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# THE EXPERIENCE OF OBESITY, ITS TREATMENT AND WEIGHT LOSS: A QUALITATIVE STUDY OF OVERWEIGHT COUPLES

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University of Plymouth

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**THE EXPERIENCE OF OBESITY, ITS TREATMENT AND  
WEIGHT LOSS: A QUALITATIVE STUDY  
OF OVERWEIGHT COUPLES**

Brenda Potz Kieffer, B.S.N., M.A.

A Dissertation Presented to the Faculty of the Graduate  
School of Saint Louis University in Partial  
Fulfillment of the Requirements for the  
Degree of Doctor of Philosophy

2007

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## Abstract

This study utilized a qualitative, phenomenological methodology to study obesity. The purpose was to better understand the experiences of obesity, treatment and weight loss from the perspectives of formerly obese individuals, their partners and as couples.

The participants consisted of six couples mostly from rural communities. In each couple, at least one the partners had experienced weight fluctuations into the obese range and had achieved at least 50% of his or her weight loss goal. The couples participated in two semi-structured interviews, both individually and as couples. A genogram was constructed with each couple to help identify family of origin influences on their weight individually and as a couple. The participants were considered the experts.

The findings of this study were enhanced by use of multiple data sources. Salient meta-themes from the findings included:

- 1) Fluidity of the experience
- 2) Family of origin: weight metaphors, childhood stories and obesity fear factors
- 3) Weight gain, role changes, and social isolation
- 4) Weight communication: perceived boundaries and inadequacies
- 5) First-order/second-order changes
- 6) Body image dysphoria
- 7) Weight as the third person in the relationship

Recommendations for weight loss must include hope about weight loss treatment, and how to begin the journey. Marriage therapists cannot assume that weight loss resolves peripheral issues for the couple; indeed, for some couples, weight loss further complicated their marriages regarding issues of sexuality, social connections and quality

of life. Body image dysphoria may persist after weight loss and may require psychotherapy.

This study further identified the need to educate and provide support to the partner of the overweight spouse. Some partners are able to provide support; others feel incompetent and intimidated by the sensitivity of weight. Perception of partner support was also identified as an important factor in weight fluctuation. The overweight individual may require guidance in recognizing and receiving partner support. Ostensibly, the importance of support from partners through treatment and weight loss cannot be overemphasized.

COMMITTEE IN CHARGE OF CANDIDACY:

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Chairperson and Advisor

Adjunct Associate Patricia Kyle Dennis

Associate Professor Hemla Singaravelu

## DEDICATION

There are many people to acknowledge when any project draws to its close, and this dissertation is no exception. I want to sincerely thank all those who in any way contributed and helped in the completion of my dissertation. Now that the work is completed, I would also like to thank those who made it even harder to complete. They helped by allowing me to focus more intensely, knowing this research is important to the understanding and development of new tools and methods to gain insight into the single biggest health problem of the twenty-first century: obesity.

I would like to dedicate this work to my daughters, Victoria Grace and Elizabeth Anne, and to the memories of their grandparents, Vernon L. and Alberta L. Melton and Rudolf and Emilie Potz.

I offer a special tribute to my parents, Vernon and Alberta. In very different ways, both contributed greatly to what success I have had in my life. They were **passionate** about their marriage, their children, their country and service to God.

My father taught me the value of discipline, honesty, perseverance and respect for others. He graduated summa cum laude from Washington University School of Engineering after many years of night school. His life was an example of **integrity** and **selflessness**. The single example I will cite, of dozens available, is that when he died at age 51, he gave his company to his employees. Twenty years later, it is still one of the largest and most prosperous companies in Washington, Missouri.

My mother taught me the value of friendship, thoughtfulness and love. She taught quietly, with great humility, and **truthfulness**. Through her I have come to know that if you seek friends and friendship, you must first be a friend, and no one had more

friends than she. She was a good listener with an abundance of patience and common sense. That combination earned her great respect and esteem among all who knew her. Her last ten years of life were *marred* by diabetes, the result of which was obesity and depression; yet even that could not dampen her zest and her love.

My years of service as a counselor, nurse, psychotherapist and pastor's wife have allowed me to become connected to my family, the community, life and God in such a way that the attributes which come to mind when I think of my father and mother are the same as the ones that have guided me in my career and have allowed me to stand at this place.

I thank them, I honor them, and I salute them.

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## Chapter 1 - Introduction

### *Focus of the Study*

Obesity, weight gain and treatment have become a topic of unprecedented interest to medical health care professionals, mental health care professionals and the general public. Some have referred to obesity as an epidemic. In fact the World Health Organization (WHO) declared obesity a “global epidemic” in 2005 (Retrieved June 25, 2007 from <http://www.who.int/nutrition/topics/obesity/en/index.html>). Much controversy and many unanswered questions exist regarding the complexity of obesity. This study focused on one aspect of obesity: the experiences of obesity in overweight couples.

This study explored the phenomenological experience of obesity, treatment and weight loss from the perspectives of the formerly obese individual, and his or her partner and their experience as a couple. The design utilized a qualitative, phenomenological method using multiple data sources for analysis.

Several important dynamics were identified through a Family Systems Theory (FST) lens. A better understanding of how these dynamics emerged and affected overweight couples was a significant contribution for the clinicians providing treatment.

### *Background*

#### *Obesity and Public Health*

In 2005, WHO contrasted obesity with the global growth of poverty:

Obesity is a complex condition, one with serious social and psychological dimensions, that affects virtually all age and socioeconomic groups and threatens to overwhelm both developed and developing countries. In 1995, there were an estimated 200 million obese adults worldwide and another 18 million under-five children classified as overweight. As of 2000, the number of obese adults has increased to over 300 million. Contrary to conventional wisdom, the obesity

epidemic is not restricted to industrialized societies; in developing countries, it is estimated that over 115 million people suffer from obesity-related problems. Retrieved June 25, 2007, from <http://www.who.int/nutrition/topics/obesity/en/index.html>.

The 2001 the United States Surgeon General's "Call to Action to Prevent and Decrease Overweight and Obesity" declared obesity a national priority and called on individuals, families, communities, schools, businesses, organizations, the media, the health care system, and the government alike to work together to seek a unified vision for a healthier nation. According to Frieden, Galvez and Landrigan (2003):

With the high and rising rates of morbidity and mortality due to obesity, the lost productivity, the impact on quality of life, and the burden on our health care system dollars -- an estimated \$117 billion in the year 2000 -- it is a problem that is too costly to ignore. (p. 684)

Healthcare professionals have long believed that being obese carries with it many serious health risks for adults; the psychosocial issues involved with obesity concern both psychological health as well as the ability to relate to family members and peers (Daniels, 2006). These issues may have many determinants, some of which are genetic and some, socioeconomic. The physical, social and economic consequences of the current high incidence of obesity among the general American population are enormous. According to Daniels (2006), of all the economic issues related to obesity, perhaps the most important is the cost of its associated health problems; it has been estimated that of people younger than 65 years, obese adults' medical expenses are 36 % higher than those of their non-obese peers.

Confounding researchers today is the fact that some of the most pronounced increases in obesity have been identified among those with more education. States in the mid-and south-Atlantic regions have demonstrated the largest increases (Thayer, 2003).

However, the obesity epidemic is becoming readily apparent throughout the nation with weight gains taking place with no substantial change in concomitant physical activity. For instance, Anderson, Butcher, and Levine (2003) emphasize that, "Overweight and obesity may soon cause as much preventable disease and death as cigarette smoking" (p. 30).

Differences of opinions exist regarding obesity and personal responsibility. A public shift from thinking of overweight and obesity as strictly personal matters has expanded to include broader public responsibility. "There is much that communities can and should do to address these problems" states Kopelman (2001 p. 30). Indeed, according to Kopelman, "Obesity can no longer be regarded simply as a cosmetic problem affecting certain individuals, but an epidemic that requires effective measures for its prevention and management" (p.1).

Legislators are acting on the above beliefs and enacting legislation to try to decrease the epidemic of obesity. The most widely publicized legislation has been related to new laws for schools. Soda and candy machines are being removed from the schools, and new requirements for school lunches have been instituted. Most recently, the state of New York passed legislation to prevent restaurants from using trans-fats. Many labels now advertise "No Trans Fats."

Some professionals and laypersons alike are beginning to question the right of the government to "legislate fat" (Gaesser, 2003; Szwarc, 2003). They are questioning the Surgeon General's "Call to Action to Prevent and Decrease Overweight and Obesity." Does this somehow imply a failure on the part of clinicians to treat overweight/obesity in society?

These different views are having an impact on the conceptualization of obesity and treatment. "The dilemma which then arises is how to encourage people to take responsibility for their eating and exercise behaviors, without blaming them for being overweight" (Boutelle; Neumark-Sztainer; Story & Resnick, 2002, p. 532).

In protest, there is a growing movement known as "Health at Any Size." This movement is composed of many different disciplines and has the support of lay persons, mental health professionals and physicians. Supporters of "Health at Any Size" view obesity from perspectives differing from most of the government publications and are quick to point out the limitations of medical research. For example, correlation does not equal causation. The chronicity, comorbidity and health hazards of obesity are challenged by members of this movement.

In protest of the Surgeon General's call for action, members of this movement have announced a set of priorities of their own which include;

- 1) Undoing the damage already done by educating the public about weight prejudice and obsession with thinness.
- 2) Cease endorsing traditional weight loss approaches until such time as they are shown to be effective and safe.
- 3) Redirect the focus for people of all sizes by promoting self acceptance, positive self image, and the idea of "holistic" health approaches that allow for the social, emotional, and spiritual, as well as the physical aspects of the human experience. (Robinson, 2003, p. 16)

This researcher had wondered how individuals and couples really felt before and after weight loss. With the wide range of treatments available; the endless advertisements of obese individuals' *before pictures* [emphasis added] of the new miracle weight loss product, and immediately followed by elated and passionate individuals in their *after pictures* [emphasis added]; diet centers on every corner; and endless diets on the web, it is a mystery why overweight/obesity is on the rise.

### *Obesity and Medical Perspectives*

Parallel with public concern about weight, thinness, and obesity, the medical community has made significant changes in their response to obesity. Three significant changes that were important for this study included: 1) the new definition of obesity as a medical disease, 2) the focus on comorbidity of obesity, and 3) obesity as a chronic illness (Atkinson, 2002, p. 95).

Atkinson (2002) has written about the history of obesity. He states, “The realization that obesity is a medical illness demands that medical evaluation be carried out to identify the biochemical alterations in overweight patient” (p. 97). Atkinson provides a comprehensive summary for the medical evaluation of the obese patient. He describes at least six endocrine dysfunctions to further evaluate the etiology of obesity. Re-defining obesity as a medical disease has already had significant influence on multiple disciplines.

Obesity is now listed with a number of comorbid diseases in most medical journals, books on treatment of obesity, websites on obesity, WHO and the American Surgeon General. Complications cited as a direct result of from obesity itself are numerous. Atkinson (2002) has a table listing 22 diseases linked to obesity (p.128). He is not alone in making these bold statements. He is joined by numerous researchers, including, but not limited to the American Surgeon General (2005); Bray (2003); the Center for Disease Control (2007); Field, Barnoya & Coditz, (2002); and Wadden and Stunkard, (2002).

