. Participants were aged between 40 and 59 years (Mean = 51 years), were Caucasian and had lived predominantly in the UK. Five participants were married or in long-term relationships, two were divorced. One participant was registered disabled due to a problem unrelated to her weight but was able to walk with aids.

Data analysis

The interviews lasted from between 40 and 100 minutes. Verbatim transcripts of the interviews served as the data for analysis. Transcripts varied in length from 3,900 to 8,900 words (Median = 5,770, Total = 44,400). Analysis was carried out by the investigator, although emergent themes were discussed with two colleagues familiar with I.P.A. who had examined several transcripts as a credibility check. An ideographic, case-study approach was adopted (described by Smith, Jarman & Osborn, 1999) and detailed in Table 2.

Table 2. Description of the analytic process

Initially the first transcript was examined and preliminary observations were noted in one margin. These comprised summaries or preliminary interpretations of the account, highlighted important or interesting extracts or described associations. Following this a preliminary list of emergent themes was drawn up through an iterative process, involving numerous re-readings of the transcript, and incidences of these themes were noted in the other margin. This entire process was repeated for each consecutive transcript. After this stage the lists from the whole sample were read together and a consolidated master list of themes was constructed, organised coherently under superordinate themes (themes that act as a 'magnet' for other themes). All interviews were then examined for incidences of these themes and they were further developed in a cyclical process. When a final draft of the master list of themes had been constructed, all relevant quotations were arranged under each theme to check that the theme titles and list appeared to represent accurate descriptions of what the participants had actually said. (A more detailed description is given in Appendix B.)

Analysis

Four super-ordinate themes emerged (detailed in Table 3). The most pervasive, 'Explanatory Models', articulated participants' attempts to understand their condition and set the scene for subsequent themes relating to beliefs about the controllability of weight, the personal implications of being obese and processes that appeared to mediate between being obese and its impact on the individual.

1. Explanatory models

Participants frequently presented models that served to explain how they had come to be overweight and why they did not lose weight. They gave poor eating habits and lack of exercise as key factors in the aetiology and maintenance of overweight. They described numerous barriers to changing eating and exercise habits. For example, leading a busy lifestyle was seen to get in the way of planning meals, taking time to buy appropriate food and exercising. Participants gave emotional reasons for overeating, saying that they really enjoyed food and eating and that it brought about feelings of comfort and well-being. For example,

Table 3. Description of emergent themes

1. Explanatory Models: represents attempts to understand their condition. Participants presented and searched for explanations for how they had come to be overweight, why they remained overweight, and searched for solutions.

Reasons for weight gain and maintenance	• Eating habits: eat too much, eat wrong food • Lack of exercise • Physiological/hormonal reasons: heredity, menopause, slow metabolism and particularly pregnancy
Reasons for poor eating and exercise habits	• Lifestyle constraints: aspects of the participant's lifestyles were seen to get in the way of weight control: participants felt they were too busy to plan meals, buy and prepare appropriate food and take exercise. The eating habits of people around them affected their own eating habits (e.g. treats in house for children) and a preponderance of food in the environment promoted overconsumption (e.g. work around food). Bad habits were established early in life and were therefore difficult to change. Exercise was said to be difficult due to disability, disease or injury or physically unpleasant due to excess weight (e.g. excessive breathlessness) and emotionally unpleasant due to reluctance to be seen exercising in public due to concern about what others think of them. • Emotions associated with food and eating: participants said they enjoyed food and eating, that it represented a way to treat oneself and brought about feelings of comfort and well-being. Not eating represented denying oneself something and participants felt reluctant to do this. Food could be used to alleviate feeling despondent about failed dieting and dissatisfaction with personal appearance. Boredom was described as a common precursor to overeating. Periods of weight gain were linked with emotional periods of participants' lives, although this could be both happy and relaxed or upsetting and stressful times. • Personal characteristics and failings: participants felt they were big due to their personal failings such as lack of self-control, will-power or self-esteem, inability to motivate oneself, being too lazy to make the required effort and changes, and greed. They drew attention to, and were puzzled by, the apparent paradox that they knew how to and wanted to lose weight but did not achieve it. • High costs of losing weight and staying slim: participants believed that dieting was not a helpful long-term strategy, linking it with eating disorders and weight regain (the "yo-yo" phenomenon). Weight loss was seen

to necessitate making lifelong lifestyle changes. Achieving and maintaining weight loss were believed to result in becoming obsessed with food or weight. Financial costs of healthy food and weight loss groups and aids were also prohibitive.

2. Beliefs about the controllability of weight

Weight can be controlled	• Explicitly participants indicated that they believed weight control to be possible.
Weight control is not currently possible or desirable for me	• However, weight control was only possible if one was sufficiently motivated, had sufficient self-control, and was prepared to pay the costs associated with weight loss and maintenance. • More implicitly participants indicated that they were unable to control their weight at present due to reasons presented under the 'explanatory models' heading (i.e. lifestyle constraints, personal failings, unwilling to pay the costs of weight loss and maintenance). These explanatory models were not viewed as being subject to the individual's control.

3. Personal meaning of being big: implications of being big on self-concept and emotions

Implications for self	• Being big was seen to indicate some very negative personal characteristics including lack of self-control, determination, will-power, and self-esteem, laziness (being too lazy to motivate oneself to lose weight or to make the necessary lifestyle changes), greediness, and deceitfulness. • Participants reported having lower self-confidence, being concerned that others must see them as greedy, lazy and lacking in self-esteem and having less confidence in their own physical competence. • For some being big was part of who they were. For others being big clashed with their sense of identity.

Emotional impact	• Being big could engender negative emotions, including feelings of self-blame, guilt, and shame related to size and eating. When confronted with their size (e.g. through seeing reflections or photographs of themselves, through trying on clothes or finding daily activities more difficult) participants described experiencing shock, displeasure, disgust, shame, and despair. • Being slim was associated with feeling good, energetic and confident.
Physically unattractive	• Participants often referred to themselves as physically unattractive and this had implications for their sexual relationships.

4. Mediating processes: processes that appeared to mediate between being big and its impact on the person

Avoiding thinking of self as big	• Participants described not seeing themselves as big unless confronted by reminders or putting negative thoughts about their size out of their mind. Some described avoiding experiences that would force confrontation with size (e.g. seeing self in mirror).
Size as unimportant	• Participants talked about their size as though it were a relatively minor or unimportant aspect of their lives. Other aspects were seen as more important in determining how they think about themselves, such as self-acceptance through spirituality, personal achievements, achievements in the workplace, being valued by family and friends.
Negative personal meanings limited to weight and eating	• There was little evidence that negative personal meanings associated with being big were generalised to other aspects of participants' self-concept. Some felt that this aspect of themselves clashed with their view of themselves in other domains of their lives.
Comparison with others and previous selves	• Participants talked about other 'very big' people, about themselves as previously very big or about their previously 'bad' lifestyle habits. There was a sense that they were distancing themselves from the category 'very big' and from previous selves who were very big or responsible for their current size.

> *Eileen*[1]*:* it *(food)*[2] makes me feel secure, full and comforted, *(...)*[3] when I do things for people I like to make sure they're full and comforted and have had enough to eat and all that and that's probably my way of looking after something. Perhaps I'm looking after me by making myself feel like that.

Personal failings, such as lack of self-control and an inability to motivate oneself, were given as reasons for being big. Interestingly some participants drew attention to, and were puzzled by, the apparent paradox that they knew how to and wanted to lose weight but did not achieve it. All participants spoke of high costs of losing weight and staying slim, believing that lifelong lifestyle changes were necessary for weight control. However, there was a sense of the hugeness of the task of losing the amount of weight that they thought they should lose and the extent of the changes they would have to make to achieve this.

2. Beliefs about the controllability of weight

Implicit in the participants'explanatory models were indications of their beliefs about the controllability of weight. In addition, participants were asked explicitly whether they thought it was possible for people to control their weight. They indicated that they thought weight was largely controllable. For example Brenda replied

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[1] Pseudonyms used throughout

[2] Words in bracketed italics added by author to help the reader make sense of the quotation taken out of context

[3] Indicates that irrelevant material has been omitted

> Course it is, it's in everybody's hands isn't it? *(...)* it's a bit like an alcoholic or a gambler, its entirely up to you, its your choice, really.

Several participants had successfully lost weight in the past and this supported their view that weight control was possible. However, participants qualified this standpoint, stating that it was only possible if you really wanted to, if you had self-control or if you were prepared to pay the costs associated with weight loss and maintenance. Thus, whilst participants stated that they believed weight to be controllable, they believed that it was only possible provided certain conditions were met, and those conditions were not currently possible or desirable for themselves.

3. Personal meaning of being big

It was apparent that at times being big could have implications for individuals in terms of how they saw themselves and impacted on them emotionally. Being and staying big was seen to indicate negative personal characteristics such as lack of self-control, laziness and greed.

> *Daphne:* I'd like to be in control of it really and I know I'm not, I'm letting it go. In some ways I would… I'd like to be master of it.
> *Researcher: What difference would it make if you were master of it, as you say?*
> *Daphne:* I suppose it'd make me feel that I wasn't… that I'm not weak. I don't like to think that I'm weak but I suppose I am really, if I can't say "no" to a Mars Bar.

Participants described experiencing some degree of shock and negative emotions when forced to confront their size by experiences such as trying on clothes or seeing photographs or reflections of themselves. Some described feeling guilty, ashamed of their size and eating. Being big had implications for self-confidence in terms of concerns about what others thought of them and what they were physically capable of. Being slim, losing or maintaining weight were associated with feeling good physically and emotionally, and these were given as major reasons for wanting to lose weight.

4. Mediating processes

Participants described a number of processes that appeared to mediate between the person's size and the impact that this had on them. Several described chains of events that led from the experience of being confronted with their size to its impact on them. For example,

> *Cath:* I may not even think I'm overweight in my mind without seeing myself. *(...)* I don't think I'm thin or anything but *(...)* it's a shock to me sometimes to see I'm a bit overweight. Then I think "oh I'd like to lose weight" you know, I know I'd look smarter and I'm sure I'd feel better about myself. But I haven't… you know I don't think I've got what it takes

Thus, for Cath the experience of being confronted with her size resulted in her feeling shocked, wishing she could lose weight but doubting her ability to achieve it. Another participant described being reminded of her lack of self-control and culpability for her

size when seeing herself in the mirror. Participants described a number of strategies that appeared to be used to either avoid or cope with these feelings.

4.1. Avoiding thinking of self as big

Participants described not thinking of themselves as big. This may have involved having a mental representation of themselves as slimmer than they appeared to themselves in reality or just not thinking about their body size.

> *Daphne:* if I didn't see myself in the mirror I probably wouldn't think I was this big, do you know what I mean?

Others described putting negative thoughts about their size out of their mind to avoid associated emotions. Another strategy was to avoid things that forced them to confront their size.

> *Gina:* I still look at myself and think… that's interesting, I actually look at myself in the mirror. There was a time when I was… when I considered myself to be really fat where I was look… where I just avoided looking at myself.

Thus, by not thinking of themselves as big, participants may be able to avoid experiencing any negative emotional impact of their size for much of the time.

4.2. Size as unimportant

Many participants talked about size as a relatively minor and unimportant part of their lives or about it being important in some respects but not in others. All mentioned it as having an impact on their day-to-day quality of life in terms of feeling less energetic, being less agile, worrying about fitting into things such as seats, seatbelts or turnstiles, and having little choice of clothes. However, when considering the overall impact that their size had made on their lives, most felt that it had not had a significant impact and that things would not be much different if they had been lighter.