According to the Surgeon General (2005), approximately half a million Americans die each year from diseases of the heart, especially coronary artery disease, or



diseases of the blood vessels supplying blood to the heart. Furthermore, increased mortality due to cardiovascular disease has been identified in adult relatives of persistently obese children; this relationship between childhood obesity and family mortality appears to be particularly strong if the obese child also has elevated blood pressure (Hersen & Van Hasselt, 1998). In this regard, Clinton and Smith (1999) emphasized the medical nature of the condition and adds that,

This disease doesn't just develop overnight. It is a slow, degenerative process that can begin in childhood. Adults who are obese, who have high blood pressure or abnormal blood cholesterol levels, who use tobacco, and who engage in little or no physical activity appear to be at high risk for this degenerative process. (p. 50)

Likewise, Thayer (2003) noted that obesity has increased in both men and women in all age groups; because those between the ages of 18 to 29 years have gained the most weight, it is clear that it is not just the older population that is suffering, nor do socioeconomic factors completely account for some of the trends in obesity that have been identified in recent years.

Comorbid diseases associated with obesity are chronic and have devastating results on the individual. Furthermore, obesity is being newly defined as a chronic illness by many organizations (American Obesity Association [AOA] (2002); National Health and Nutrition Examination Survey [NIMH] (2002), and experts in the medical field (Bray, 2003). Considering obesity in the context of a chronic illness will have new implications for overweight couples and the clinicians who provide their treatment.

### *Obesity and Mental Health Perspectives*

Obesity issues and the changes that have been reported in the general public and medical field have the potential to affect the manner in which mental health treatment is rendered. The belief that obesity is a medical disease and not a behavioral or

psychopathological problem may change the way therapists respond to overweight and obese individuals. Perhaps, there will be more empathy and understanding for the complex issues facing overweight couples.

Having the mindset of obesity as a chronic illness may potentially influence mental health treatment. This researcher wondered if this belief could contribute to recidivism by “the colluding of the clinician with the chronicity of obesity.”

Mental health professionals are challenged by their own beliefs and experiences with weight when treating overweight individuals. As so eloquently described by Dennis (2004), many clinicians have negative feelings about “fat clients.” Weight is an issue that most therapists feel uncomfortable talking about with their clients.

In the mental health field, the clinicians who provide treatment along this controversial continuum are divided and not at all in agreement. At one extreme end of the spectrum are those who identify with the Health at Any Size movement, which emphasizes that obesity is not a psychological or physical concern. At the other end of the spectrum are clinicians who believe obesity is a medical disease. In addition to obesity being a medical disease on Axis Three, there are proponents for listing obesity as a psychopathological disease classified as Binge Eating Disorder or Eating Disorder, not otherwise specified; according to the Diagnostic and Statistical Manual (DSM-IV) of the American Psychiatric Association (2000).

This researcher remained closer to the medical model on this spectrum. Both ends of the spectrum contribute to a better understanding of overweight individuals and couples. The Health at Any Size group brings much needed empathy, respect and acceptance of overweight individuals. The medical professionals of Health at Any Size,

who are scrutinizing obesity research and raising controversial issues, may reinforce the need for more research and a better understanding of obesity. On the other hand, adapting an extreme view of obesity as a world wide epidemic, the comorbidity of numerous obesity related diseases and psychopathology may be harmful and shameful for obese individuals.

This researcher believes that obesity is a medical disease. However, as with any medical illness, obesity is stressful for the couple and psychological treatment may become necessary. As a registered nurse, this researcher has witnessed the benefits of weight loss. For example, some patients have lost 10 to 20 lbs. and no longer required insulin for diabetes or antihypertensive medications. Although not in the scope of this study, the researcher believes that rapid weight loss and many of the conventional medical treatments of obesity such as surgical procedures, drug therapy and diets consisting of only a liquid supplement also have significant health risks.

### *Obesity and Marriage*

The dynamics of a marital relationship that has experienced obesity are truly complex. While the experience of obesity in couples may have similarities to other stressors experienced by couples, obesity may or may not have the same impact on the couple relationship or how these experiences are presented. For example, couples who have experienced the stress of a terminal illness, depression, alcoholism, or career change, may or may not have similar experiences with obesity in their relationship. Each couple's experience with obesity is unique and may not be similar to other couples or experiences with other stressors.

The challenges of weight loss treatment do have a significant impact on some overweight couples. According to Pool (2001),

Overweight has always seemed as if it should be one of the simplest medical problems to solve: just have people eat fewer calories. But as doctors in the 1930s quickly found out, and as every generation of doctors after them has verified, it's not that easy. (p. 10)

Pool (2001) pointed out that even the most motivated overweight individuals have problems losing a significant amount of weight and then keeping it off: "Many people can maintain a loss of ten or twenty pounds by watching what they eat or exercising more; few can sustain a loss of fifty, one-hundred, or more no matter what the technique" (p. 10). The success or lack of weight loss has an impact on the individual, and, from a family systems perspective, will also impact the overweight couple. Weight loss has proven to be challenging to achieve and to sustain. In this regard, Latner, Stunkard, Wilson, Jackson, Zelitch and Labouvie (2000) reported that,

Despite the well-documented success of behavioral techniques in producing temporary weight loss, treatment is typically followed by weight regain. The maintenance of treatment effects may therefore be the greatest challenge in the long-term management of obesity, and continuous care may be necessary to achieve it. (p. 893)

The limited amount of research that has been conducted on these issues has focused on patients who have lost weight and kept it off for a year or more, the so-called "reduced obese" or "formerly obese" patients. An earlier study of four reduced-obese women determined that these individuals had depressed metabolisms similar to those of patients who had recently lost weight (Pool, 2001). Other studies have shown mixed results; for example, in 1999, a group of Danish researchers (Astrup, Gotzsche & Werken, 1999) conducted a meta-analysis on a dozen such studies and concluded that some formerly obese do seem to have lower-than-expected metabolic rates, but it is a

smaller effect than earlier researchers had found. "Indeed, they said, it seems to be only a minority of the reduced obese—about one in seven—that have significantly lower metabolic rates than expected.... Most formerly obese people have completely normal metabolisms" (Pool, 2001, p. 176).

Obesity, as described in a substantial amount of the literature, is a potentially life-threatening condition that represents a significant public health threat today (Pool, 2001). In addition to the potential life threatening disease of the spouse, obesity is a factor in some dysfunctional relationships (Van den Broucke, Vanderycken & Norre, 1997). One authority reported that, today,

Obesity is now so common within the world's population that it is beginning to replace under-nutrition and infectious diseases as the most significant contributor to ill health. Major advances in the understanding of overweight and obesity have confirmed that they constitute an important medical condition. (Kopelman, 2001) p. 1

In this regard, Mead (2004) reported that approximately 59 million people in the United States are classified as being obese, and 300,000 of them die each year from related causes, making this condition the second-leading cause of death in the U.S. after smoking. These statistics, as with any other medical disease, adds to the stress on the marital relationship. As the numbers of persons with obesity continues to increase, the overall amount of research conducted on obesity and overweight couples remains disproportionate to research of other issues for which individuals and couples typically seek treatment.

While there remains a paucity of research concerning the implications of the obesity experience on the formerly obese and even less on their partners, studies have shown that poor psychological well-being is not always the inevitable consequence of the

obese individuals. Obesity is often correlated with low self-esteem, poor peer relationships and marital dissatisfaction (Hill & Williams, 1998). According to these authors, "These, and problems with eating control, are features of psychological morbidity that require recognition and therapeutic attention" (p. 578).

Other studies have shown that depression and binge eating are common adverse psychological responses that are associated with attempts to achieve weight loss in overweight and obese adults (French & Jeffrey, 1994). If the overweight individual attempting to lose weight is psychologically affected, the quality of their marital relationship may also decline.

The interactional patterns of overweight couples may be influenced by weight gain and weight loss, present couple interactions may affect weight gain and loss, and the individual and couple responses to weight fluctuations may further influence and affect couples. If the obese individual also experiences negative psychological responses to being overweight, additional stress is also added to the overweight couple. The intricacies of these influences in overweight couples were important to further understanding of the experiences of obesity, treatment and weight loss.

Clinicians and overweight couples have been affected by emerging research and new concepts. A better understanding of overweight couples as presented in this current study provided insights and implications for medical health care professionals, mental health professionals and overweight couples. This study provided significant and valuable recommendations for clinicians and overweight couples; including, to prepare for more changes in the treatment of obesity as the research of overweight couples continues.

## *Theoretical Perspectives*

### *Family Systems Theory*

A family systems theoretical model that looks at relationship dynamics and family interaction was employed throughout this study. Because of the significance of the marital relationship and the interest in how it affects and is affected by obesity, treatment and weight loss, Family Systems Theory (FST) is helpful to understanding interactions between weight and marriage study (Stevenson-Hinde, 1990).

General Systems Theory (GST) was proposed to formulate principles of functioning that would be characteristic of all biological systems. Credit for much of the seminal thinking in GST has been given to the late Ludwig von Bertalanffy, an Austrian biologist (Gurman & Kniskern, 1981). This theory emphasized the importance of understanding the interaction of activity within the organism and between the organism and its environment. Concepts from GST have been embraced by the fields of education, psychology, counseling and family therapy.

Several definitions for a system are in the literature. The following comprehensive definition underlies GST and the theoretical framework of this study:

System (from Latin *systema*, in turn from Greek *σύστημα* *systema*) is a set of entities, real or abstract, comprising a whole where each component interacts with or is related to at least one other component and they all serve a common objective. Any object which has no relation with any other element of the system is not part of that system but rather of the system environment. A subsystem then is a set of elements, which is a system itself, and a part of the whole system. <http://en.wikipedia.org/wiki/System> (2007)

The family, as any system, has subsystems. It is part of larger systems and interacts with many different systems in unique ways. The family, as a living system maintains wholeness through continuous input and output from the environment (von Bertalanffy, 1950). A change in any one part of the system results in changes in all parts

of the system. Additionally, influences from outside of the family context (i.e., neighborhood, schools, work place, culture) are all affecting the functions and dynamics, of an ever changing family system.

Cybernetics contributed to the understanding of family dynamics. Like GST, cybernetics was not developed by the field of family therapists. Cybernetics was developed by the mathematician, Norbert Wiener, and its concepts were then applied to FST (Haley, 1963). Cybernetics studied the processes of control in systems and was useful in analysis of the flow of information in a closed system (Bateson, 1979).

Haley (1963) applied positive and negative feedback loops as another way of viewing the family system. Some additional concepts described by Haley include: family rules, negative feed-back processes, and sequences of family interactions.

Bateson (1979) was a central family therapist who helped pioneer the shift from linear to circular causality. Linear thinking leads to descriptions of symptoms in terms of prior events, or A causes B. Explanations for the etiology of symptoms include disease, emotional conflict, psychopathology, learning history and other causes.

The concept of circularity causality relates to the idea that events are related through a series of interacting loops or repeating patterns. The shift to circularity is significant. Conceptualization from a linear observation examines the cause for and the effect of family processes, whereas circularity doesn't focus on history or etiology. Ables (1976) described events as being visualized and inter-related through a series of ongoing, interacting, circular feedback loops.

For example, linear observations may interpret Michael's decrease in grades as a direct result of changing schools when the family moved. Circularity in thinking would



obtain an academic history and look for changes in the academic system (new curriculum); the family's reasons for the move and how other family members are responding to the move; and ask if the family had also experienced other changes. Essentially, one would search for additional changes in family subsystems and other systems outside the family impacting the family system, including Michael.

The study of any family system requires a format, map or schema for depicting the system. One of the best ways to understand how subsystems operate is to construct a genogram with the individual, couple or family (Bowen, 1960; Gottman, 1999).

The genogram is a map of family content and process, a schematic representation of families that charts the interactional patterns over three generations (McGoldrick and Gerson, 1985). The genogram records important facts, life-changing events, and complex relationships of a family system. These are recorded with standardized symbols that indicate dates, descriptions of events, perceived relationships between family members, pertinent information about birth, death, addiction, illnesses and family secrets known to the individual. The genogram provides a framework for participants to understand the influences of their families of origin.

The genogram has multiple applications and is used in assessment of belief systems, serious illnesses, aging issues, career choices, family developmental issues, sexual attitudes, family health issues and weight issues. Thus the genogram is widely used for assessing family dynamics, either in general or focused around specific issues. This versatile instrument is used in therapy, consultation and research. Its value resides in objective and subjective evaluation, as well as the collaborative development of narrative stories (Gottman, 1999; McGoldrick & Gerson).

FST is a meta-theory with many theoretical approaches. Many family systems theorists have contributed to a better understanding of complex dynamics in families (e.g. Bowen, 1978; Haley, 1963; Hoffman, 1981; Imber-Black, 1988; Jackson, 1965; Madanes, 1980; Minuchin 1974; Nichols, 1987; Palazzoli, Boscolo, Cecchin & Prata, 1978; and Satir, 1971). Most concepts are best understood in the framework of the theory developed by the individual theorist. With respect to these great theorists and contributors to FST, germane concepts to the understanding of the findings of this study were gleaned from the literature. The following important FST concepts guided the research in this study:

*Equifinality* is the “ability of organisms to reach a given final goal from different initial conditions and in different ways” (Davidson, 1983, p.77). Bertalanffy (1950) had a disdain for a mechanistic view of living systems. He believed this mechanistic view of individuals led to valueless-ness. Bertalanffy embraced equifinality with a passionate belief that individuals had capacity to protect and restore wholeness (Davidson, 1983, p.77).

Equifinality brought emphasis to the different paths overweight couples traveled with weight. Overweight couples have numerous treatment options. Research supports varying degrees of effectiveness with weight loss treatments. Overweight couples may try several treatment options and changes in their relationship with weight to bring a sense of wholeness to them and their relationships.

The second GST concept, *a system is more than the sum of its parts*, validated the significance of interviewing couples. The experiences and stories from the spouses (the parts) cannot possibly help a researcher understand any couple. Overweight couples

cannot be understood without directly interviewing the couple. The couple is greater than the sum of two spouses.

The third concept, *meta-communicating*, contributed to a better understanding of how overweight couples communicate about obesity. Satir (1972), described meta-communicating as the way couples communicate about their communication. Satir further stated that this process can lead to a change in communication rules.

For example, a couple may communicate about weight related issues. Meta-communicating would include the couple's description of how, when and where do they talk about weight. This description may include raised eyebrows, teasing, yelling and talking about weight in public. Meta-communicating about weight, may bring about changes in how the couple talks about weight. For example, rules for communication may change to include, no teasing in public or deciding not to discuss weight during family meals.

A fourth major concept was *first-order/second-order* change. First-order change is a change in a system, in which the same rules and patterns of the system overall remain constant. Second-order change involves an accompanying change in the family rules. (Watzlawick, Weakland & Fisch, 1974). A first-order change could be establishing a set time for family meals. A second-order change would be improved communication in the family.

A fifth concept, *triangles*, was important to this study. According to Murray Bowen (1978), the forming of triangles is a natural human tendency in the face of anxiety. A three-person system, according to Bowen, is the smallest stable unit of human relations. This is especially true when couples experience stress and a third person (or

process) will get pulled into the couple. The term “triangulation” is used to describe this process. Bowen (1978) wrote:

The two-some might ‘reach out’ and pull in the other person, the emotions might ‘overflow’ to the third person, or the third person might be emotionally programmed to initiate the involvement. With the involvement of the third person, the anxiety level decreases. (p. 400)

Bowen used genograms to demonstrate family triangles. For stabilization of the couple, weight may become triangulated into their relationship. If the couple has been unsuccessful or uncomfortable in resolving another issue (management of finances), weight may become the focus of their relationship. Management of finances would be ignored and emphasis placed on weight.

In summary, FST is a broad, interlocking and overlapping framework. The theoretical concepts all contributed to a better understanding of the overweight couples in this study.

### *Need for the Study*

Obesity has been described as an epidemic world wide. Genetic pre-disposition, metabolic systems, dietary habits, eating behaviors, sedentary jobs, the current environment, cultural and socio-economic lifestyles all are culprits but fall woefully short of the complete answer as to why obesity has become the number one health problem in the world today. Research has focused mostly on the physiological aspects of obesity. Most researchers have not considered the effects of obesity on the partner, nor have they heard from the perspective of the obese individual’s partner. An overwhelming majority of the research studies reviewed lacked a qualitative component.

The background for studying obesity in today’s society was vast and interest from many complex systems and professional fields were evident. Lost in the vastness

and complexity of the subject were the overweight individuals, their partners, and their experiences. It was as if the overweight couples, their insights and their experiences were independent of and were not connected to the research being conducted. Their insights and experiences were a vacuum that touched not at all the investigation studied. This points out the real need for the phenomenological research conducted in this study, as well the importance of including overweight couples in future research.

There were practically no studies of overweight couples with interviews of couples. There were even fewer studies in which the obese partners, their non-obese partners and the overweight couples had voices.

Narratives of the experiences of obesity, treatment and weight loss from the perspectives of formerly obese individuals, and their partners and their experiences as couples provided new insights into the dynamics and patterns of change in overweight couples. The narratives of these couple participants contributed to the research which provides clinicians with new directions for their work with overweight couples.

#### *Purpose of the Study*

The purpose of this study was to better understand the experiences of obesity, treatment and weight loss from the perspectives of the formerly obese individual, his or her partner, and their experiences as a couple. The combination of the literature review, professional inquiry and clinical experience were part of the semi-structured interviews developed for this study of overweight couples. This researcher believed the use of semi-structured interviews developed from these resources superseded the need for a grand tour question.

### *Definition of Terms*

*Body Mass Index.* Body mass index is defined as weight in kilograms divided by height in meters (Pool, 2001). The classification ranges for BMI include 1) Healthy: 18.5 - 25, 2) Overweight: 25 – 34), obese 35 – 40; and very (morbidly) obese greater than 50.

*Comorbidity.*: A concomitant but unrelated pathologic or disease process; usually used in epidemiology to indicate the coexistence of two or more disease process (Williams & Wilkins (2005).

*Obese.* This term refers to a person who has a body mass index (BMI) equal to or greater than the 95th percentile (i.e. BMI 30 and higher). BMI and waist circumference measurements are the minimum physical criteria for determining obesity (Bray, 2003).

*Obesity.* The American Obesity Association [AOA] (2005) defines obesity as a disease that is characterized by excess body fat. The AOA insists on this definition because obesity meets the established criteria for a disease (Williams & Wilkins (2005). The AOA noted that a disease is defined as having at least two of the following three features:

- 1) Recognized etiologic agents;
- 2) Identifiable signs and symptoms; and
- 3) Consistent anatomical alterations.

In addition, the AOA reported that the “recognized etiologic agents” that are used to diagnose obesity include (a) social, (b) behavioral, (c) cultural, (d) physiological, (e) metabolic, and (f) genetic factors.

*Overweight.* This term refers to an increase in weight relative to some standard such as the BMI in this study. A BMI of 25 to 29.9 is considered overweight.

*Overweight Couple.* One or both partners have experienced weight fluctuations between normal and obese classification. The term, “overweight”, holds fewer stigmas than “obese” in this sensitive area.

### *Summary and Overview*

The purpose of this study was to better understand the experience of obesity, treatment and weight loss from the perspectives of the formerly obese individual, his or her partner, and their experience as a couple. Obesity is a medical condition which may or may not have psychological implications. Treatment traditionally has been an individual choice.

The study uses a five-chapter format to develop the relevant background and present the study findings. Chapter One presents the background for the study and provides a statement of the problem, need for the study, its purpose, and the theoretical framework from which data is interpreted. Chapter Two provides a critical review of the scholarly and peer-reviewed literature, and Chapter Three describes the methodology used in the study. The penultimate Chapter Four consists of an analysis of the interview data of the participants into themes and Chapter Five provides a summary of the research, relevant recommendations, and conclusions.

## Chapter 2 - Review of the Literature

### *Introduction*

Obesity has become more prevalent and persistent than ever before and has reached epidemic proportions worldwide. Nearly 60 million American adults between the ages of 20 and 75 years, an estimated one in three are obese. Obesity is a chronic condition. Its effects are insidious. The condition's origins are complex and poorly understood. Its treatment is often discouraging. Some of the complications of obesity, such as heart disease, begin in childhood, but do not become apparent until adulthood (Clinton & Smith, 1999).

A literature review of the treatment of obesity is beyond the scope of this study; treatment options are varied and diverse, and there is no consensus on the best treatment or combination of treatments. However, it is a vast subject and an important area of research. It should also be noted that diet, medication, and surgical treatment of obesity have all resulted in a significant number of deaths

Much controversy and, even some acrimony, surround the causes of obesity, "viewpoints among professionals tend to differ with regard to the main contributing factors, and the range from these in which the major focus is on genetic factors to those which focus more on individual choices regarding behavioral implementation" (Neumark-Stztainer, 1999, p. 532). Others see the family and society as determining the conditions that have a major impact on one's eating patterns and weight gain. These different views of etiology have an impact on treatment decisions. "The dilemma which then arises is how to encourage people to take responsibility for their eating and exercise behaviors, without blaming them for being overweight" (p. 53). Neumark-Stztainer



described the controversial views on obesity in terms of two extremes: those who believe that obesity has negative consequences for the individual and society, and those who believe that the treatment is difficult, ineffective, and not worth undertaking.