Participants described other aspects of their lives as being far more important than their size in determining how they thought about themselves. Freda described how self-acceptance, gained through her spirituality, enabled her to minimise the impact of negative comments made about her size. Others described how they had gained self-esteem through getting older, their achievements, being good at their work or being valued by people close to them. Participants described just getting on with things despite their weight. Brenda said:

> at my age I've just thought "right, this is me and if you don't like me to hell with it". You know you can lose weight if you've got the self-control and I haven't so fine, you've just got to live with it. But when I was younger obviously it affects you more doesn't it but as you grow older you just think "well I'm running out of time so I don't really care, I'll just get on with everything".

4.3. Negative personal meanings limited to weight and eating

As already described, being big had negative personal implications such as indicating lack of will-power, greed and laziness. However, there was little evidence that this feeling generalised beyond issues related to weight control and eating. Indeed some noted that these negative personal meanings clashed with their view of themselves in other domains of their lives.

> *Gina*: being overweight means a lack of control and a lack of self-discipline. I like to think of myself as a person who's self-disciplined so therefore I've got this aspect of myself to do with my weight which is nothing… which is almost contrary to the other parts of my… what I consider to be my nature.

4.4. Comparison with others and previous selves

Participants occasionally made references to 'really big people'. Such downward comparisons could have the effect of making participants feel their size was not a problem

> *Cath:* I mean looking around I see very fat people *(...)* and I think "well I'm not that fat, I'm really quite thin" *(...)* Amongst fairly fat people or a mixture you feel "well, I haven't got a problem".

However for others seeing 'really big' people could introduce worries about becoming that big themselves.

Participants also described their current efforts to lose or maintain weight. There was a sense of distancing the current self from the self that was responsible for gaining weight.

> *Cath:* I think now I'm not an irrational eater but in the years past *(...)* what I am is probably not what I'm eating now, it's what I've eat in the past

Discussion

Through encouraging participants to give their personal accounts of being big, this study attempted to throw light on their world in relation to obesity. Four inter-related super-ordinate themes emerged, the most pervasive of which was participants' attempts to understand how they had come to be and remain in their situation. The pervasiveness of this theme perhaps reflects the strength of participants' need to make sense of their situation, which has been observed in other participant groups (e.g. people with chronic back pain, Osborn & Smith, 1998). It also seemed to reflect a need to present an explanation of their condition to the researcher; participants wanted the researcher to know that they knew why they were overweight. The Explanatory Models revealed beliefs about the causes of weight gain and barriers to weight loss. Participants showed understanding of the principles of energy balance, indicating that they thought that they had gained weight predominantly through overeating and lack of exercise.

Participants' understanding of their situation set the scene for the rest of the analysis, providing the basis for their reflection on themselves in the situation. The issue of feeling in control over weight, or self-efficacy, has emerged in previous qualitative studies (Adams, 1998; Blackburn, 1996; Colvin & Olsen, 1983; Kayman, Bruvold & Stern, 1990) and seems to be key to whether individual engage in weight control behaviour. Participants indicated that they believed that they ought to be able to control their weight, perhaps due to having internalised the cultural view that weight is under individuals' control. However, they also believed that they could not currently control their weight. Two patterns of attribution for this failure were identified. One response was for participants to infer that they must have personal weaknesses; being big was

seen to indicate lacking self-control, being greedy and lazy, and make participants feel to blame and guilty about their weight and worry about what others might think of them. This is commensurate with Sternberg's (1985) premise that dieters attribute dietary transgressions to internalised constructs rather than lack of strategies for coping with high-risk situations. She also suggested that failed dieters change their cognitions about themselves in light of dissonance between self as controlled eater and self as failing to control eating, coming to see themselves as not the sort of person who can control their weight and who is destined to remain fat and therefore there is no point in trying to control food intake. The present study provided some evidence to support this as women did endorse this view of themselves at times. This attributional style has been associated with higher levels of psychopathology than a more external attributional style and may represent the mechanism by which internalising the cultural view that weight is controllable generates psychological distress (suggested by French & Schmid, 1990). The other response was to attribute weight control failure to external and uncontrollable factors (e.g. eating habits dependent on other household members, lifestyle too busy). This attributional style has been hypothesised to preserve self-esteem in the face of failure (deJong, Koomen & Mellenberg, 1988) and may fulfil this role in these women.

The most interesting collection of themes was the description of processes that appeared to mediate between being big and the impact of this on the individual: not thinking of themselves as big, viewing size as a relatively minor part of their lives, limiting negative meanings to discrete aspects of themselves and favourable self-comparisons with others and with other selves. Attributing weight-control failure to external

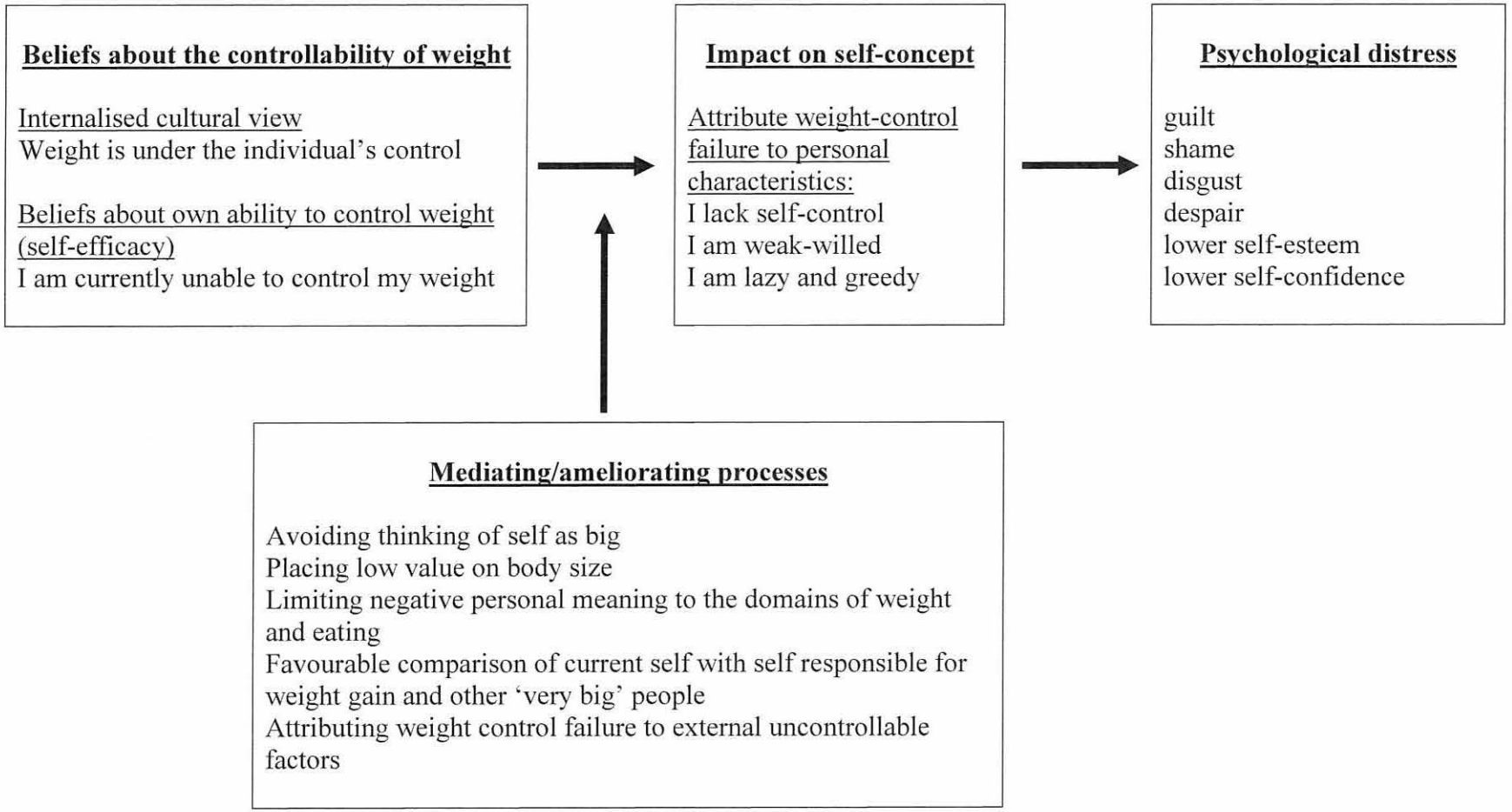
uncontrollable factors (as outlined above) may also fulfil this function. Early in the analysis this collection of themes was termed 'coping processes' but was renamed 'mediating processes', as participants did not describe themselves as using these strategies to manage a problem. Coping can be thought of as a buffer between challenge and stress, and can be conscious or unconscious (Salmon, 2000). Some participants were clearly distressed about their size at times and these processes may well represent conscious or unconscious attempts at emotion-focussed coping. For others it was less clear whether they saw their weight as a significant problem. If weight was not viewed as a significant challenge then mediates between being big and it's impact but does not represent an attempt to manage a problem.

Participants described how they derived self-esteem from different aspects of their lives such as through their work, spirituality, or family life. Self-esteem may be seen as a product of perceived competence in areas deemed personally (and culturally) important, together with the approval of significant others in one's life (Harter, 1993). People with eating disorders have been found to derive a large proportion of their self-esteem from their body shape and weight, and this is associated with increased psychopathology (Geller et al., 1998; Geller, Johnston & Madsen, 1997). Treatment approaches based on this finding have aimed to decrease the extent to which a person values themselves according to their weight and increase feeling of competence and worth in other domains. Similarly in deeming size as relatively unimportant in their lives and limiting negative meanings of size to narrow aspects of themselves, these participants may buffer against any negative impact of being big on self-esteem.

Figure 1 summarises the emergent themes and the possible inter-relationships between the themes discussed above.

Thus, several processes appeared to ameliorate the impact of being big. This may be seen as beneficial for the individual, protecting them from undue psychological distress related to their size. However, an alternative perspective comes from Acceptance and Commitment Therapy (A.C.T., Blackledge & Hayes, 2001). This is based on the premise that normal cognitive processes distort the experience of unpleasant emotions, leading clients to engage in problematic behaviours that avoid or attenuate those unpleasant emotions. The theory postulates that such avoidant behaviours can hinder clients' movement toward valued goals and place them in harmful situations. When applied to healthcare-seeking behaviour the theory suggests that avoidance behaviours that reduce discomfort decrease the likelihood of the individual taking the appropriate action to address their health problem, leading to worsening of the health situation. A.C.T. involves the individual experiencing the problematic emotions in the context of them no longer serving as obstructions to moving forward. In the present study the question arises as to whether these Mediating Processes actually serve to allow the obesity to be maintained or worsen through attenuating the emotional impact of being big. This is discussed further below.

Figure 1. Summary of emergent themes and proposed inter-relationships



Clinical implications

As a non-clinical sample, these women were likely to be more typical of the majority of obese women than a clinical sample. This study revealed cognitions of a group of obese women about themselves and their situation, its impact, and possible mediating processes. These phenomena relate directly to decision-making in terms of weight control attempts. This will have implications for those working clinically with obese people or those interested in understanding why many obese people consistently fail to take the necessary action to control their weight.

Although they saw overeating and lack of exercise as the main reasons for overweight, participants gave many and varied reasons for why they had engaged in these behaviours and why they found them difficult to change (e.g. from being too busy to being bored). The beliefs about weight control and lifestyle factors thought to contribute to overweight may vary considerably between individuals, and clinicians may need to assess individual cases in order to advise appropriately, as this will have implications for individuals' compliance and expectations of treatment. The cultural view, endorsed by participants, that weight is controllable appeared to conflict with their beliefs about their inability to control weight. This cultural view fails to acknowledge that weight loss may be very difficult for many people, as the appetite control system responds to negative energy balance through activating physiological and psychological mechanisms to restore energy balance. Educating about this and working on changing attributional style for weight control failure may help people to make their expectations of themselves more realistic and reduce their experiences of failure. Participants showed very low self-efficacy with respect to their current ability

to control weight, likely due to repeated failure to lose weight and maintain lost weight, and this may be a significant barrier to taking weight control action which will need to be considered by clinicians.