Dennis (2004) interviewed clinical social workers' reactions to "fat patients". She reported that these clinicians reacted to fat patients in ways similar to those of the general population, with feelings and attitudes that were more negative than positive. Included were:

Variations of discomfort, detachment, anxiety, disgust, anger, powerlessness, and guilt. Often the focus of these feelings was what the subjects perceived as self-destructive behaviors leading to weight gain....The subjects reported a belief that weight gain is the result of overeating due to emotional distress. A few showed awareness that genetic, social, and physiological factors may contribute to fatness, but they did not consider these to be of much importance. p. 173

It would seem that overweight couples seeking weight loss treatment are at risk for iatrogenic complications of their treatment. They are living in a society that supports thinness and from professionals who may mirror the general population's feelings about obesity.

Body dissatisfaction is an important factor in this current research, in part because of the relationship between low self-esteem, depression, and obesity. Weight and gender are so tightly intertwined that they often seem inseparable (Sobal & Maurer, 1999). In turn, weight problems are associated with a plethora of personal, social, and medical pathologies. Reflected-appraisal theorists maintain that self-evaluation of some personal attribute is largely a function of how individuals believe others view them on that dimension (Tantleff-Dunn & Thompson, 1995). This concept of self-identity development and maintenance has been held by philosophers and continues to be an active area of inquiry. The frequency and strength of messages regarding the slenderness

of ideal female bodies have greatly increased over the last five decades (Adams-Curtis, Forbes, Jobe, Pokrajac-Bulian, Revak, White & Aivcic-Becirevic, 2005; Hoyt & Kogan, 2001). In the literature on women's body image concerns, body image was defined in terms of body dissatisfaction. Women are objectified more than men; women's bodies are more often looked at, evaluated, and sexualized. Correspondingly, men place greater emphasis on a potential mate's physical attractiveness than do women (Wiederman & Hurst, 1998).

The associations between a disturbance in body image and psychological, social, and sexual dysfunction for different populations are not well understood, as Davison and McCabe (2005) report in their research. Researchers (Rodin, Silberstein & Striegel-Moore, 1985) have demonstrated a relationship between body image and self-esteem, not only among teens and young adults, but also in later years. There are preliminary indications that young women who report dissatisfaction with their physiques are at a greater risk of experiencing symptoms of depression and weight gain, although this relationship is less well understood among older women (Tiggermann & Lynch, 2001).

Davison and McCabe (2005) stated that there are inconsistencies in the literature, and it appears that results may be dependent on the particular aspect of body image measured. For example, self-esteem was found to be unrelated to weight concerns among young women, but strongly related to overall physical appearance. Researchers have not previously attempted to determine systematically which body image measures are most closely associated with different facets of psychological functioning.

Remarkably few researchers explicitly referenced the social context when investigating body image, which has resulted in the impression that body image evaluations

and behaviors occur in social isolation. The research demonstrated a growing awareness of the social nature of body image among female college students through their engagement in comparisons of their own appearance with that of others; such comparisons appear to be associated with negative evaluations of their bodies. In addition, researchers reported that a concern about others' evaluating one's body negatively, a variable termed social physique anxiety, is related to low levels of body satisfaction (Hart, Leary, & Rejeski, 1989). This suggested that evaluations individuals make of their bodies are related to the evaluations that they expect others may make. However, the relative importance of social aspects of body image compared to individual aspects of body image evaluations and related behaviors was not examined. It is currently unclear whether being dissatisfied with one's physique, considering oneself unattractive, rating one's appearance as important, applying effort to improve or conceal one's body, appearance comparisons, or social physique anxiety are of greatest relevance to people's psychological, social, and sexual functioning (Davison & McCabe, 2005).

Mead (1934) suggested that individuals see themselves from others' perspectives. Other researchers, such as Felson (1987), maintained that the influence of reflected appraisals may represent one of the most important issues involved in terms of how people feel about themselves in terms of physical attractiveness and degree of popularity. In this regard, when examining the effects of reflected appraisals in the area of physical attractiveness, Felson (1987) found that elementary school children's perceptions of their peers' evaluations had a significant impact on self-evaluation. Interestingly, he found that others' actual appraisals had less impact than the children's rather inaccurate perceptions of these appraisals. Felson's results also indicated that the effects of strangers' appraisals

were small and insignificant, supporting Hoelter's findings (1984) that the sources of reflected appraisals are important in determining the degree of their influence.

Interestingly, researchers in the area of body image have generally failed to investigate the degree to which body image is influenced by romantic partners. However, a good deal of research has focused on the discrepancy between one's perception of opposite gender's preferences of body size and the actual ideals of the other gender. In perhaps the seminal investigations in this area, Fallon and Rozin (1985) and Anderson, Durkin, Norris, Paxton, and Wertheim (2005) conducted studies in which men and women rated schematic figures ranging in size from thin to overweight. The men's ratings of their ideal size, current size, and figure they thought most attractive to women were found to be almost identical; however, women's current size rating was larger than the figure they thought would be most attractive to men, and both of these ratings were larger than their ideal size selection (Anderson et al., 2005).

More important for the purposes of this study, though, was the issue concerning the differences between the male and female figures each sex selected as its ideal. The male figure size that men thought would be most attractive to women was larger than the male figure women actually picked as their preference. In contrast, the women's selection of the female figure that they thought to be most attractive to men was actually smaller than the female figure men actually picked as their preference. These findings have been replicated and extended in several investigations (Fallon & Rozin, 1985; Thompson, 1996) and also applied to aspects of appearance other than overall body size (Jacobi & Cash, 1994).

Sobal and Maurer (1999) conducted semi-structured interviews with obese individuals, which averaged one and a half hours in duration. These researchers explored

each person's history as a large person, experiences with size discrimination and how they dealt with them, as well as current practices and feelings about their bodies. The respondents discussed the effects of being obese, their self-images, and their consequent behaviors. The interviews were conducted and presented in two sections (Sobal & Maurer). The first section of this study documented the informants' difficulties with their families, at school, at work, in romantic relationships, with the medical profession, and with the general public; this first section was the context for the second section, which focused on the main coping mechanisms of the informants, the tactics, strategies and patterns of reaction, and resistance to the stigmatization of obesity.

If people's appearance is in fact founded on how they perceive that others view them, there seems to be some degree of inaccuracy in the encoding of this information. Otherwise, one's perception of others' preferences would be congruent with their actual preferences; however, on closer inspection, there is a simple explanation for the lack of perceived-actual similarities in ratings: to date, researchers have focused on ratings of self, ideal, perceived other ideal, and actual other ideal, primarily in samples of men and women who are not acquainted with one another. Therefore, researchers have not been able to examine specific ratings made by romantic dyads about each other, which is especially important, given that one's romantic partner is most likely an influential source of feedback which might play a role in one's level of appearance satisfaction via reflected appraisal (Tantleff-Dunn & Thompson, 1995).

In those cases where two individuals are already intimately familiar with each other and have developed an emotional involvement as well, Tantleff-Dunn and Thompson note that researchers are able to measure two additional metrics: (a) a partner's actual rating of

their partner, and (b) one's perception of his or her partner's rating of their partner; the use of these additional measures provides researchers with the ability to extend the examination of perceived-actual disparities from those of the "ideal other" to an individual's romantic partner.

With this methodology, one can ask a variety of questions, including: Is there consistency between one's perception of how his or her romantic partner rates one's body and that partner's actual rating? How do these more personal ratings relate to size selections based on one's own ideal, the partner's ideal, or one's perception of the partner's ideal? Are these ratings related to levels of overall body dissatisfaction, eating disturbance, or general psychological functioning? These questions were investigated by Tantleff-Dunn and Thompson (1995) using samples of men and women involved in a romantic relationship for various periods of time, which completed interviews privately and in conjunction with interviews conducted with their significant others.

### *Childhood Obesity*

Adults who were obese as children often continue to tell obesity stories through that same childhood prism. As more and more children gain obese status earlier and earlier it is becoming alarmingly clear that these children have almost no chance of not being obese as adults.

While a number of obese children and adults appear to be comfortable with their weight condition, others may experience poor images of themselves and become socially withdrawn; furthermore, some obese children and adults can even experience serious depression because of their weight condition and may require psychotherapy or medication as a result (Clinton and Smith, 1999). According to these authors,

Youngsters who are obese and want to lose weight often give 'being able to do the things that other kids are doing' as their reason; they want to go where their peers are going, wear the same kinds of clothes, be invited out on dates, and form the normal everyday relationships that their friends have. p. 12

The extent that these young obese individuals fail to achieve these types of normal relationships may be the extent to which they grow up lacking social skills, having difficulty in being accepted by colleges, finding and retaining employment, and developing the intimacy and trust necessary for marriage (Clinton & Smith, 1999). Moreover, the negative attitudes of non-obese children toward their obese counterparts or others they may regard as being otherwise "different" are created early during their lives; the results of one survey found that children as young as six years of age rated obese children as "less likable" than those who are not, and rated obese kids even more negatively than children having facial disfigurement or missing limbs (Clinton & Smith, 1999).

All but one of the individuals utilized in the research conducted by Sobal and Maurer (1999) were overweight/obese as children, and the family was the first environment where they learned they were overweight. Informants were aware at an early age that they were a source of humiliation and disgrace to their parents and a figure of derision and scorn to their siblings and other relatives. They reported being cajoled and threatened into losing weight by their parents. The majority of the women indicated that their mothers criticized them constantly and warned them "nobody loves a fat girl," although none of the male respondents reported this advice. Many times parental exhortations turned into cruelty and insensitivity. Fathers were more likely than mothers to torment an overweight child. When the respondents reached school age, they were derided and ostracized by their peers. They were also punched and kicked on many occasions. They pointed out, with outrage, that their teachers often did not intervene to prevent the bullying. More often, the teachers

themselves made sarcastic, hurtful remarks (Sobal & Maurer, 1999). Furthermore, these researchers singled out physical education professionals as being especially sadistic towards fat children: "Two of the sample members dropped out of school as a result of the constant harassment and abuse" (Sobal & Maurer, 1999, p.53).

### Adolescence, Early Adulthood and Obesity

The maturation process and the transition from adolescent to adult is difficult and challenging for everyone. The added burdens for the obese adolescent are of Sisyphean proportions.

Anderson and her associates (2005) hypothesized that it is reasonable to posit that the lower the self-esteem and the higher the rate of depression involved, the more important being popular with others will be for the girl involved; in the instant situation, a boy may represent a means of achieving self-validation. Likewise, it is possible that these same factors contribute to greater sensitivity to socially endorsed notions of the requirements of attractiveness to others, for example, thinness as a requirement of attractiveness to boys. Previous research has consistently indicated strong relationships between low self-esteem, depression, body dissatisfaction, and disordered eating in adolescent girls (e.g., Paxton, Schutz, Wertheim, & Muir, 1999; Stice, Presnell, & Spangler, 2002; Wertheim, Paxton, Schutz & Muir, 1997). Thus, previously identified relationships between dating behavior, dating concerns, a belief that thinness is important in attractiveness to boys, and body dissatisfaction may also be influenced by psychological variables such as low self-esteem and depression in mid-adolescence.

In past research, adolescent girls have reported that attractiveness is important for success with boys, that body shape is an important component of attractiveness, and that



thinness is associated with dating success (Damhorst, Littrell & Littrell, 1987). Interview studies have resulted in similar findings, where a substantial proportion of girls (in one case almost 50%) held the belief that boys preferred girls who were thin and that a girl would have difficulty being popular with boys unless she was thin (Nichter, Nichter & Vuckovic, 1995; Wertheim, Paxton, Schutz & Muir, 1997). In addition, Lieberman, Gauvin, Bukowski, William and White (2001) posited that attributions about the importance of weight and shape for popularity and dating were important predictors of body esteem and eating behavior. In this regard, Anderson and her associates (2003) report that,

Beliefs about the importance of popularity to boys and the importance of thinness for attracting boys may themselves be influenced by psychological well-being, and, in particular, by low self-esteem and depression. It is quite likely that the lower the self-esteem and the higher the depression, the more important being popular with others, in this case boys, might be as a means of obtaining self-validation. p. 665

### *Obesity and Body Image Dysphoria*

The choice of the word *dysphoria* [italics added] was deliberate because it can and does mean many things, but is not specific. It implies a heightened emotional state most notably characterized by anxiety, restlessness, unease, depression and discontent; it is more than the opposite of euphoria because it also connotes a malaise and a discomfort that contributes to the isolation suffered by the one suffering from dysphoria. The added, extra-hard-to bear quality results in partial or sometimes total inability to function.

The literature suggests that poor body image or self-worth plays a role in the manifestation and perpetuation of obesity. Still, the reverse may be true in that obesity can result in low self-esteem. Two researchers looked at the relationship between female body image and sexual satisfaction. In both studies, a pervasively negative self-concept

existed with women classified as obese (Shapiro, 1980; Spiegel, 1988). In this regard, Areton (2002) examined the results of the studies conducted by Shapiro (1980) and Spiegel (1988) and found that not only did the obese women generally have a negative self-concept, but they also reported other negative effects, which they linked to their size.

According to Areton (2002):

The survey results indicated that the obese women...felt more inhibited in discussing sex with their partners, rated their primary relationships unhappy, and compared their physical attractiveness negatively to that of other women around them. They frequently wished they could change some part of themselves, and felt that their weight frequently interfered with their relationships. p. 7

Modern society constantly sends messages that thinness is desired and expected, and that those who are thin will live happier lives than those who are overweight or obese. The literature indicates a link between low self-esteem or poor body image and obesity. Many individuals seem to equate obesity with failure, and that signal permeates so deeply that the self-worth and esteem of obese individuals is often significantly affected (Foster, Wadden, Vogt & Brewer, 1997). The lowered self-esteem and poor self/body image often leads to psychological distress, which may then bring about additional stress within relationships (Foster et al., 1997). Therefore, it is vital that if the obese individual cannot manage weight loss, he or she must somehow strive to overcome his or her feelings of low self-esteem and negative body image if he or she is to withstand the overwhelming pressures and expectations within Western society (Maurer & Sobal, 1999).

A number of studies have examined another powerful factor: the link between mind and body. Hayes and Ross (1986) examined 401 females who were randomly studied to judge the effects of exercise, being overweight and physical health on their

psychological well-being. Low and moderate income groups received more enjoyment from active participation in exercise regimens than was reported by subjects in high income groups; although those women who enjoyed good physical health related the condition to a positive sense of psychological well-being, those women who were overweight did not necessarily experience psychological stress as a result.

The following two studies depict how a person's perception of his or her weight can be as important, if not more so, than the test of the scale. In the first study conducted by Yanovski, Yanovski, Sovik, Nguyen, O'Neil and Sebring (2000), 200 subjects from a convenience sample that resembled the general population were studied for a year. The purpose of this qualitative and quantitative study was to identify the validity and prevalence of holiday weight gain. Fifty-one percent of the subjects were women, and included normal, overweight, and obese individuals, with half of the subjects falling in the normal range for weight. The study was masked with the subjects not knowing what was actually being studied until after the holiday season had ended. During the interviews, the subjects were asked to assess the amount of weight gained during the holiday period before being weighed, and their individual guesses were approximately four times greater than the actual amount of weight gain.

A second study that illustrates the mind-body connection was conducted by Friedman, Schwartz, and Brownell (1998). Two measures of weight cycling, history and experience, and indexes of psychological functioning were examined in a large sample of dieters. The history measured actual weight lost and gained over their lifetime, as well as the number of dieting attempts and cycles of more than 20 pounds. The experience aspect of the study sought to measure the respondents' perceptions of being a so-called

“yo-yo” dieter who that bounced from active dieting to periods of relapse, and the participants’ view of whether they had been successful in their dieting attempts. The study showed that their actual dieting history was not linked to psychological variables, yet their perceptions of whether they had been successful or unsuccessful in their dieting attempts were indeed linked to psychological variables. Therefore if one participant believed himself or herself to have failed at dieting, then he or she was more apt to experience psychological problems, even if his or her history had showed that he or she had not failed.

### *Obesity and Sexuality*

Few researchers have studied whether a disturbance in body image is relevant to interpersonal functioning (Adams-Curtis, Forbes, Jobe, Pokrajac-Bulian, Revak, White & Aivcic-Becirevic, 2005). These authors note some preliminary findings from the study of American college students that there is a link between concern about individual appearance and impaired social functioning (Adams-Curtis et al., 2005). In addition, the study by Davison and McCabe (2005) found that American college students that perceive themselves as being unattractive were more likely to avoid cross-sex interactions, to engage in less intimate social interactions with members of the same and opposite sex, and to experience higher levels of social anxiety; therefore, negative body image may also be related to problematic sexual functioning.

Many researchers have tried to determine what role weight, waist-to-hip ratio (WHR), breast size, and hip size play in men's ratings of women's physical attractiveness (Furnham, Tan & McManus, 1997; Hens, 1995; Marlowe & Westman, 2001;

Molarius, Seidell, Sans, Tumilehto & Kuulasmaa, 1999). It has been repeatedly shown that overall men rate women with low WHRs as being more attractive, more feminine, and healthier. While less prevalent, some men preferred women with a higher WHR. Overweight women are typically stigmatized, particularly with regard to issues of sexuality and dating. In addition to having a low WHR, women are rated as being most attractive when they have a slender figure, small hips, and large breasts, a combination that is impossible for many to achieve without the help of plastic surgery (Hoyt & Kogan, 2001).

Jagstaidt, Golay, and Pasini (2001) studied the sexual behavior of 62 obese female patients between the ages of 20 and 45 years old. These women were compared with 35 normal weight subjects and 32 bulimic patients. Forty-eight percent of the obese patients presented with symptoms that met the criteria for an eating disorder. In addition to the eating disorder, these individuals more frequently exhibited other symptoms such as depression, sexual avoidance (sexual dysfunctions), and body image dissatisfaction. The authors of this study suggested that obese individuals with an eating disorder may benefit from sexual counseling during weight loss treatment.

A previous study by the same authors (Jagstaidt, Golay, Pasini, 1997) specifically looked at the sexual behavior and dysfunction of obese males, and compared the subjects with a group comprised of normal weight males. The study sample showed more eating and sexual disorders, and body image dissatisfactions than the sample of normal weight individuals. The authors also noted the sample group showed a lack of sexual desire, erotic fantasies and motivation in sexual advances.

In one hospital-based, multidisciplinary treatment program pilot study, changes were assessed in sexual functioning and body image after weight loss treatment of obese



females. Thirty-two females participated in this study and completed a questionnaire regarding sexual functioning pre- and post-treatment. Findings showed that significant increases in the frequency of sexual activity, as well as improved body image, were observed post-treatment by the subjects (Werlinger, King, Clark, Matthew, Pera, et al., 1997).

Regan (1996) looked at the perceptions others have regarding the sexuality of both males and females. Ninety-six undergraduates received information on male/female, obesity/normal weight individuals and were asked to give their opinions along several sexual dimensions. The findings of this study indicated that there is a clear stigmatization of obese women in modern American society, but obese men were expected to have attained a level of sexual activity and experience that was comparable to normally weighted women. This stigmatization of obese women compared to their obese male counterparts was most evident in that participants found the obese women less attractive, less skilled, cooler, less responsive, and not as likely to experience the same desire and sexual behaviors as a normal weight woman or obese males.

### *Couples and Psychological Distress*

Very few qualitative studies examined the effects of psychological distress of obesity in the couple relationship. Where studies were found, the main focus was often on body image, health habits, and marital distress. Dr. John Gottman (1999), one of the most published and renowned contemporary marriage and family researchers, provided one of the most comprehensive reviews of research and theories of marriage. In his book, *The Marriage Clinic*, Gottman (1999) cited the high relapse rate of marital therapy and the escalating divorce rate and related these to what he described as “myths

and mistakes in marital therapy (p 8). To identify potential areas for improvement, Gottman performed comprehensive analyses of marriages and reviewed current marital therapy research. Gottman's meta-analyses concluded that marital therapy has little or no effect with a high rate of relapse. He specifically stated, "In our longitudinal research we have typically found a strong positive correlation (about 50%) between having been in marital therapy and getting divorced" (p. 5). In addition, Gottman stated that in "the best studies, conducted in universities with careful supervision, only between 11 percent and 18 percent of couples maintain clinically meaningful initial gains when treated with our best therapies" (p. 5).

While Gottman (1999) used primarily empirical and quantitative methodologies, many of his interviews were qualitative, and many of his observations and conclusions are applicable to this study. He wrote extensively about how each "family creates a unique culture; a unique compilation of meanings; complete with its own symbols, metaphors, and narratives" (p. 108). The values, ideals, and philosophy of life are manifested in the way the family thinks of, and the meanings that they assign to them, and even to the most routine activities in the marriage. When Gottman explored shared meanings within the marital relationship, he examined four areas:

- 1) Rituals: This included a broad range of shared activities, from daily routines such as dinnertimes and running errands to annual events such as religious holidays and family vacations.
- 2) Roles: Wife, husband, son, daughter, doctor, homemaker, student, dancer, etc.

- 3) Goals: These tangible markers involve both short- and long-term aspirations: from working out four times a week, to owning a home, to getting an advanced degree or a raise in salary, to becoming a grandparent.
- 4) Symbols: These involve the intangible existential ponderings around the fundamental question, what is the meaning of home, family, love, trust, autonomy, etc.

Gottman (1999) asked couples to bring in their photo albums (childhood pictures as well) to get a good idea of what the family was like and what is important to the family. He instructed couples to use the photo album to "give a tour of the main characters and events in your life growing up, and in your lives together" (p. 405). The shared meanings (or their absence) with couples are applicable to this study. Insight regarding the meaning of weight for the individual and his or her partner contributes to a better understanding of overweight couples' experiences.

One qualitative study performed by Keicolt-Glaser and Newton (2001) focused on the role of marriage and physiological health. This study indicated that mental functioning was consequential to the health of the partners in the marriage. The study also indicated how negative marital quality correlated with poorer health (e.g. bad health habits, which could include overweight/obesity, as well as depression). Indirect physiological effects of poor marital functioning were also identified (e.g. cardiovascular, endocrine, immune, neurosensory, and other physiological mechanisms).