Interestingly this study elucidated mechanisms by which people manage to live with obesity without feeling bad all the time ('Mediating Processes'). Clinicians need to be aware of such processes for two reasons. Although it may be unrealistic for many people to achieve culturally approved slimness, moderate weight loss (i.e. up to 10% of initial body weight) of benefit to health may be a realistic goal for many. In the context of helping people to maintain good self-esteem whilst remaining overweight, awareness of the identified Mediating Processes may inform therapeutic strategies. For example, in a similar way to the approach described above for people with eating disorders, increasing emphasis on other aspects of patients' lives or on health and fitness rather than body size in their self-evaluation may be beneficial. It is worth noting that, as found by others (Smith, Flowers & Osborn, 1997), downward comparisons with others 'worse off' than themselves was always not a useful coping strategy, as it promoted fear in some.

In the context of helping people to control their weight, Mediating Processes as possible obstructions to positive change must also be considered. A.C.T. theory would suggest that the mediating cognitive and behavioural process, in reducing distress, reduce the likelihood of the person being able to control their weight, and hence lead to maintaining or worsening the obesity. In the present study there was no evidence to discredit this hypothesis. This finding may shed light on why so many people live with

obesity without significant levels of psychological suffering and without losing weight in a society that stigmatises fatness. A psychodynamic interpretation of the Mediating Processes is that they facilitate denial of the problem. Therapeutic confrontation of denial may be important in motivating people to take initial steps toward change.

Study limitations and future research

This study permitted several women with obesity to express their experiences and presented of an analytic exploration of their views. However, the study had several limitations. Despite attempts to check the credibility of the interpretations, analysis of the narratives necessarily involved interpretative work by the researcher. Furthermore, a very small number of women were interviewed, the majority of whom were only moderately obese, and whom had volunteered to participate and talk about their experiences. Thus no claims can be made about the representativeness of the sample. Further qualitative research of these issues is warranted to allow different groups of participants' accounts to be examined through the analytic work of different researchers. A particular finding of this work that warrants further investigation relates to the functions of Mediating Processes. Although possibly protective against psychological distress, these processes may act as significant barriers to people engaging in weight control behaviour and improving their health status. Prospective methodology would be useful in examining changes in cognitive processes as a person moves through stages of change and takes weight control action. In particular, what relationship do changes to the use/experience of mediating strategies have to the decision to take action?

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References

Adams, P.M. (1998). Taking charge of one's life: a theoretical model for weight management success. *Dissertation Abstracts International: section B: The Sciences & Engineering, 58(12-B),* 6483. Univ. Microfilms International, US.

Blackburn, A.L. (1996). Self-efficacy and learned helplessness as determinants of relapse in the obese population. *Dissertation Abstracts International: section B: The Sciences & Engineering, 57(5-B),* 3401. Univ. Microfilms International, US.

Blackledge, J.T. & Hayes, S.C. (2001). Emotion regulation in acceptance and commitment therapy. *Journal of Clinical Psychology/in session, 57(2)*, 243-255.

Blundell, J.E. (2001). Obesity: adaptation failure in a technological world – appetite control. *Meeting of the Association for the Study of Obesity 'Tackling obesity in tomorrow's world'*, London 17th July.

British Nutrition Foundation (1999). *Obesity: Report of the British Nutrition Foundation Task Force.* Blackwell Science Ltd., London.

Brownell, K.D. (1993). Whether Obesity should be treated (editorial). *Health Psychology, 12,* 339-341.

Cachelin, F.M., Streigel-Moore, R.H. & Brownell, K.D. (1998). Beliefs about weight gain and attitudes towards relapse in a sample of women and men with obesity. *Obesity Research, 6,* 231-237.

Carpenter, K.M., Hasin, D.S., Allison, D.B. & Faith D.S. (2000). Relationship between obesity and DSM-IV major depressive disorder, suicide ideation, and suicide attempts: results from a general population study. *American Journal of Public Health, 90,* 251-257.

Colvin, R.H. & Olsen, S.B. (1983). A descriptive analysis of men and women who have lost significant weight and are highly successful at maintaining the loss. *Addicitve Behaviors, 8,* 287-295.

Cooper, Z. & Fairburn, C.G. (2001). A new cognitive behavioural approach to the treatment of obesity. *Behaviour Research and Therapy, 37(1),* 499-511.

Delargy, H.J. (2002). Psychological aspects of obesity: can qualitative approaches to research increase understanding and inform practice? In *Women's experience of obesity: an interpretative phenomenological analysis.* DClinPsy Thesis, University of Wales, Bangor.

deJong, P., Koomen, W. & Mellenberg, G. (1988). Structure of causes for success and failure: a multidimensional scaling analysis of preference judgements. *Journal of Personality and Social Psychology, 55,* 718-725.

Fitzgibbon, M.L., Stolley, M.R. & Kirschenbaum, D.S. (1993). Obese people who seek treatment have different characteristics than those who do not seek treatment. *Health Psychology, 12(5),* 342-345.

Friedman, M.A. & Brownell, K.D. (1995). Psychological correlates of obesity: moving to the next research generation. *Psychological Bulletin, 117*, 3-20.

Geller, J., Johnston, C. & Madsen, K. (1997). A new measure of the role of shape and weight in self-concept: the shape and weight based self-esteem inventory. *Cognitive Therapy and Research, 21,* 5-24.

Geller, J., Johnston, C., Madsen, K., Goldner, E., Remick, R. & Laird Birmingham, C. (1998). Shape and weight based self-esteem and the eating disorders. *International Journal of Eating Disorders, 24,* 285-298.

Harter, S. (1993). Causes and consequences of low self-esteem in children and adolescents. In: R.F. Baumeister (Ed.) *Self-esteem: the puzzle of low self-regard.* Plenum Press: New York, pp. 87-116.

Hill, A.J. & Williams, J. (1998). Psychological health in a non-clinical sample of obese women. *International Journal of Obesity, 22,* 578-583.

Jebb, S. (1999). The weight of the Nation: obesity in the UK. *A report commissioned by the Bread for Life Campaign*, The Flour Advisory Bureau, London.

Jeffery, R.W., French, S.A. & Schmid, T.L. (1990). Attributions for dietary failures: problems reported by participants in the hypertension Prevention Trial. *Health Psychology, 9(3),* 315-329.

Kayman, S., Bruvold, W. & Stern, J.S. (1990). Maintenance and relapse after weight loss in women: behavioral aspects. *American Journal of Clinical Nutrition, 52,* 800-807.

Kirschenbaum, D.S. (1996). Helping physicians make useful recommendations about losing weight. In R. J. Resnick & R. H. Rozensky (eds.), *Health Psychology Through the Lifespan: Practice and Research Opportunities.* American Psychological Association, Washington DC.

Kolotkin, R.L., Head, S., Hamilton, M. & Tse, C.K. (1995). Assessing impact of weight on quality of life. *Obesity Research, 3(1),* 49-56.

Morris, S. (2001). Costs of treatment of obesity. *Meeting of the Association for the Study of Obesity, UK,* London, 29th March.

Osborn, M. & Smith, J.A. (1998). The personal experience of chronic benign lower back pain: an interpretative phenomenological analysis. *British Journal of Health Psychology, 3,* 65-83.

Rand, C.W. & MacGregor, A.M.C. (1990). Morbidly obese patients' perceptions of social discrimination before and after surgery for obesity. *Southern Medical Journal, 83*, 1391-1395.

Rodin, M. Price, J., Sanchez, F. & McElligot, S. (1989). Derogation, exclusion and unfair treatment of persons with social flaws: controllability of stigma and the attribution of prejudice. *Personality and Social Psychology Bulletin, 15,* 439-451.

Salmon, P. (2000). *Psychology of medicine and surgery: a guide for psychologists, counsellors, nurses and doctors.* John Wiley & Sons, Chichester, England.

Smith, J. (1995). Semi-structured interviewing and qualitative analysis. In J.A. Smith, R. Harre, and L. Langenhove (Eds.), *Rethinking Methods in Psychology*, London: Sage (pp. 9-26).

Smith, J.A., Jarman, M. and Osborn, M. (1999). Doing interpretative phenomenological analysis. In: M. Murray and K. Chamberlain (Eds.), *Qualitative Health Psychology: theories and methods.* Sage. London (pp. 218-240).

Smith, J.A., Flowers, P. & Osborn, M (1997). Interpretative Phenomenological analysis and the psychology of health any illness. In: L. Yardley (Ed.), *Material discourses of health and illness*. Routledge (pp. 68-91).

Sternberg, B. (1985). Relapse in weight control: definitions, processes, and prevention strategies. In G.A. Marlatt & J.R. Gordon (Eds.), *Relapse prevention: maintenance strategies in the treatment of addictive behaviors*. The Guildford Press, London.

Strauss, A. & Corbin, J. (1998). *Basics of qualitative research: techniques and procedures for developing grounded theory (second edition)*. Sage. London.

Tremblay, A, Doucet, E, Imbeault, P, Mauriege, P, Despres, J.-P. & Richard, D. (1999). Metabolic fitness in active reduced-obese individuals. *Obesity Research, 7*, 556-563

Appendix A

Further Quotations from the Participants to Illustrate the Themes Described in the Research Paper

1. Explanatory models

Reasons for weight gain and maintenance

Daphne[1]: I know with me yeah it was just bad eating habits and lack of exercise really.

Eileen: Eating too much. There's no… and I know that's what it is with me. It's eating too much of the wrong things and probably at the wrong time.

Eileen: *(How to lose weight)*[2] Just stop eating all the rubbish that I eat, you know. I eat a lot of bread, that's the big downfall. I eat a lot of fatty things, I like fat, you know. Who doesn't? *(...)*[3] I like all the things that taste good.

Gina: it comes down to the amount of food you put into your body if that is excess of what your body's burning up or using then you're going to store it as fat and that's going to make you overweight.

Cath: I do believe that metabolism has something to do with this but erm… I'm sure that if I ate like my *(slim)* sister I would lose weight like my sister *(laughs)*.

Eileen: I suppose there are medical reasons. How often are they? Sometimes I don't believe that, you know when people say like they're fifty stone and it's because of… I don't believe it, I think it's all due to overeating.

Amy: personally I think hormones have got a lot to do with it. I don't think you can… you can do what you can do but I don't think you can alter the way you're made

Interviewer: *How about erm genetics and anything like that... do you think that some people may be more susceptible to gaining weight than others?*
Daphne: Erm do you mean like hereditary? Er, well yes, probably, it probably does have er… I mean I think my mum was overweight. *(...)* But you know you can see it in families can't you where mum and dad are plump and their children are but I think all of that again is eating. You eat what your parents give you don't you?

Gina: I think some people there might be a tendency… a genetic vulnerability or a genetic loading towards maybe storing energy in a different sort of way but a lot of it is about people learning about food as well

Freda: I were always very slim until I had my last child *(...)* what with being about thirty-six - thirty-seven I suppose your metabolism changes and everything so really what I could do before eating-wise… I never changed really my eating habits but now I couldn't eat the same

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[1] Pseudonyms used throughout
[2] Words in bracketed italics added by author to help the reader make sense of the quotations taken out of context. All text not in italics are quotations from participants.
[3] Indicates that irrelevant material has been omitted

Reasons for poor eating and exercise habits

Lifestyle constraints

Interviewer: *what do you think stops people from being the weight they want to be?*
Freda: What stops them, erm, your actual lifestyle itself, what you're doing, your job, what you do *(...)* I think the actual times you get up, the actual way you just live really to be honest

Daphne: I think a lot of people have… they have convenience foods and… instead of eating sensibly. I think we tend to get things that are quick and not particularly, you know, what we should be eating.