Faricy (1990) used a qualitative design to look at 25 couples in which one member lost at least 25 pounds. She wondered if the weight loss had the effect of stabilizing the marriage and/or bonded the couple, was a battleground for control, and/or



if it served as a sexual distancing mechanism. She also studied family origin and gender differences. Most were in first marriages and were not obese when they married. Faricy determined that, for most, the obesity of one partner was not a statement about the relationship. However, while the marriages were not dependent upon one member being obese, the obesity did affect the marriage due to the poor self-esteem of the obese member. This sense of low self-esteem ended up adversely affecting the marriage more so than did the level of obesity involved; therefore, the obesity appeared to be a secondary influence on the quality of the marriage rather than a primary one. Most of the obese members were confident in their own fidelity and that of their partners. The non-obese partners also did not try to force the weight loss of their spouses and were cooperative in their partners' weight loss efforts. More females than males believed the obesity had a negative effect on the relationship and the females' lowered self esteem was also believed to create a negative effect on the sexual relationship (Faricy, 1990).

In yet another study, Markey, Markey, and Birch (2001) investigated 187 married couples' dieting behaviors, marital quality, body mass index, weight concerns, depression, and self-esteem through the use of questionnaires. The authors found that the marital quality was similar for men and women in the study; yet, wives more often than their husbands suffered from unhealthy eating habits when there was marital discord. Wives also had problems with self-esteem, which affected marital discord when unhealthy eating habits were present. This qualitative research appeared to suggest that wives internalized problems more than husbands did. Further understanding of the differences in coping supports the need for more qualitative studies in this area.

The majority of patients who seek psychiatric treatment present with individual diagnosable conditions. The relationship with a marital partner often represents a significant contextual variable for the diagnosis and treatment of such psychological problems. Alternatively, spouses seeking marital therapy often present with individual psychiatric symptoms as well. There is a connection between the occurrences of psychiatric disorders and the quality of marital functioning (Beach & O'Leary, 1993; Biglan, Hops, Sherman, Friedman, Arthur & Osteen, 1985). However, there are no conclusive findings to support which occurs first, individual or marital distress.

### *Couples and Obesity*

The experience of becoming "an item" or a married couple not only brings two families together, but also additional systems enter the lives of these individuals. For example, socioeconomic status, gender issues, cultural issues, etc. must be embraced by these individuals for the couple relationship to survive. Bringing marital satisfaction into the relationship may be more challenging for obese couples.

While some individuals might prefer obese partners to normally weighted individuals as partners, some will view such overweight conditions in a potential mate as a serious blow to the viability of such a mate as a marital partner. Sobal and Maurer (1999) stated that for many people, obesity in a potential mate represents a death knell:

Overweight and obesity have proved to be stumbling blocks to courtship and marriage, especially for women....Subjects said that they would prefer to marry an embezzler, cocaine user, marijuana user, shoplifter, recovering mental patient, and others before they would marry an obese person. The researchers noted that the males expressed greater resistance to the possibility of an obese partner....Similarly, high school students surveyed indicated an unwillingness to date an overweight person. The males, in particular, were reluctant to consort with a heavy peer. p. 55

Sobal, Rauschenbach and Frangillo (1995) gathered and analyzed data on obesity and marital quality from the National Survey of Personal Health Practices and Consequences Database (1979-1980) on married adults. Weight and five other variables (age, race, socioeconomic status, employment status, and presence of children) were reviewed and data on their impact on marital quality showed that body weight was not associated with the majority of aspects that defined the quality of the marriage. The authors found that obese women were happier with their marriages, obese men had more marital problems, men who lost weight tended to have fewer marital difficulties, and people who gained more weight were happier with their marriages (Sobal et al., 1995).

Sexuality is a very real part of every couple's relationship. While obesity has often been shown to have a negative effect on self/body image, some obese individuals are no less likely to enjoy sex with their partners than of those of normal weight (Williams, Sander & Foreyr, 2000). In this regard, Williams and colleagues suggested that although opportunities for sexual encounters may not be as frequent because of social pressures, social perceptions, and the lack of self-esteem and competence in a percentage of obese individuals, the desire for healthy sexual relations is nonetheless there in most obese people (Williams, et al., 2000).

Ledyard (2004a), in her dissertation, used a qualitative phenomenological research design to examine the marital quality of 11 couples who struggled with obesity. Ledyard conducted individual and joint interviews with the participants. The themes from her study included obesity as a psychosomatic illness, the mind and body as one, two spouses become one system, and that weight balances the system. Additional underlying themes described by Ledyard included:

marital quality and weight; health issues; mental health issues; sexuality and intimacy; weight as protection; conflict styles; weight gain in the marriage: appearance and acceptance; messages from the media and society, couples as a team; the family of origin and its messages, values, and fear of change: change back! p. 153

The couples in her study described weight as being a very significant part of their relationships, including how they related to each other and the effect of weight changes. Descriptions of marital dynamics and weight included control issues, conflict styles and weight as a protection.

In her public presentation of this study, Ledyard (2004b) elaborated on these interactions and likened them as being very similar to dynamics of couples when anorexia is present in one of them. She raised a question about a connection between obesity, trauma and addictions. Family of origin similarities between alcoholism and obesity and/or the comorbidity of alcoholism and obesity were identified (Ledyard, 2004). The findings cited in Ledyard's study and discussed in her presentation, showed the need for additional qualitative research regarding couples and weight.

In a study discussed earlier by Sobal and Maurer (1999), two of the fourteen members of the sample were divorced. While the sample was small the stories were germane to the current study. Both men and women indicated that their failure to lose weight led to the breakdown of their marriages. One's ex-husband told the subject that her obese condition was the reason why he had numerous adulterous relationships, and another man's former wife concluded that his failure to lose weight amounted to a lack of respect for himself, and by extension, for her. Of the five married members of the sample examined by Sobel and Maurer, four reported that their spouses were obvious in their displeasure about their overweight condition: "In particular, the two married women

complained that their husbands berated them openly or made cruel remarks cloaked in the guise of humor, especially in the presence of friends" (Sobel & Maurer, 1999 p. 55). Moreover, the spouses of both of these women consistently refused to recognize their insensitivity; rather, they accused their wives of being overly sensitive and when asked why they remained in such unsatisfactory marriages, both women admitted that the primary motive for marrying their husbands although they did not love them was the fear that the opportunity for matrimony might not present itself again. Further, both women felt threatened by the prospect of divorce if they did not lose weight, and they were alternately relieved and frightened by the ultimatum to lose weight: "Frightened of being alone the rest of their lives, relieved because at least they would not have to tolerate verbal abuse" (Sobal & Maurer, 1999, p. 54).

Emerging evidence suggests psychosocial factors such as partner support may play an important role in improving the success of intervention programs (Porter and Wampler, 2000). Whether partner support makes a difference in the happiness and marital satisfaction of obese people, and whether those with supportive partners lose weight and keep it off more easily, has long been debated. One researcher, Black (1988), studied this issue and concluded that there may be more to harmony in the couple relationship than simply whether one spouse gained or lost weight.

An analysis of thirteen different studies was conducted by Porter and Wampler (2000) indicated that having partner support while dieting increased the chances of success, but the impact of partner support waned as time went by and completely disappeared two to three months after weight loss was achieved. Kagan (1983) found that how a non-obese partner treated an obese partner before, during, and after weight



loss had a significant effect, not only on the weight loss but also on how much self-esteem the obese partner had and how he or she felt about his or her body image.

Any resulting marital discord based on weight related issues can be quite pronounced, but those partners who are able to work together to achieve weight loss often fare much better than those who are unwilling or unable to do this (Margolin & White, 1987). These researchers stated this was a result of the physical attractiveness that one partner sees in the other. When one partner is seriously overweight or obese, the other partner often does not see him or her with the same degree of attractiveness that he or she did when the obese partner was thinner.

When the non-obese partner works with the obese partner to set weight loss and other health conscious goals, the chances of successful weight loss rise higher than they do with only basic support (Dubbett, 1982; Dubbett & Wilson, 1984). Studies have shown that those partners that are willing to work hard along with their obese partners to achieve that partner's desired weight loss will help them achieve greater success; this shared victory can serve as a platform that leads to higher degrees of marital satisfaction for both partners involved. By working together in a marriage to help one partner achieve weight loss both partners receive satisfaction from the relationship at an increased level, therefore boosting the happiness in the marital relationship at the same time that the weight loss occurs (Brownell, Heckerman, Westlake, Hayes & Monti, 1978; Cohen, Schwartz, Bromet & Parkinson, 1991).

### *Summary*

Few research studies have been conducted in the areas of obesity and self-esteem; obesity and body image; and obesity and sexuality within the context of couple

relationships. Most findings that were gleaned from research conducted within the past two decades used a quantitative research designs. In these few qualitative studies that have been done focused primarily on spousal support (usually the wife) for the one who is attempting to lose weight. The focus is on the weight loss. It is not about obesity, treatment and weight loss and the overweight couple relationships. Faricy (1990) in her study did individual interviews, not conjoint interviews. Ledyard (2004) was the first study to conduct individual and conjoint interviews about the meaning of weight.

Obesity is a very complex, multi-causal issue. There remains a wide and as yet still unaddressed gap in the literature on obesity; that gap is the voice of the overweight couple as expressed by the individual, their participating partner and the couples themselves speaking directly about their experiences with obesity, treatment and weight loss.

## Chapter 3 - Methodology

### *Rationale for the Study Design*

This was a qualitative study using a phenomenological approach. In general, qualitative studies are used in areas where there is little known information and/or the information needed is of a more subjective nature. Phenomenology was particularly useful in providing an understanding of the experience of obesity, treatment and weight loss from the individual perspectives of the formerly obese individual and his or her partner and their experience as a couple.

Phenomenology is a method used to describe phenomena or experiences from the participants' point of view. It is the study of lived experiences or existential meanings. The focus is not to determine if in fact the experiences occurred but rather what meaning those real or perceived experiences had for the participants (Van Manen, 1997). It has also been described as a philosophy, a way of experiencing phenomena (Dreyfus, 2002). Merleau-Ponty (1962) described phenomenology as the study of essences.

Husserl (1970) described phenomenology as the study of the life world of an individual. He stated that the aim of phenomenology is to gain a deeper understanding of the nature and meaning of life experiences from the participant's perspective. In order to arrive at the essence of phenomena, it is necessary for the researcher to suspend or "bracket" all beliefs about the phenomena. The researcher starts an interview by bracketing all preconceived ideas and then asking broad, open-ended questions (Husserl, 1970 in Zahavi & Stjernfelt, 2003).

This study was a qualitative phenomenological investigation that looked at the lived experiences of participants who received treatment for obesity and weight loss. The



focus of this study was on describing the participants' experienced meanings as opposed to describing overt actions or behaviors (Gottman, 1999).

The descriptions and procedures for phenomenological research as outlined by Moustakas (1994) were used as a guide for organizing and analyzing data. This model requires the principal investigator to adhere to the following four steps: 1) horizontalizing the data, 2) listing meanings or meaning units, 3) clustering, and 4) describing the experience. The techniques employed by Moustakas (1994) seemed to be most applicable in this study. These techniques support thinking systematically about data and relating to them in very complex ways. According to Moustakas (1994):

Organization of data begins when the primary researcher places the transcribed interviews before him or her and studies the material through the methods and procedures of phenomenological analysis. The procedures include horizontalizing the data and regarding every horizon or statement relevant to the topic and question as having equal value. From the horizontalized statements, the meaning or meaning units are listed. These are clustered into common categories or themes, removing overlapping and repetitive statements. The clustered themes and meanings are used to develop the textural descriptions of the experience. From the textural descriptions, structural descriptions and an integration of textures and structures into the meanings and essences of the phenomenon are constructed. (p.118-119)

Horizontalizing of the data has several dimensions. When the researcher initially begins horizontalizing data each phenomenon has equal value as its nature and essence is disclosed. Horizons are unlimited; yet no horizon lasts indefinitely. As the phenomenon becomes horizontal, "things far away are viewed differently when they come near; inevitably we make corrections as things come into sharper focus and clarity" (Moustakas, 1994).

Statements irrelevant to the topic and question as well as those that are repetitive or overlapping are deleted, leaving only the "horizons," from which meaning or meaning

units are listed. In phenomenological research meanings are arrived at through intuition and reflection on conscious acts of experience, leading to ideas, concepts, judgments, and understanding (Moustakas, 1994).

These meaning units or essences are clustered into themes that can provide a textural description of the phenomenon. From the themes and delimited horizons of each research participant's experience, a textural description is constructed. Participants' experiences are quoted "verbatim" to support the textural description.

Structural descriptions of the experience in this phenomenological research are brought about by the researcher's "awareness through imaginative variation, reflection and analysis, beyond the appearance and into the real meaning or essences of the experience" (Moustakas, 1994).

The essences of any experience are never totally exhausted and the horizons are unlimited, yet there comes a particular time and place from the vantage point of the researcher to end the data analysis. The textural-structural synthesis represents this vantage point and it drives the final descriptions of the experiences. The composite textural and structural processes were the final steps of data analysis for this study (Moustakas, 1994).

As theoretically described above, the researcher began the process of horizontalizing by gathering all data collected from the genograms, journals, self-report instruments, and interview transcripts. All statements were then ascribed equal value.

Phenomenological research is important to a study of this kind in that it allows the exploration of the *lived experiences* [italics added] of various individuals. In this case, these experiences dealt with obesity, treatment and weight loss, and the meaning of the

experiences for each participant as an individual and as part of a couple. The rich descriptions of the issues provided more insight than could be obtained from simply completing a questionnaire. This study attempted to gain multiple perspectives of the primary participant and his or her partner's experiences by conducting semi-structured interviews, both separately and jointly.

### *Sample Description*

Participants for the study were sought from both the rural community of Franklin County and the urban communities in and surrounding St. Louis, Missouri. The sample size of six couples came from Franklin County, St. Charles County, and St. Louis County. The sample size was chosen due to time constraints, availability, and the interest of the public to participate. It has also been noted by the researcher that several other studies used four to six couples in their samples (Weisz & Bucher, 1980). Qualitative studies, however, do not start with a set number of participants, but rather they continue to study participants until they see the patterns or the themes becoming repetitious (Creswell, 1994).

### *Inclusion/exclusion Criteria*

The main criterion for selecting subjects for a phenomenological study is that the subject has experience with the phenomena under investigation. Another criterion is that the subjects are willing and able to describe their experience. The inclusion and exclusion criteria for this current study are listed below:

#### *Primary participant inclusion criteria.*

- 1) The primary participant had to have reached a BMI at least 30 or above within the past three years. The researcher used a standardized BMI height and

weight chart (Appendix A). In order to respect the participants' privacy, the waist circumference was not measured.

- 2) The primary participant had to have participated in a minimum of at least one self-help weight loss program so that the researcher was able to discuss with the participant experiences while in the weight loss program and how he or she felt about himself or herself at various times throughout the program. Weight loss program was defined by the participant. The programs were physician recommended, commercial program or self-prescribed; and included any or all of the following: use of over-the-counter products, exercise, and/or dieting. A minimum of three months in a weight loss program was required, since it takes some time for weight loss to begin and to ensure participants were able to describe the experience of weight loss.
- 3) The primary participant had to have achieved 50 percent of his or her weight loss goal at some point during the past three years, in order to more accurately indicate to the researcher how his or her weight loss made him or her feel at the time and how he or she feel about his or her weight at the time of the interview. The goal BMI was defined by the participant, although this may not have been established with the assistance of a weight loss program.

*Primary participant exclusion criteria.*

- 1) The primary participant must never have met the criteria for anorexia nervosa, bulimia nervosa, or any other eating disorder diagnosis.
- 2) The primary participant had to be willing to participate in the entire study.

*Partner participant inclusion criterion.*

The partner had to have been willing to participate in the research, since questions and questionnaires were required by both partners.

*Partner participant exclusion criterion.*

The major exclusion criterion for the partner participant included a history of anorexia nervosa, bulimia nervosa, or any other eating disorder diagnosis.

*Couple participant inclusion criteria.*

- 1) The couple was required to have been together for at least three years.
- 2) Within the age range of 18 to 75.
- 3) Both partners had to participate in the Telephone Screening Interview (Appendix B).

*Couple participant exclusion criteria.*

- 1) If one of the partners decided to not participate in the study at any time.
- 2) Couples experiencing marital conflict or excessive stress, as defined by at least one of the participants in the Telephone Screening Interview (Appendix B) were excluded.

Original non-obese/overweight BMI criterion for partner participants was changed with IRB approval, due to the difficulty obtaining a sample where only one of the partners was obese. There was still a substantial difference in the BMI between the primary and partner participants, even when the partners had BMIs over 25. All of the participants met the criteria to participate in the study both as individuals and couples.

### *Recruitment Procedures*

The sample for this study was recruited by a variety of methods: placing flyers (Appendix C) in the local library, press releases (Appendix D), websites (Appendix C) and public announcement sites were utilized (Appendix E). Recruitment agreements (Appendices F and G) were signed by a number of health care professionals, who strongly supported the research; however no participants came from this recruitment method. The researcher gave several presentations about her research to physicians and licensed mental health professionals and self-help organizations and weight loss treatment programs were notified about the study. While the intent was purposeful sampling in order to select participants from diverse populations and treatment programs, most participants learned about the study through the suggestions of family, friends and colleagues.

### *Instruments of Data Collection*

#### *The Participants*

The researcher's first contact with participants was by telephone (Appendix B). A brief overview of the study, including compensation, was given and the caller was asked to have his or her spouse call to verify willingness to participate in the study. Initial telephone contact questions were limited by Health Information Protection and Portability (HIPPA) laws, since height and weight are health indicators. Participants were informed that after they had signed the consent form (Informed Consent for Participation in Research Activities, Appendix H), more questions would be asked to determine if they met the criteria for the study. Participants were informed that all



interviews and follow-up phone calls would be audio recorded. Two interview sessions were scheduled after the couple agreed to participate.

In addition to the interviews, participants completed self-report instruments questionnaires. They participated in telephone member checks and/or e-mail conversations. Participants were encouraged to answer journal questionnaires and select photographs for the optional photo album review.

*Protection of the Participants.* Participation was voluntary. Participants were informed that the content of the interviews, which were audio taped, would be confidential, and that their names would not be used in written results. Each person was told he or she could refuse to answer any question and/or could end the interview at any time. Participants were informed that they could discuss any issue(s) in more detail should they choose to do so. Participants were also informed that they could withdraw from the study at any time without consequences to them.

Prior to beginning data collection, the researcher received permission to conduct the study from the Saint Louis University Institutional Review Board. Participants also signed the Informed Consent for Participation in Research Activities (Appendix H), prior to participating in the study or being asked for any HIPPA protected data.

Due to the sensitivity of the subject being studied, weight, the primary participant was always interviewed and/or contacted before pursuing data collection with his or her partner participant. Participants were also informed that information shared in the individual interviews, member checks and any self-report data would remain confidential. However, some participants chose to share information from their individual interviews in the joint interviews.

Confidentiality of participants was maintained through a coding system that matched participants with his or her audio taped interview sessions and journal entries but did not use personal names or other recognizable identifiers. The Master Code Sheet was kept separate from the raw data and only the researcher had access to the Master Code Sheet. Committee members and the auditor reviewed coded materials only. All data collected was stored in locked file cabinets within a locked private office with a security alarm system. All transcripts were destroyed at the conclusion of the study.

A de-briefing was conducted before concluding the last interview. If any participant had experienced undue anxiety, they were referred to a mental health professional.

#### *The Researcher*

The researcher was the primary data collection instrument (Creswell, 1994) through asking questions, taking notes, conducting interviews and analyzing the data. Her background, experience, education and clinical supervision as an interviewer were important; her interview skills and intuition influenced the flow of the semi-structured interviews.

The researcher was a doctoral candidate in the Department of Counseling and Family Therapy at Saint Louis University. As a student, she completed qualitative and quantitative research methodology courses. She was a Registered Nurse and a Licensed Professional Counselor. The researcher had conducted previous research both as a nurse and a counselor. In her private practice she had developed excellent interview skills and was very experienced with genogram construction. Thus, the researcher had the experience necessary to conduct interviews, which is the focal point of qualitative



research (Patton, 1990). These experiences and her education enhanced the trustworthiness of the data and the study.

### *Instrumentation*

In order to better understand the experience of obesity, weight loss and treatment from the perspectives of formerly obese individuals, their partners and their experience as a couple, this researcher developed a series of semi-structured interviews. The literature, discussions with other researchers and clinicians, the experiences of the researcher, and focus groups conducted by the researcher were all sources of questions for the semi-structured. Appendix I (Focus Group Questions for Preparation of Semi-Structured Interview Guides) provides a summary of these questions.

These processes provided the basis for validity of the questionnaires. The reliability came from the repetition of themes as participants responded to the questionnaires.

The surveys and questionnaires that the participants filled out provided basic background information as well as quantitative and some qualitative information for the study. Qualitative information also came from the genograms constructed and field notes recorded. Most of the qualitative information for the study came from the interviews. One participant brought photographs, which were examined and discussed. One participant brought in a childhood recording of her father encouraging her to eat. Some participants reflected on which photographs they had considered bringing. The thoughts and feelings of the couples relating to weight, treatment and weight loss were discussed without excessive prompting from the researcher.

The primary instruments used in this study were the semi-structured interviews involving participants both individually and as a couple. The following interviews were developed for this study: 1) Semi-Structured Guide for Genogram Construction (Appendix K), 2) Semi-Structured Individual Interview Guide (Appendix L), 3) Telephone Interview Check One following first interview (Appendix M), 4) Photo Album Review Explanation (Appendix N), 5) Semi-Structured Interview Guide for Photo Album Review (Appendix O), 6) Semi-Structured Interview Guide for Couple Interview (Appendix P), 7) Couple De-Briefing Interview Guide conducted at end of Joint Interview (Appendix Q, and 8) Telephone Member Check Two following final interview (Appendix R). Self-report instruments and journaling were included in the study.