Brenda: Well, I mean a lot of it's habit isn't it? You go round the supermarket, *(...)* if you're in a rush you just go round and you have your own route don't you round the shop wherever it is and you just pick up the same things and you carry on eating the same things.

Gina: you have to change lifestyle and I know that I should be doing more exercise and I look at my diary and I think to myself "when am I supposed to be doing this?"..*(...)* I suppose it's busy lives as well that you're rushing around and you're maybe grazing during the day, catching kind of mealtimes, not having a mealtime maybe

Interviewer: *You've kind of been talking about it already, but one of the things I was going to ask you was what reasons do you think people become overweight?*
Amy: Well, as far as I can see, it is, I would say, I mean overeating. Um… if… living here… my husband lives from one meal to the next meal. As soon as he's had his breakfast he wants to know what's for dinner

Gina: my husband *(...)* was a very good cook, used to cook erm three course meals, starter, main meal, pudding. It would be things like curries, and not just one curry, it would be three different sorts of curries with a veg dish on the side as well and rice which would be cooked in the Persian style. Erm, yes, it was difficult because it was there in front of me.

Cath: I worked also in a place where *(...)* the first thing I did when I went there was have breakfast and things like that, cooked, which you wouldn't have at home *(...)* So I would enjoy that and then the toast would come and then second toast *(laughs)*. It was nice, there were nice meals made. I think maybe I eat well maybe when it's cooked for you.

Eileen: Er and I do work in catering *(...)* the food's there and you get what you want, you eat it.

Cath: I think it was fashionable to have bonny babies when I was born and apparently my mother brought me up by some regime that was fashionable which was that you feed at a certain time, not on demand. *(...)* I think that that clock was very much

probably put in me. *(...)* that you have to have your meals three times a day or whatever times and that you don't miss any of them and I don't think many times in my life have I missed any meals at all particularly *(laughing)*.

Cath: And I would be urged if that's the right word. I mean nobody would say "well you've had enough now, that's being a bit greedy" or something, it's just in my opinion I was never taught that it was greedy to eat all sweet things or something like that.

Daphne: I think a lot of it is just habit, habit that you get into, probably set by your parents, you know, what you eat

Amy: …and of course in my case I think its lack of exercise because they tell me I've got structural damage in me back

Brenda: the fact I'm disabled is always a good excuse "oh well, you can't move around the same", which is a load of rubbish probably but *(...)* I have to say a lot of it I think is to do with being disabled. It's got… it has… it must make a difference and the two are linked in a way.

Eileen: I've had two slipped discs so I won't entertain doing any… going to a gym or anything like that because I daren't risk that again and I have a bad knee *(...)* and I do work so hard I really haven't got the energy to do anything at night. I wish I had.

Gina: I was actually reducing the number… the amount of exercise I was having because I didn't like the feeling of being out of breath and a bit sweaty after kind of walking up the hill.

Gina: Probably now I'd start considering going to the gym without feeling that everybody would look and stare and make fun of me but whilst certainly when I was at my fattest I wouldn't have dreamed of going anywhere near a gym, that would have been far too awful to inflict that on anybody else *(laughs)*.

Brenda: You know the first time you go *(to the gym)* you go "if there's anybody in there I'm going home" but now you think "well, no, to hell with it, I've got as much right to be here as anybody else".

Emotions associated with food and eating

Brenda: I suppose it's just eating too much basically and there's always this thing where I enjoy going out, I enjoy meeting people and eating out and all that sort of stuff

Daphne: You know if things aren't going right emotionally I think you can comfort eat. Erm, I… I know I do, if I'm feeling a bit fed up I'll get a Mars Bar and a cup of tea and I'll feel better after it, you know. Erm… I… I mean that's what I've heard that people comfort eat.

Daphne: I mean I've been on these diets, *(...)* you lose your weight and you feel good *(...)* and then as you get… I think when things get erm… well possibly when I'm feeling a little down I think "oh, I'll just have a bit of chocolate" and then once you start on that road again…

Daphne: The best way to lose weight, forgetting any, you know, sort of any feelings or anything like that is just to eat sensibly and to exercise.

Eileen: I just love food, simple as that. I've always had a good appetite, yeah. There's nothing I don't like. You know like some people say "oh I couldn't eat that", there's nothing. I'm shocking *(laughing)*.

Eileen: you just feel like you want this full feeling. You know, if you just have ordinary meals you just don't have it. I wonder if it's a comfort thing? *(...)* I think it's to do with being secure, content, thinking feed me up and you know you're being looked after OK.

Interviewer: *So there's like this feeling that you should really be on a diet but you don't...*
Freda: Yeah, you don't want to do it because you enjoy your food, enjoy your food.

Gina: oddly, doing that *(buying low fat foods)* I'd feel I was actually missing out on something erm, if I was putting something low fat in I'm going to be thinking "that can't possible be as tasty as the stuff on the next shelf along which is kind of not low fat" so I go for the stuff that isn't low fat and stick it in my basket. *(...)* other boring things like thinking "perhaps I should be cutting down on how much maybe wine I'm drinking or if I go out I'll maybe have a pint of beer then" thinking "oh there are calories in this, oh I shouldn't be drinking it" and life's too short I keep thinking "why should I deny myself this" so therefore yes it's kind of indulging too much.

Freda: you think "I don't want to look like that" so that can get you despondent, you know and when you get despondent you want to eat because you want comfort and then you think "oh what's the use anyway, I'm just like this"

Eileen: And I think boredom's a lot to do with my eating. *(...)* because I'm on my own all day. *(...)* sat at a desk writing or, you know, I'm in and out and I think "oh I'll have a drink" but then I don't have a drink without having something to eat.

Freda: I think comfort eating actually, boredom, more… I would say for me it's more… isn't it awful to say… boredom than anything else. If I sit down like with a cup of tea or anything I feel as though I have to be sat down eating *(...)* well you've got to be sitting down for something

Brenda: I went through a period in my life… I went to a school where I hated it, absolutely hated it, erm and I think I went through an unhappy time then and I think that's when it started *(weight gain)* so there must be a link there somewhere, although I wasn't aware of it for a long time.
Interviewer: *And has that tended to be a pattern, that it's the unhappy times in your life when you've tended to put on weight?*
Brenda: Not necessarily, no. That was the start of it. No, I know there is this thing where you have a row with somebody and you reach for the biscuits. No, I have thought about that and it isn't necessarily that at all. I'm more likely to eat when I'm happy, going out, enjoying life and stuff.

Brenda: you know I was married at one time so there was always this "well I must lose weight to get married, for the wedding day and all this rubbish." Then you're happy and you start going up again

Daphne: I could probably do it but I don't have time *(...)* but having said that I suppose I've had time in the past and I've let it go. Perhaps I've got a little bit fed up and… *(unfinished)*

Cath: I did put on weight to eleven *(stone)* and I don't know if it's linked with the fact… I think that I had this boyfriend for four years and erm after that relationship ended I seemed to put on weight at a particular time. Erm, well, I don't think I wanted him to be the love of my life but it was a bit of an upsetting time.

Gina: And then when that relationship was breaking down I actually lost two and a half stone in a matter of about four months probably but that was stress *(...)* sitting down to a meal was so stressful that I used to try and avoid so therefore the food didn't taste of anything anyway.

Personal characteristics and failings

Brenda: I'm not dieting but I'm still trying to control something but it would appear as though I'm totally out of control with it… *(laughs).* Perhaps I'd be twice the size if I didn't, I don't know.

Cath: Maybe fat people have also got the ability, you know that when they... they can eat more than when they're full they will eat more than when they're full at times as well, they don't know how to say "no"

Interviewer: *What do you think it is that stops people being the weight they want to be?*
Eileen: Probably will-power. Or having some sort of incentive to look after yourself better. I wonder if it's a low esteem thing?

Gina: It comes down to self-control again doesn't it, of actually changing what you're eating and probably the amount of exercise you take as well…

Gina: it's boring *(laughing)*. I was reading something recently that said I need to be eating, what, five pieces of fruit and seven vegetables or something or other… a combination which I looked at and I thought to myself " they must be joking" you know "if they think I'm going to eat that, they must be joking". *(...)* I'm one of these people, I don't like to compromise. I don't like margarine, I don't like things with lots of additives in it so I prefer butter so therefore it's butter that will go on… into my cooking or onto the piece of bread.

Brenda: it's probably laziness a lot of it *(not changing your shopping habits)*
Daphne: I think with myself anyway I think it's laziness, can't be bothered, erm, enjoying just not making an effort, eating what I want. *(...)* I don't want to make the effort. *(...)* I would like to lose weight, yeah, I would like to but it… it's such an effort to eat sensibly. It sounds terrible, I'm dead lazy!

Freda: You can eat what you like but just eat less of it whereas most times I find that I'm greedy.

Freda: when I fast *(for religious reasons)* I can fast quite easily, it doesn't bother me. *(...)* I can be disciplined in certain ways but when I'm not doing it I can't… I have got to have my bread and butter no matter what.

Eileen: I could write a book on dieting. You know, when you've always been overweight you read about it. I could tell you what to do but I don't do it.

Gina: on one level I'm very, very aware that how much I eat is related to my weight and to other people's weight and then it's amazing how you can actually not… or you conveniently forget it at the time when you're actually wanting to eat.
I wonder what it is that makes that so hard? *(putting knowledge into practice)*

Gina: I used to think to myself "this is ridiculous I'm supposed to be an intelligent woman so why in hell can't I lose weight or keep the weight off, why is it that I can't seem to grasp the idea that the amount of food that I put in my mouth is actually related to the size I am".

Daphne: You see I know it *(what should eat)* up here *(pointing to head and laughing)* it's a question of putting it down here isn't it *(indicating stomach)*.

Brenda: I think I know a lot about food and that *(...)* I'm a pain, looking at labels like a maniac *(laughs)*. But it still doesn't make any difference.

High costs of losing weight and staying slim

Amy: I mean you find nearly all these people that go to slimming clubs they nearly always put it back on again when they go back to their normal eating habits and ways of eating and this sort of thing. Um, you know, um, its eating habits that do it. *(...)* I don't think that dieting as such is good for you.

Gina: *(on attending a weight-loss group)* It's kind of like social humiliation though isn't it, when people put on weight. *(...)* but it's really unhealthy because they were actually almost encouraging an eating disorder… the kind of binge-purge pattern which I think is really bad.

Amy: I would love to lose some weight but er, whether I ever do I don't know, yes, yes, but er, I'm not prepared to starve myself to lose it.

Eileen: I would have to let dieting totally dominate my life for the rest of my life to stay slim. I would not be able to eat what I liked for the rest of my life. *(...)* At the moment I don't think I could do it, I wish I could, I don't think I can.

Brenda: I think being my weight you think "oh God, it's such a long road I can't be bothered".

Cath: *(when dieting)* you become obsessed with food in your mind…

Cath: maybe it's a defeatist attitude you know about this there's too much *(weight)* so why bother you know *(laughs)*.
Interviewer: *What do you mean?*
Cath: Too much to, you know, to deal with it maybe "oh let's forget this bit, just accept me as I am" that type of thing.
Daphne: I think really you need to get into that habit and I think it takes an awful long time. *(...)* to change the habit of, you know, eating incorrectly

Eileen: I think I could do to lose four stone and I just can't envisage how I'm going to do it and that's what makes it… I think… it's a vicious circle then so you think " why bother?" you know, " you're never going to do that". So I just think "how am I going to change? Am I going to be like this for the rest of my life?" *(...)* It's a nightmare, I just don't know how I'm going to do it because I like food so much,

Eileen: this is the biggest I've ever been and erm I'm feeling desperate at the moment wondering exactly what I'm going to have to do, you know, and it's not an overnight thing, it's going to take months and months and months so I've got to be really, really positive haven't I to do something?

Freda: to lose the weight all you've got to think all the time is being prepared beforehand. That's the only way you can do it and it's as though it's on your mind continually twenty-four hours a day you're thinking "weight, weight, weight" and you cannot do it because you find that your enthusiasm wanes quite a lot. *(...)* I can't keep it up, in fact I've got other things to think about besides keep thinking about weight *(...)*. I've found that it is too much

Daphne: maybe with some people it could be money as well, because to eat sensibly and to eat you know… is expensive.

Daphne: I think people find it easier to slim to get with a few people you know like Weight Watchers and that's quite expensive as well, that's nearly five pounds.

Eileen: You only need to go and buy like vegetables now they're such a price aren't they? You know and salads, I mean, I love them but they're so expensive. Whereas you can go and buy bread, you know, and it's reasonably cheap. So all the things that are bad for you, you can go and buy dead cheap. All the stuff you should eat is dead expensive.

Cath: I think poverty's a bit of it as well *(...)* there was a period in our life when we were unemployed and you just can't buy the things that you want at those times and you do tend to eat, you know, the wrong things. *(...)* I think I did put on weight

2. Beliefs about the controllability of weight

Further examples of participants holding apparently conflicting beliefs about weight control

Brenda

Interviewer: *Do you think it's possible for people to control or change their weight?*
Brenda: Course it is, it's in everybody's hands isn't it. It's a bit like… it sounds dramatic doesn't it… it's a bit like an alcoholic or a gambler, its entirely up to you, its your choice, really. *(...)* in the end it's up to you, and there's only you can do it. There's no good doing it for anybody else it doesn't work does it?

Brenda states that weight control is entirely under the individual's control but throughout her account cites other influences on her weight that would not appear to be easily subject to her control. These include her disability, her busy lifestyle, enjoying food and eating, not being motivated to try to lose weight because she believes she has so much to lose (see relevant sections for examples). One statement suggests that she does not believe she is able to lose weight.

Brenda: You know you can lose weight if you've got the self-control and I haven't so fine, you've just got to live with it.

Cath

Interviewer: *OK. Do you think it is possible for people to control their weight, to change their weight?*
Cath: Well, it is possible, you read about it and sometimes people say that if you go to Weight Watchers and you lose weight, which I have, that you put it on any sometimes a bit more than you've lost, that you become obsessed with food in your mind and things like that.

Interviewer: *Do you think you could control your weight if you wanted to?*

Cath: Maybe I'm not determined enough. Or maybe it isn't… maybe I think that can't enough so I don't bother to try. Maybe the price of it is too much for me, if you know what I mean? Maybe I feel I can't do it with my own ability, things like that. Because really you only do things you feel you can achieve or there's no point trying really

Cath believes weight control is possible but suggests that there are unpleasant costs associated with losing weight and that she lacks the determination and self-confidence to try to achieve weight loss.

<u>Daphne</u>

Interviewer: *Do you think it's possible for people to control or change their weight?*
Daphne: *(Laughing)* Yes. Yes I do. I think you can do… well that's not for everybody I suppose but erm I think a lot of people could. I know I could if I really wanted to but er… that's the secret isn't it, really wanting to, yeah.

Daphne states that weight control is possible for herself but she lacks sufficient motivation to achieve it. She also described numerous influences on her weight that she did not perceive to be easily subject to her control, such as busy lifestyle, longstanding habits, emotional aspects of food, being too lazy to change her dietary habits and inability to put her knowledge into action (see relevant sections for quotes).

<u>Eileen</u>

Interviewer: *Do you think it's possible to control or change your weight at all?*
Eileen: Yeah, if you really, really want to yeah I think so. I just wonder what makes you really, really want to. (*Eileen*)

Eileen: I've still not got the incentive to do something about it. I've not got to that stage yet.

Eileen: And I can do it (lose weight), you know, I know I can do it and I've done it more than once, you know, it's not as though it's a one off thing

Having previously lost weight Eileen was convinced that she could lose weight but was unable to motivate herself currently. Throughout her account she also presented explanatory models of her situation which were not perceived to be subject to her control such as her preference for unhealthy foods, her inability to exercise due to injury, the comforting properties of food and being unwilling to allow dieting to dominate her life and deny herself the food she wanted for the rest of her life.

3. Personal meaning of being big

Implications for self

Size as indicative of negative personal characteristics

(See also quotations cited in themes 1 and 2 for further examples)

Freda: *(my husband)* will say "you're on that diet" and I'll say "yeah" so I'll come in the kitchen and have a look in the cupboard and I hide things, you know, I think I shouldn't be doing it yeah and I'm like this trying to put it in your mouth without it showing that you're eating *(laughing)*. It's terrible, isn't it terrible?

Freda: the more you think about it the more you can't do the thing. The more you think "oh I've failed, I can't do it" so you eat more to comfort

Cath: I mean like it could be greediness, you know, it could be just plain… see I don't smoke and I don't drink but I do… I don't abstain when it comes to food.

Cath: This girl came to my house *(...)* she worked in the hospital *(...)* she really tried with me but I think it was a total failure. I felt I was wasting her time really.

Less confidence in appearance and physical competence

Freda: So it makes you become very vulnerable in the way that you feel about yourself, your confidence, you know. *(...)* you have to depend on people actually doing simple things for you that you wouldn't normally… that you find you would get to, you know, just because of your weight.

Eileen: I worry about how other people see me now. Like you know, I think "is it... being fat going to affect what they think about me?"

Gina: So suddenly I'm kind of thinking "people will think that I'm" you know "weak willed, that I'm erm gorging myself all the time, eating a very unhealthy diet".

Eileen: I feel more lacking in confidence now…because I am a confident person but I worry about how other people see me now. Like you know, I think "is it... being fat going to affect what they think about me?"

Eileen: I think they *(society)* think if you're bigger you're either not as intelligent or, you know, you're a different class, you're a lower class because you're fatter. I do, I think people have a bit of a down on big people.

Being big and sense of identity

Cath: I remember there were times when I was quite slim *(...)* it wasn't a very comfortable feeling to be very slim although it was nice to look at maybe but it was like part of me wasn't there *(laughs)*.

Brenda: if you've always been overweight you don't know any different do you? *(...)* But then there's also that you don't miss it *(...)* you're used to it, you are what you are.

Brenda: you hide behind it *(being big)*. Erm… you get so used to it that all of a sudden if you were thin and perhaps be able to do things that you don't normally do, its perhaps too scary.

Gina: So there was a lot of deception going on really about how much I was eating, which is kind of interesting *(smiling)* because I don't think of myself as somebody who deceives other people, but I certainly was at the time.

Gina: it makes me feel a failure, *(...)*... which is strange because it's one aspect of me and I'm quite successful in other bits of my life, but it seems to be one thing that I would focus in on then *(during times when felt low)* that because I'm fat it actually negates anything else that I've done and accomplished.

Self as physically unattractive

Brenda: I find it difficult to relate to the opposite sex because of that, because I always think if you see somebody that you vaguely know out somewhere and he's with some mates you think "oh well, I'd better not speak to him because everybody will think "what's he talking to that fat cow for"". *(laughs)*.

Brenda: if you were thinner you'd probably have more men coming to your door. Erm, there is always that. I know that people say "oh it doesn't matter what you look like, it's what you're like inside". What a load of rubbish *(laughs)*!

Eileen: But he loves me too much and he wouldn't dream of saying I was overweight. He'd be horrified if he, you know, if he upset me, yeah, you know. He's looking through the rose-coloured glasses at me I think, yeah *(laughing)*. You know, I'm sure in his own mind he must think "oh she's putting more and more weight on". *(...)* obviously he's not blind is he?

Eileen: he's *(partner)* not seen me without clothes for a long time. *(...)* I worry that the physical side of our relationship is totally nil at the moment, simply because I feel too fat.

Freda: You know what I mean, it's just disgusting *(laughing)* and that and you don't like yourself and you think "oh gosh, what made me get like this, what do I look like this for? Look at the state of me" you know, "how could anybody else", you know, "fancy you or anything like that?".

Cath: I think they see me as who I am as a person but I think that they would like me to be a bit thinner. Yes I think so. I mean my husband, fair play to him, *(laughs)* he says "you're alright as you are" and that's nice because it could be horrible but maybe he would really like me to be a bit slimmer. I'm sure you know it would be nice to be thin for him and for my children

Emotional impact

Being big engendered negative emotions

Freda: And knowing that you've done that *(eaten when not hungry)* you feel rather guilty, you're thinking "you didn't even want it, you didn't even need it, you definitely weren't hungry" and that "and yet you had to go and do it" you know. And then you think "well, it's no wonder I'm this size, it's your own fault".

Gina: *(when see an overweight person)* I must admit there's a part of me which is thinking " if she had more self-control she wouldn't be the size she is, she wouldn't be having a struggle to get out of chair and she wouldn't…" and yes, it's negative isn't it, it's actually about almost blaming her in that situation and therefore if I'm doing it there then I think I'm probably doing it to myself as well.

Eileen: I do feel disgusting fat at the moment. I mean I've always been big but I've always had a good figure but I just feel horribly fat and I don't know why

Gina: I tend to see things and think "oh that'll be nice, I can treat myself now and again, that doesn't matter" but of course the treats add up and maybe you look at your basket at the end of the shopping trip and think to yourself "half this stuff shouldn't be in this trolley if I was eating healthily" and then the panic thinking "I hope nobody knows me in the check-out because then they'll look at me and they'll look at what's in my basket and then they'll know why I'm fat.

Freda: it's like an effort, everything's an effort and bending down I feel as though I've done a day's work *(laughs)* if I bend down to pick something up, out of breath *(...)* it becomes a "can't be bothered" and I think your whole erm… whole outlook becomes as though everything is just an effort

Eileen: I try it on *(clothing*) and I can't… I think "my God I can't even get that on" and I'm so disgusted and I look at it and I think "I can't believe that won't fit me" because they look that big anyway.

Eileen: I'm disgusted with myself. I look at myself in the mirror and I think "oh God".

Amy: When it really gets me is when I see myself in a photograph. *(...)* oh I hate it

Eileen: I've beautiful clothes that doesn't fit me and that makes me so sad. You know I keep looking at them and thinking "I'll never be able to wear that again".

Positive feelings associated with being slim

Eileen: I know how… how good I feel when I'm, you know, thinner than I am now and… and I feel really good and feel really confident about myself

Eileen: it's such a good feeling when you lose some weight. You know, every time you go and you've lost weight and you… it's just fabulous and you feel really good and then you just wonder how you get back on this cycle again of getting bigger and bigger and bigger.

Brenda: *(when trying new medication)* You get that awful sort of excitement where you think "this is it, this is it, it's going to work, I am going to be thin" which I haven't had for a long time. You know, that feeling that something might actually work.

Freda: personally, for myself, I'd feel healthier if I was slimmer, not for vanity reasons or anything…

4. Mediating processes

Avoiding thinking of self as big

For some there was a sense that thoughts about weight were always there in the background. Others described not generally thinking of themselves as big unless they were confronted by something that made it evident.

Daphne: I think I get a shock sometimes when I look in the mirror. That's why I don't like going for clothes because I think "oh I didn't realise I was looking that bad" *(laughs).*

Daphne: I can't really remember thinking "oh I wish I was slim again" except when I'm trying to cut my toe-nails and things like that *(laughing).* You know there's things that I go to do that I think "oh that'd be a lot easier if I was slimmer" *(...)* bending down and things like that and climbing up hills… not that I do that every day… but you know, then I think "oh yeah, if I was slimmer I could do that better"

Gina: I avoided looking at myself in a mirror for a period of time because I felt… when I looked at myself I thought "urgh" you know "if you had a bit more self-control you wouldn't be looking like this".

Interviewer: So, in the past when you were heavier you would probably have tried to avoid describing your weight at all?
Gina: Yes, yes, because if I didn't face up to it then I didn't have to do anything about it. *(...)* I'm probably more conscious of my weight in the last few months which is interesting because I've actually lost weight and I think I'm probably more aware of my

weight at the moment than I have been for a long time before. So I think there was some sort of, kind of denial going on before because I really didn't like the way I looked so I was avoiding it and maybe kind of pushing it to one side and I pretend that I'm not fat really.

Freda: you see yourself bodily-wise *(...)* personally it reminds you how you're not really in control as such, is that you're getting older, things change bodily inside you that you can't... that you have no control over and erm... and it makes you think about other things, not only just about your weight and the biggness of yourself but of erm the fact that you are getting older and life ends *(...)* it does make you think that things are not as in control as what you would like things to be and that includes your weight.

Gina: actually seeing it in black and white that a consultant thought I was obese was a shock erm and I think that's... again that makes you think about "I must be overweight". It didn't change my behaviour of course because I then... immediately I was out of hospital I thought to myself "oh never mind".

Brenda: Well there are times, like sitting in chairs and that sort of thing erm... a bit of a cringe factor. Erm... but in the end you just have to forget about it otherwise you'd dwell on it and it'd get out of hand. *(...)*

Brenda: you try for a couple of days *(to diet)* and then it all goes by the board and you forget about it *(laughs),* brush it under the carpet.

Brenda: it's always there *(awareness of size)* it's probably twenty-five percent of the time. I don't sit here thinking about my weight all day it's just that it's always "oh right, well if I eat that now I mustn't be eating that later on" and then you get to nine o'clock and you think "oh to hell with it" *(laughs).* I would say it's always there.

Size as unimportant

Freda: it doesn't affect me as a person as such because I am the personality that I am and I'm confident in who I am. *(...)* last night like walking behind these young boys or whatever saying "oh look at that fat..." *(...)* You think "yeah well I am" but now... if somebody said that to me I'd say "well I am but so what?" you know what I mean? *(...)* I'm can only answer like that because of the way that I feel inside myself.

Freda: It's not been a factor... a big factor as such, where I am what am I doing, no. I can still do what I want to do, I just find it harder to do, I still do everything that I want to do. *(...)* as for the weight, it affects me physically but it is a minor part of who I am.

However, Freda went on to express what appeared to be a conflicting viewpoint:
I can't understand anybody being satisfied with the way they are being big because of the fact of not being able to move around and not be able to feel as well as what you could be because it's bound to tell on you, on er you health-wise.
Interviewer: So you find it hard to imagine anyone could be happy with being the way they are if they're overweight?

If they're really overweight? No I can't particularly think of them being happy. I mean they say they're happy and they might be a jolly person inside, which is different again than what it is, but normally no.

Brenda: I'm not saying I enjoy it. Erm… I've just made a decision to get on with it. There's a difference isn't there?
Researcher: *What do you think made you come to that decision?*
Brenda: Age mainly *(...)* I think you do get more confident as you get older. You either get confident or you just don't care any more. Erm… things I've done in the last ten years I thought I'd never ever do. Erm… and I think you just… you just think "well to hell with it, it's my life, if I don't enjoy it it's my fault if I don't"

Brenda at my age I've just thought "right, this is me and if you don't like me to hell with it". You know you can lose weight if you've got the self-control and I haven't so fine, you've just got to live with it. But when I was younger obviously it effects you more doesn't it but as you grow older you just think "well I'm running out of time so I don't really care, I'll just get on with everything".

Brenda: You always come away *(from the doctor's surgery)* feeling guilty and you can't live by guilt, it's stupid. You've got to get on with life.

Brenda: Erm and I started teaching the odd course, the odd night class, doing talks in front of people which, if somebody had told me thirty years ago I'd be doing that then you know, I'd have thought they were bonkers. *(...)* but now I do it and I love it, I really get… and that has given me a lot of confidence as well and a case of I'm standing up here, I'm talking about my work… I suppose in a way you hide behind the work but you are you. Erm… its just given me confidence, through that, through the work because people admire your work and they ask you to come back.

Daphne: I think I'm me and I don't think it would make any difference if I was fat, thin or… no I think this is me.

Cath drew attention to having minimised her degree of overweight during her account: I think it is a nice thing not to look thin or anything but not to be a bit overweight. I think it's… you see I call myself a <u>bit</u> overweight!

Eileen: (if she were thinner) I'd probably feel a lot better about the way, you know, the way I looked and that I'd feel a lot better. I'd probably have more confidence to approach things but I'd still have to… I've still got to do them whether I'm big or small haven't I. I suppose you've got to make the best of it, yeah.

Gina: I've got the training I wanted to do, I've been offered jobs, people seem to think that I'm OK at what I'm doing so, no, I don't think my weight has affected that.

Freda: people close to you like family and things like that don't… don't see you like that *(...)* personality-wise, once somebody gets to know you they see a different side to you. It's people who don't know you…
Daphne: I think they *(my family)* accept me as me. You know sometimes my husband says I wish you'd lose some weight. *(...)* sometimes he says "oh", you know, "I

remember when you were a lot slimmer" but I mean I remember when he was a lot slimmer as well *(laughs)* you know. I think it's more jokey that he says it. I think the only time he's serious is when he says "you know really you could do with losing some weight because of you know, your health"

Comparison with others and previous selves

Gina: I'm working at the moment with a woman who is extremely obese, I mean we're talking huge

Gina: when you see kind of really, very, very fat people where you think to yourself "they're actually harming their health so much that that's… they should be doing something about it".

Freda: goodness knows how people feel when, you know what I mean, when… when they're permanently… you know… well I am permanently like that. I don't know why I keep saying that *(laughs)*.

Eileen: *(when see big people)* I think "I hope I don't end up so fat". I look at them and think "ooh" *(indicating displeasure)* and I often think "oh God what if I end up like that".

Amy: But now *(compared with previously)* I struggle, I'm very good and er, do all the right things

Gina: There was a time when I was… when I considered myself to be really fat where I was look… where I just avoided looking at myself. In the house I had before there was a long corridor upstairs and a mirror at the end of this corridor in the bedroom so as you walked down the corridor you could actually see yourself and I hated it because I really didn't want to see myself because I didn't like the way I looked, I didn't like, you know, kind of the way I had to wear kind of clothes that looked liked tents.

Appendix B

Further Explanation and Illustration of the Analytic Process

The Interpretative Phenomenological Analysis (I.P.A.) was carried out using Smith, Jarman and Osborn's (1999) paper "Doing Interpretative Phenomenological Analysis" as guidance. An ideographic, case-study approach was adopted. The process is described below and illustrated with examples.

1. Looking for themes in the first case

The analysis was carried out when all of the interviews had been completed but the cases were considered in the order in which they had been collected. The transcript from the first participant was read a number of times. Initial observations of the account were noted in the left-hand margin during the readings. These represented attempts at summarising, associations of connection, and preliminary interpretations. After this had been completed for the whole account the right-hand margin was used to note any emerging theme titles, i.e. key words were used to attempt to capture the essential quality of what was being found.

2. Looking for connections

The emerging themes were listed in a separate document. Where appropriate, those that appeared to cluster together were organised under superordinate theme titles. Superordinate themes are those themes or titles that act as a magnet, drawing others to them or helping to explain others. During this process the original text was checked continually to ensure that the themes and connections did represent what had been said by the participants and had not become too abstracted.

Table 1 illustrates steps 1 and 2 using a sample of transcript.

Table 1. Illustration of analysis steps I and 2 using a sample of transcript

I thought we could start off... could you tell me briefly the history of your weight?
There isn't a lot of history *(laughing)*. Er, I've just been overweight since I was about twelve, eleven or twelve, and the fact I'm disabled is always a good excuse "oh well, you can't move around the same", which is a load of rubbish probably but... Erm, I've just always been overweight. Finished. Full stop.

And has it tended to go up and down or has it been pretty much the same?
Mainly up *(laughing)*! Erm, I think at one time there was always this... erm you know when you're younger obviously there's this "Oh yes, latest diet, let's try it" you know. But I mean I do listen to all this bit where you're not supposed to go up and down. A friend of mine is... she goes from about fifteen stone down to about ten and back up to fifteen and back down to ten and back up to fifteen. I've known her for about twenty years. She's in a thin phase at the moment, she's got a different wardrobe for each set of clothes. Erm, and I think... I don't see the point and at my age I've just thought "right, this is me and if you don't like me to hell with it". You know you can lose weight if you've got the self-control and I haven't so fine, you've just got to live with it. But when I was younger obviously it effects you more doesn't it but as you grow older you just think "well I'm running out of time so I don't really care, I'll just get on with everything".

So was it a gradual increase would you say or...?
Yeah, depends on... depends on your circumstances I suppose. Erm, you know I was married at one time so there was always this "well I must lose weight to get married, for the wedding day and all this rubbish." Then you're happy and you start going up again and... but basically it doesn't fluctuate and it's basically the same and the amount it fluctuates nobody knows but me because it doesn't really show. There's certain times when it gets to you, you know you have certain times of the year where you think "yeah, got to do something about this" and then you might try for a couple of weeks and think "this is stupid" and erm just get on with it. Because there

Since childhood
Cause = disab

Explan. Model
disability

humour

previously tried dieting
Youth - age
weight-cycling = bad

Explan. Model?
if lose weight → will regain and weight-cycling = bad

No point - weight is regained
Accept me as I am
Can control weight but doesn't have self control
Don't care
Accept it + live with it

Mediating Proc.
Accept me as I am
I accept it and get on with things
Don't care

Weight is controllable but don't have self-control

happy → ↑ weight

Emotions linked with weight gain (+ve)

Gets to you → try to lose weight
Give up

Emotional impact
↳ motivates to try to lose weight

3. Table of themes

When the above process had been completed, an organised table of themes was drawn up. Using a standard word processing package, all the instances of this theme were copied from the original transcript and 'pasted' under the appropriate theme heading. This made it easy to check that what had been said in the account fitted well under the theme title/description. This process entailed selection from the text and some observations were left out if they were isolated examples, if they were judged to be relatively unimportant, or if they did not fit well into the emerging structure of the table of themes. The process thus far was cyclical so that each may have been repeated a number of times as new perceptions or connections emerged.

4. Continuing the analysis with other cases

The process described above was repeated for each subsequent case. This process was also cyclical, so that, as new themes emerged in later transcripts, earlier transcripts were examined for incidences of these. Themes and superordinate themes underwent some 'shifting' during this process, as the accounts from other participants enriched understanding of the existing themes or served to explain connections between themes. A table of themes was produced for each case, with all corresponding quotations listed under each theme title.

5. A master list of themes for the group

Finally, through following the process outlined above and considering the participants' tables of themes together, a master list of themes emerged. Once again, all relevant quotations from participants were organised under the relevant theme title. A quote

could be used more than once if it represented incidence of more than one theme. This led to the creation of a single document that listed all the themes and all incidence of each theme and had halved the original quantity of data.

6. Writing up

The writing up process entailed translating the master list of themes into a narrative account. This process necessitated being selective about the themes that were reported in an attempt to summarise and organise the material into a digestible quantity and quality. When doing this, consideration was given to the points that were likely to be of interest to clinicians and researchers in the field. Inevitably there was further refinement of the analysis, and some themes that had survived thus far were pared away at this late stage.

As a final credibility check of the analysis process a selection of the participants' quotations were appended to the research paper to enable the reader to consider their relation to the theme descriptions.

Reference

Smith, J.A., Jarman, M. & Osborn, M. (1999). Doing Interpretative Phenomenological Analysis. In M. Murray & K. Chamberlain (Eds.), *Qualitative health psychology: theories and methods.* Sage. London (pp. 218-240).

Critical Review

To review this work I will consider its development chronologically and reflect on issues that were salient at each stage. In this way I hope to further consider its strengths, limitations and implications and highlight process issues. One theme will be my attempts to 'own my own perspective' on the topics. This is particularly important in qualitative research as it encourages the analyst to consider the influence of their own values and expectations and consider possible alternative interpretations. The reader also has the opportunity to interpret the work in light of the analyst's perspective and consider alternatives.

How I came to do this study

I became interested in the psychology of appetite and obesity as an undergraduate (due to an enthusiastic lecturer) and completed a quantitative research project on the stress levels and dieting habits of underweight, normal weight, overweight and obese women. I was surprised by the extent to which many women worried about and tried to control their body weight and shape. In particular I met a group of obese women who were undergoing medical treatment for their weight and related problems. I was struck by the degree of physical and psychological suffering these women experienced as a result of their weight, and any notions I may have had about being fat and jolly or self-acceptance as a fat person were well and truly challenged! Of course the women I met were a clinical sample and thus unrepresentative of the obese population but it was still a learning experience. At that time available treatment mainly comprised medical intervention for weight-related problems, weight monitoring and advice on diet. These women needed to make huge changes to their lifestyles but there appeared to be little or no attention to psychological aspects of this. In recent years there has been increasing

interest from psychology, although there is still only one centre in the UK offering an intensive treatment programme incorporating a large psychological component to my knowledge (led by Fairburn, see references for details).

Following my degree I worked for several years researching psychobiological factors that contribute to overconsumption of food. I conducted tightly controlled quantitative studies which involved manipulating features of food to see what effects it would exert on subsequent food intake and psychological parameters. I enjoyed the 'hard science' aspect of this work but felt frustrated by what I felt to be a narrow view of obesity. My interests lay more in the characteristics of the people with obesity than their appetite control systems (important though they are!), and when reading journals or attending conferences it was always the clinical research that grabbed my attention.

Given the opportunity to do a piece of research entirely of my own choice in the present project I decided to study people with obesity. One aspect that interested me was how many obese people live with a debilitating and stigmatized condition without apparently suffering significantly psychologically from their condition and without losing weight. Several years ago at a conference I learned about a treatment approach for people with eating disorders. People with eating disorders tend to derive a large proportion of their self-esteem from their body shape and weight, and the treatment aimed to decrease the extent to which the person valued themselves according to their weight and to increase feelings of worth and competence in other domains. I wondered whether deriving a low proportion of self esteem from body shape/weight might be one mechanism by which psychological distress may be mediated in obesity. I decided to investigate this

hypothesis quantitatively as I felt it safer to 'stick with what I know'. However, after considerable investigation, it appeared that it would be very difficult to recruit a large enough non-clinical sample. This led me to consider using a qualitative approach, which would require fewer participants. At this time I began to search the literature on psychological health and obesity and found it under-developed. The predominant approach was to get people to fill in questionnaires about the factors in question and compare levels of the factor in obese and non-obese groups. There were few attempts to look more closely at the phenomena, to consider mediating mechanisms or look at psychological factors involved in weight control. In the literature there was little evidence of the voices of obese people and few attempts at understanding the experience of obesity. This led me to think that a qualitative perspective was exactly the approach I should be adopting to investigate these issues.

The decision to use qualitative methodology and my search of the literature led to me broadening the research question to finding out about the way obese people think and feel about their condition. This approach had proved useful in other areas of health psychology and I felt that the findings could provide a starting point for future research. I chose to carry out an Interpretative Phenomenological Analysis (I.P.A.) of the data for a number of reasons. Most importantly this approach suited my research question in aiming to gain insight into the participants' views of the world. Philosophically this approach seemed particularly relevant to health psychology (in which one's appraisal of one's situation is thought to impact on physical health and coping), and the clear acknowledgement of the interpretative work of the researcher appealed to me.

The next step was to submit my proposal for approval by the School of Psychology Research Ethics Committee. This proved to be straightforward and approval was given.

Recruitment, meeting the participants and the interviewing

Recruitment, even of the small number of participants required for this approach, proved difficult. I had hoped to recruit all participants from the Community Participant Panel but my assumption that there would be the same proportion of people with obesity on the panel as in the general population appeared to be inaccurate. Despite speaking to or emailing over one hundred people only a few thought that they might be overweight and of these only three met inclusion criteria. Putting up posters proved to be more successful but they had to be widely and copiously distributed before enough participants were recruited.

I feel very grateful to the people who took part in the study. Weight and eating were sensitive topics for most people, yet they were willing to be open and frank and generous with their time. They had interesting and varied stories to tell and I enjoyed listening to them. I found conducting the research interviews different from conducting clinical interviews as I felt more able to listen to what the person was telling me, to get a better insight into their world due to being less concerned about information collecting, formulations, what to do next etc. This was refreshing and something I should consider when carrying out future clinical interviews. Although I did not intend the study to influence participants' views on the topics, I was aware of an element of 'constructing a coherent account of the situation' going on through the fact that the interview was taking place. In addition I had no therapeutic intentions for the study but I felt that

elements of the study (i.e. having an interested person listening non-judgementally) did impact positively on participants. Interestingly, two participants said at the end of the interviews that they felt motivated to start to lose weight.

Transcription and analysis

Perhaps I should not admit to it but I enjoyed the transcription! I enjoyed the experience of spending time 'immersing myself' in each person's story and making my own sense of it. Listening to the recordings of the participant's telling their stories was the time that the themes really began to emerge. I found the analytic process absorbing, and must have been boring company at that time, as I found myself thinking and talking about it a good deal. The circular nature of the process, re-visiting each account and examining it for evidence of new themes or perspectives and then trying to stand back and examine the validity of the theme description in the context of this new account appealed to me. To this point all had seemed to be fairly straightforward.

Writing up

I tackled the research paper first as I felt that my findings would, to some extent, dictate what I should cover in my literature review. ***I*** found my findings fascinating. The difficulty was presenting and clearly explaining them and providing corroborating evidence within the word limit. I struggled with it and eventually only began to approach the word limit by completing a draft during which I told myself that it was 'just an experiment to see what it would be like at 5,000 words' and I was 'not really going to submit it'. I felt that I had sacrificed some of the richness of the data and analysis to achieve this word limit, as well as selecting the most succinct quotations

rather than the most informative or interesting. Looking back I think that a number of factors contributed to my finding this part so difficult. From my previous experience of writing up research I know that I am not usually fast or succinct at this part of the process! A second factor was the quantity and richness of the data; the participants raised many issues and processes which were worthy of presentation and comment. Clearly organising and summarising the data is important when presenting research findings, and qualitative research is no exception. Achieving this within any reasonable word limit for data as copious and rich as in the present study would be challenging. Furthermore, in a quantitative study one's data does not count towards the word count, and a table or graph can serve to clearly represent the findings. In qualitative work however, participants' quotes and one's verbal explanations of the findings (which represent the data) *do* count. I noticed that several qualitative papers in the journal I planned to submit to were several thousand words over the journal's stated word limit of 5,000 words. The editor informed me that there was some flexibility for qualitative work (see Appendix A for correspondence). On balance, I think that the word limit imposed for this thesis was too stringent for this kind and quantity of research and that more leeway is necessary. This problem could possibly have been avoided by having carried out less investigative work (i.e. fewer participants, more focussed interviews or more basic analysis).

On reflection, having found the process of over-simplifying my results demoralising, I lost enthusiasm and found it difficult to concentrate on writing the rest of the project. Of course advanced pregnancy and giving birth at around this stage didn't help the concentration factor much either! During maternity leave I watched my colleagues

struggle on, complete, submit and celebrate. This might have been difficult had I not had something else to occupy my mind and waking moments! My difficulty with the literature review was related to its dual purpose: to provide a 'stand-alone' review paper as well as a logical introduction and rationale for my study. The two purposes did not always seem compatible.

Credibility checks

Inevitably with this research approach the findings are dependent upon the analyst's own interpretation. A number of measures were taken to check the credibility of the findings. The first stage was when designing the interview schedule and during interviewing. Efforts were made to keep the questions open-ended whilst keeping the person on track, encouraging them to tell their story. During interviewing efforts were made to reduce communication of my own interests and values. At the end of the analysis process a master list of themes was constructed with all relevant quotations arranged under each theme to check that the theme titles represented accurate descriptions of what the participants had actually said. After the initial analysis phase member checking was carried out. I contacted two of the original participants and discussed my understanding of their accounts with them. I found this to be of limited use however, as they tended only to agree with me. In addition I was uncomfortable with this method as I was aware that their perspective on the topics may have been changing due to hearing my summary and interpretations. Another check was of internal consistency. The themes reported were those that were consistent within and between participants' accounts. Two other researchers (familiar with I.P.A.) assisted with the credibility check. One read a summary of the analysis and a sample of

complete transcripts. The other only read a sample of transcripts and generated her own list of themes. I found this a useful and interesting exercise. Efforts were also made to make the analysis process as transparent as possible to enable the reader to evaluate it.

Triangulation

One way to check the credibility of qualitative work is to triangulate it with quantitative work (Good & Watts, 1996). As well as their interviews, participants completed the Rosenberg Self-esteem Scale, the Shape-and Weight-based Self-esteem Inventory and the SCL-90. I had intended to consider these in light of participants' accounts. However, having completed the qualitative analysis, the data from the RSES and SCL-90 no longer seemed relevant to my research questions or findings. I was unsure how to use the data and therefore did not use or report it. However the data for the S.A.W.B.S. did seem relevant and are presented and discussed in Appendix B. (Space limitations precluded including this in the Research Paper.) These data lent support to the findings from the qualitative data about body shape and weight being relatively unimportant in obese participants' self-evaluations.

Further discussion of the analysis

Although conceptually distinct, the super-ordinate themes were inter-related. The themes differed in the extent to which they were explicitly evident. Most aspects of the 'explanatory models' and 'personal meaning of being big' themes were explicitly apparent, and I believe that most psychological researchers, having read the transcripts, would identify these themes and label them similarly. However I think that the 'beliefs about the controllability of weight' and the 'mediating processes' themes were more

implicit and may have been more subject to my own perspectives. Before beginning the study I was interested in attributions about the causes of overweight, why people fail to lose weight, and how they cope with being overweight. Perhaps it is not surprising therefore that I found these themes within the data. Although I genuinely set out to find out what the participants had to say, I was undoubtedly led to consider certain interpretations by my own interests. Nevertheless, my interests and expectations were shaped and informed by working within the field of obesity, and one might therefore suppose them to be of relevance.

Study strengths, limitations and indications for future research

I have already considered some of the study's strengths and weaknesses in the Research Paper and above. As with all research approaches, elements of the qualitative approach taken, such as the small sample size and open-ended questioning, can be considered both as strengths and weaknesses. The bias introduced by the analyst could also be considered a weakness, although it is explicitly acknowledged. However, one aspect of my experiences as a *quantitative* researcher that disturbed me was the extent to which quantitative data can be interpreted to satisfy researchers' (or sponsors') interests and expectations. I believe that all research findings should be interpreted in light of the circumstances in which the research was carried out. A further limitation of this particular study is that the sample was biased toward older women. As suggested in the literature (Friedman & Brownell, 1995) and noted by the participants themselves, body size may become less important with age, possibly due to reduced social pressure to be thin as one ages (Striegel-Moore, Silberstein & Rodin, 1986), and people may be more

inclined toward self-acceptance. This may have led to lower levels of concern than would be found a younger group.

This was one small qualitative study and the findings should not be overstated. However, it provided insight into how a group of women with obesity thought and felt about their condition. At this early stage of understanding the psychology of this modern disease there is a need for more qualitative research of the condition. Of particular interest would be further investigation of processes that mediate between the personal impact of being big, as this may be important clinically in terms of attenuating distress and in understanding why many people live with the condition without suffering psychologically and fail to lose weight.

References

Clinical/research group offering treatment programme for obesity incorporating large psychological element: led by Prof. Christopher Fairburn, Wellcome Principal Research Fellow, University of Oxford, Department of Psychiatry, Warneford Hospital, Oxford, OX3 7JX.

Friedman, M.A. & Brownell, K.D. (1995). Psychological correlates of obesity: moving to the next research generation. *Psychological Bulletin, 117(1)*, 3-20.

Good, D.A. & Watts, F.N. (1996). Qualitative Research. In G. Parry & F. Watts (Eds.). *Behavioural and mental health research: a handbook of skills and methods. Second edition.* Erlbaum (UK) Taylor Francis.

Striegel-Moore, R., Silberstein, L. & Rodin, J. (1986). Toward and understanding of the risk factors for bulimia. *American Psychologist, 41,* 246-263.

Appendix A

Correspondence with the Editor of the British Journal of Health Psychology Regarding Word Counts for Qualitative Work

Query

Dear Professor Carroll,
I wonder if you can answer my query? I would like to submit a paper to the British Journal of Health Psychology. It is a qualitative study of women's experiences of being obese. I note that in the instructions for authors the word limit is specified at 5,000 words. Including participants' quotations to back up my analysis of the data means that I am finding it very hard to keep to this word limit. However I have two qualitative papers from the journal that are clearly over this limit. I wonder if the participant quotations are included in the word count for qualitative studies and how stringent the journal is about the word limit in general.
I would be grateful for any information you could give.
Thankyou.

Yours sincerely
Helen Delargy

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Reply

Date sent: Mon, 30 Apr 2001 08:49:10 -0700 (PDT)
From: Helen Delargy <helendelargy@yahoo.com>
Subject: query
To: carrolld@bham.ac.uk

Dear Dr Delargy
I believe that the answer to your question is yes; the word limit does include quotations. However, we do appreciate that qualitative work may often exceed the word limit. In my experience, editors bear the word limit in mind but use it as a guideline rather than a rule. My advice would be not to over obsess about the word limit, although you should try and get as near to it as you can. I hope this is helpful.
Best wishes
Doug

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Appendix B

Shape- and Weight-based Self-esteem: presentation and discussion of results for triangulation purposes

Originally it had been intended that data be collected using the S.A.W.B.S. and viewed in conjunction with the qualitative data. However, due to the need to focus the research paper on the main aspect of the work and space constraints, these data were not presented. These data are therefore presented and discussed here and in the Critical Review.

Introduction

Shape- and weight-based self-esteem has been identified as a "central cognitive substrate" of the eating disorders (Cooper & Fairburn, 1993). The S.A.W.B.S. (see Ethic Proposal, Appendix G) is a relatively new tool designed to assess the contribution of shape and weight attributes to a person's overall self-esteem. To complete the S.A.W.B.S. inventory the individual is required to select from a number of attributes those that are important to how they have felt about themselves in the past four weeks. In constructing the inventory the list of attributes was generated from previous measures that have identified specific dimensions of self-esteem. The list comprises: intimate and romantic relationships, body shape and weight, competence at school/work, personality, friendships, face, personal development, competence at activities other than school/work and other (individuals are asked to list an attribute if it is not covered in the preceding list. After selecting the personal attributes that are important to how they feel about themselves, individuals rank order the attributes in terms of how much their opinion of themselves is based on each. They are then required to divide a 'pie' into pieces such that the size of each piece reflects the extent to which their self-opinion is based on each of the ranked attributes. The S.A.W.B.S. score is calculated by measuring the angle of the shape and weight piece of the circle. It gives an indication

of the relative contribution of shape and weight to overall self-esteem: the higher the S.A.W.B.S. score, the greater the importance attached to body shape and weight by the individual.

The psychometric properties of this questionnaire have been established in non-clinical and clinical (eating disordered and psychiatric) adult populations (Geller, Johnson & Madsen, 1997; Geller et al., 1998). S.A.W.B.S. scores were found to be stable over time, correlate strongly with measures of body dissatisfaction and eating disorder symptomatology, and to discriminate individuals with eating disorder from psychiatric and non-psychiatric controls.

Although the development of the S.A.W.B.S. was based within the eating disorder literature, the concept of the relative contribution of shape- and weight-based self-esteem is relevant to people with obesity. Within the eating disorder literature, the higher the portion of self-esteem assigned to shape and weight, the higher the eating disorder symptomatology and psychological distress. It could be hypothesised that women with obesity who derive a low proportion of their self-esteem from their body shape and weight would show lower levels of psychological distress and higher global self-esteem than those who derive a high proportion of their self-esteem from their body shape and weight. Alternatively, ranking one's body shape and weight as relatively unimportant in one's self-esteem may be seen as a coping strategy for people with obesity.

This part of the project was intended to provide information for triangulation purposes. It aimed to collect S.A.W.B.S. data for the obese participants and view this in relation to the qualitative data and the available published data to shed light on the credibility of findings regarding self-esteem from the qualitative data.

Methods

The participants were the same as those whose data was presented in the main Research Paper.

Administration of the S.A.W.B.S. was slightly modified as it was felt that it would be difficult for participants to use a circle to assign portions to each attribute, as it necessitates having a mental picture of how much of the circle should be left for all other attributes. In other words, it would be difficult to assign a portion of the circle to each attribute and leave the correct amount of space for the last attributes. With the modified method of administration the initial procedure is identical to the established method but, rather than dividing up a circle on a piece of paper, the participant is required to use a cardboard instrument designed to allow them to portion up the circle more easily. Different coloured card represented each attribute and the participant was able to alter the size of all the angles easily until they were satisfied that each one was correct. The angles assigned to the personal attributes can then be used in the same way as with the established S.A.W.B.S. administration method.

The participants completed the S.A.W.B.S. after completing the semi-structured interview.

Results

Table 1 shows the angles participants assigned to each attribute. Participants apportioned a mean of 21° of their self-esteem 'pie' (6%) to shape and weight. No participant ranked shape and weight as the most important contributor to their self-esteem and three did not assign it any portion of their pie. Participants varied considerably in those aspects of their lives that they portioned most of their self-esteem pie, with intimate relationships, competence at work, personality, friendships, personal development and competence at other things all receiving high rankings by some participants.

Table 2 shows the participants' scores alongside those available in the literature. No data for the S.A.W.B.S. are yet available in the literature for people with obesity. The sample size in the present study was too small to allow any meaningful statistical comparisons to be carried out. However the S.A.W.B.S. data was considered in relation to established norms presented in the literature for clinical and non-clinical groups of women. The participants in the present study were, on average, older than those in the other groups. The proportion of their self-esteem pie attributed to shape and weight was substantially lower than apportioned by all the other groups, representing less than half of that apportioned by any other group. As already mentioned, three participants did not include body shape and weight at all when dividing up their self-esteem pie. Of the four who did include it, they ranked it lower in importance compared with the other participants groups. The participants in the present study used, on average, slightly more pieces of the self-esteem pie to account for their self-esteem than the other adult groups.

Table 1. S.A.W.B.S. scores for the obese participants

	Degrees of S.A.W.B.S. circles assigned to each aspect of self-esteem								
Participant	Intimate relationships	**Body shape and weight**	Competence at work	Personality	Friendships	Face	Personal development	Competence at other things	Other
1	170	**58**	59	39	39	0	0	0	0
2	57	**20**	52	47	59	16	54	59	0
3	39	**0**	49	91	44	0	55	78	0
4	67	**0**	39	44	65	0	85	0	0
5	64	**45**	55	65	0	54	37	40	0
6	40	**0**	61	88	171	0	0	0	0
7	85	**25**	84	26	39	10	70	0	0
Mean	75	**21**	57	57	60	11	43	25	0
Standard deviation	(45)	**(23)**	(14)	(25)	(53)	(20)	(33)	(33)	(0)

Table 2. Proportion of self-esteem apportioned to body shape and weight by different participant groups

Participant group	Mean (S.D.) age (years)	n	Mean (S.D.) S.A.W.B.S. score (angle of circle)	Rank order of shape and weight	Mean (S.D.) total number of pieces used
Obese women (present study)	**51 (6)**	**7**	**21 (23)**	**4.8 (2.5)**	**6 (1.4)**
Female adolescents (Geller, Srikameswaran, Cockell & Zaitsoff, in press)	15 (1.2)	196	53 (not reported)	(not reported)	6.3 (not reported)
Female undergraduates (Geller, Johnston & Madsen, 1997).	21.2 (6.6)	110	57.6 (46.5)	(not reported)	5.5 (1.4)
Females with eating disorders*	27 (8.6)	48	144.8 (90.1)	2 (1.8)	5.7 (1.8)
Female psychiatric patients*	37 (7.4)	44	62.8 (63.8)	3.8 (2.1)	5.7 (1.6)
Female undergraduates* (*Geller, Johnston, Madsen, Goldner, Remick & Birmingham, 1998)	21 (6.7)	82	59.5 (42.6)	3.7 (1.8)	5.4 (3.7)

Discussion

The aim of collecting the S.A.W.B.S. data in the present study was to provide some quantitative data with which to triangulate the qualitative data. Interpretation of the S.A.W.B.S. data is clearly limited by the low number of participants and the fact that they were an older group than the comparison groups. However, the data suggest that the obese participants reported deriving a very low proportion of their self-esteem from their body shape and weight compared with the other attributes they considered and compared with other participant groups. None of the participants ranked their shape and weight as the most important attribute in their self esteem and three ranked it as being of no significance at all. Those that ranked it as a feature of their self esteem ranked it as less important than did the other participant groups. The obese participants also used, on average, slightly more pieces of the self-esteem pie than the other group, suggesting that a broader range of attributes contributed to their self-esteem.

These findings lend some support to the interpretations of the qualitative data. In the qualitative analysis participants' accounts were seen to indicate that shape and weight were relatively unimportant aspects of participants' lives (Theme 4, Mediating Processes, 'size as unimportant'. The data were seen to indicate that participants saw other aspects of their lives as more important in determining their views of themselves such as their spirituality, personal achievements, work-related achievements or being valued by family and friends.

One limitation of this triangulation part of the study is that interpretation of the qualitative data may have been influenced by the S.A.W.B.S. findings. Although the

S.A.W.B.S. data analysis was completed after the completion of the qualitative data to minimise this, the qualitative analyst had administered the S.A.W.B.S. and had some awareness of the likely outcomes. Although not practical in the present study, this problem could have been overcome by another researcher administering the S.A.W.B.S..

References

Cooper Z. & Fairburn, C. (1993). Confusion over the core psychopathology of bulimia nervosa. *International Journal of Eating Disorders, 13,* 385-389.

Geller, J., Srikameswaran, S., Cockell, S.J. & Zaitshoff, S. (in press). The assessment of shape-a and weight- based self-esteem in adolescents. *International Journal of Eating Disorders.*

Geller, J., Johnston, C., Madsen, K., Goldner, E., Remick. & Birmingham, L. (1998). Shape and weight based self-esteem and the eating disorders. *International Journal of Eating Disorders, 24,* 285-298.

Geller, J., Johnston, C. & Madsen, K. (1997). A new measure of the role of shape and weight in the self-concept: the Shape and Weight Based Self-Esteem Inventory. *Cognitive Therapy and Research, 21,* 5-24.

Appendix A

Word Counts

Thesis component	Number of words
Title	8
Abstract	299
Ethics Proposal	4,072
Literature Review	4,992
Abstract	197
Research Paper	4,979
Abstract	230
Critical Review	2,732
**Total of the above ..... **	**17,509**
Total of references, figures, tables and other appendices	18,879