### *Semi-Structured Interviews*

Semi-structured interviews combined the flexibility of the unstructured, open-ended interview with the directionality and agenda of the survey instrument to produce focused, qualitative, and textual data at the appropriate level. The questions on a semi-structured interview guide are formulated, yet the answers to those questions are open ended: they can be fully expanded at the discretion of the interviewer and/or the interviewee, and they can be enhanced by probes (Schensul, Schensul & LeCompte, 1999). Exploratory research, which includes some instructional interviewing, provides the basis for surveys and other forms of explanatory research that contest theoretical hunches or propositions (Schensul et al., 1999).

Questions primarily focused on obtaining a better understanding of the experience of obesity, treatment and weight loss. Conversely, questions were included to determine if and how other issues in the relationship affected obesity, weight loss and treatment.

*Joint genogram construction interview.* The genogram, first developed for use in family therapy, is a powerful tool that maps family relationships, history, and patterns of behavior within the family system (Bowen, 1960). Because the genogram asks such specific questions and is very detailed in what it looks for, it often persuades individuals to give more family information than they would normally give. When the genogram is constructed it gives an overall picture of the individual, his or her partner and their families of origin. The genogram has been invaluable as a format for collecting, organizing, and interpreting data, rather than being a standardized measurement technique (McGoldrick & Gerson, 1985). The genogram is also a normative and useful instrument in phenomenological research. The genogram questioning is very in-depth and often goes straight to the heart of family experiences, behaviors, relationships, and time connections. This information is collected while helping to elicit complex and emotional information in a non-threatening way (McGoldrick & Gerson, 1985). "Even the most guarded person, quite unresponsive to open-ended questions, may be willing to discuss his or her family in such a structured format" (McGoldrick & Gerson, 1985).

While it was most important for this study to determine the context of weight loss among couples, the desired weight was also considered in the context of the couple's family weight history using the genogram. It is useful to determine and understand how one feels about his or her weight in relationship to having family members who have significant weight problems or significant others who have excessively thin ideals or are

overly weight conscience (Antony & Barlow, 2002). Family of origin similarities and differences in beliefs about weight can and often does greatly impact the couple's expectations of each other.

*Joint photo album review interview.* The optional photo album review interview was another instrument used in this study. The data collection goals of a photo album review were very similar to genogram construction. Since the qualitative approach seeks to describe the experience and understand the feelings that surround a particular issue (Creswell, 1994), the use of photographs and the powerful emotions and stories that they elicit can contribute to the researcher and participant's understanding of the experience of obesity and weight loss within the couple's relationship. A deeper look into the experience as the underlying feelings of the individuals photographed are often discovered by reflecting on personal photographs. Weiser (1993) noted that "metaphors of self construction" often provide "stimuli to communication" that may help individuals to understand particular issues and expansive concerns in their lives that affect them in what often appear to be unrelated ways (p. 261).

From a family systems perspective, photos of clients with others, especially family members, can provide a wealth of information about family power alignments, triangulation, emotional cutoffs, mirroring, and other behaviors. Photographs can also serve as the stimuli for many questions about the feelings surrounding the viewing of photographs that other people have taken of the client (Weiser, 1993).

*Primary, partner and couple semi-structured interviews.* Congruent with Family Systems Theory (FST), the dialogue of each partner about the other was an important component for comparison of what was described in the individual interviews. During

interviews and review of the data, concepts of FST were included: open-ended and circular questions, family rules, circular causality, negative feedback processes, sequences of family interactions around a problem and positive feedback loops. The researcher attempted to maintain a balance between following the interview questions and following the lead of the participants. The exciting element about phenomenological research is that there is great latitude for unexpected themes and patterns to emerge.

The meanings each attributed to obesity, weight loss programs and weight loss itself was explored, as the researcher actively listened in order to hone in on the themes that emerged from the interviews. Phenomenological research is committed to descriptions of experiences, not explanations or analysis. In a sense, this allows the participants to define the parameters to be measured.

### *Self-report Instruments*

The researcher developed an instrument entitled, "Weight History and Significant Events: A Subjective Historical Time-Line" (Appendix S) for this study. This instrument was useful for the purpose of triangulation and strengthening the trustworthiness of the data. Most participants clearly identified their experience related to weight from their own perspectives. For example, some subjects defined timeframes with actual dates; others selected events similar to the family life cycle, or by their age.

A demographic questionnaire with an additional question requesting a description of obesity treatment received was completed by both participants. The Demographic and Treatment Information Questionnaire (Appendix T) was developed from the one used by contemporary marriage researcher, Dr. John Gottman (1999).

Journaling was encouraged, but optional for the study. At the end of the first interview, participants were given questions and suggestions for journaling at home (Appendices U, V, W and X). They were asked to take them home and write down their thoughts, and mail the answers or bring them to the next interview.

The journal entries were an extremely valuable research tool. More information may be gathered by including a journal entry than just relying on the interviews alone. When participants have quiet free time at home in their familiar environment, and can really reflect on their experiences with obesity, much richer information and a deeper understanding of the phenomenon may emerge from their journaling.

Having written data also gives another data source to check or corroborate the information gathered during the interviews and on the instruments. While some participants may be comfortable in the interviews, others may prefer to journal about the experiences. Including both techniques allowed for rich data to be collected in a manner most suitable to participant preferences. Journal data were analyzed with the same methodology for the interviews.

#### *Steps in Data Collection*

The use of multiple data sources added to the complexity of this study. The following table provides a chronological overview of the procedures used for data collection



Table One: Steps in Data Collection.

Telephone Screening Interview	
<ul style="list-style-type: none"> <li>a) Explanation of research study with primary participant</li> <li>b) Screening interview with primary participant</li> <li>c) Explanation of research study with partner participant</li> <li>d) Screening interview with partner participant</li> </ul>	
Session One	
Couple Participant	
<ul style="list-style-type: none"> <li>a) Explained and obtained informed consent</li> <li>b) Collected photo album and/or photographs</li> <li>c) Joint family genogram construction interview</li> </ul>	
Concurrent Individual Interview and/or Questionnaire Completion	
<ul style="list-style-type: none"> <li>a) Primary participant individual interview</li> <li>b) Partner participant individual interview</li> <li>c) Demographic and treatment information questionnaire</li> <li>d) Weight history and significant events: a subjective historical timeline</li> </ul>	
Conclusion of First Interview (Joint)	
<ul style="list-style-type: none"> <li>a) Clarified questions</li> <li>b) Journal guides given</li> <li>c) Encouraged to bring photo album</li> <li>d) Scheduled separate telephone interviews for member checks</li> <li>e) Scheduled the next joint interview session</li> </ul>	
Member Check One	
<ul style="list-style-type: none"> <li>a) Telephone member check with primary participant</li> <li>b) Telephone member check with partner participant</li> </ul>	
Session Two	
Joint with Primary and Partner Participant	
<ul style="list-style-type: none"> <li>a) Reviewed joint information shared in the first interview</li> <li>b) Collected journals</li> <li>c) Explained photo album review (if applicable)</li> <li>d) Photo album review interview guide (optional)</li> <li>e) Joint interview conducted</li> <li>f) De-briefing interview</li> <li>g) Scheduled separate telephone interviews for member checks</li> </ul>	
Member Check Two	
<ul style="list-style-type: none"> <li>a) Telephone member check with primary participant</li> <li>b) Telephone member check with partner participant</li> </ul>	
Data Clarification Member Checks	
<ul style="list-style-type: none"> <li>a) Telephone and /or e-mail clarification of emerging themes</li> <li>b) Participant approval of couple descriptions</li> </ul>	

The researcher conducted interviews with five couples in her office. One couple did not have transportation and the interviews were conducted in their home. Their diversity brought a dimension to the study that outweighed the benefit of all interviews being conducted in the office. More control over distractions and disruptions, such as the dog barking, phone calls and privacy for individual interviews was an advantage of office interviews. The office also gave greater control over the audio taping quality. Participants were less likely to cancel if their homes weren't as neat as they preferred. Since accuracy of transcription was so important, office interviews seemed to outweigh the advantages of home interviews set forth by Creswell (1994), who noted that subjects may feel more comfortable if the interviews are conducted in the familiar setting, and the more relaxed atmosphere will be more conducive to qualitative research.

### *Assessment of the Data*

#### *Researcher Bias*

Part of the philosophy of qualitative interviewing is that interviewees and interviewers are individuals with emotions, interests and biases that affect how the research is done. Personal involvement is a great strength of the methodology, but also creates problems that must be addressed. An interviewer has to be sensitive to his or her own biases, the social and intellectual baggage he or she brings to the interview (Lincoln and Guba, 1985).

Researcher bias was monitored through the literature review, through the use of a bias clarification interview and through the mentoring of the chair of the dissertation committee. These measures allowed for enhanced authenticity of this study. Throughout the interview process, the transcription of the data, and the data analysis, the researcher



reflected on and categorized responses. The researcher bracketed written notes on her thoughts in order to assure that opinions and feelings about the couples and their answers had been set aside so that the most reliable data could be collected without bias. To help identify biases and increase validity, Kathleen Glenn Doyle, a licensed clinical social worker, an adjunct faculty member in the School of Social Work at Saint Louis University and a social work practitioner, fulfilled the role of auditor for this study. A Bias Statement is provided in Appendix J.

During data collection and analysis, the committee chairperson looked for discrepancies or questionable information in order to determine if these were strictly informative or whether they were the result of bias. If they were the result of bias they are indicated as such or removed.

The researcher kept a journal of her responses to obese persons and the memories of others' comments about obesity. Keeping this journal continued throughout the data collection process.

#### *Trustworthiness of the Data*

Holistic descriptions, corroboration and triangulation were also employed to enhance the trustworthiness of the data. According to Stainback and Stainback (1989) a holistic description of events, procedures, and philosophies occurring in natural settings is needed to make accurate situational decisions. A researcher cannot understand the couple's experience of obesity without including both participants in the study.

The purpose of corroboration is to ensure that the research findings accurately reflect people's perceptions, and to help researchers increase their understanding of the probability that their findings will be seen as credible or worthy of consideration by

others. This was accomplished by including the participants in data analysis by formal member checks, follow-up phone calls and e-mail conversations.

Denzin (1997) identified several types of triangulation as important processes in establishing trustworthiness of the data. This study included the convergence of multiple data sources: semi-structured interviews with the primary, partner and couple participants, self-report questionnaires and journaling.

The detailed methodology set forth in this study enhanced its reliability. It can be replicated with other samples (Creswell, 1994; Patton, 1990). The questions asked in the semi-structured interviews, telephone member checks and journaling were quite detailed and were adhered to with little exception. External validity of the study or the generalizability of the findings in this study was limited by the small, non-random sample (Patton, 1990). Generalizability was not the intent of the study. The intent was to study the experiences and interpretations of obesity, treatment and weight loss from the perspectives of the individuals and the couples.

### *Data Analysis*

All of the interviews and most of the telephone member checks were audio taped and transcribed. Data obtained from the questionnaires and journals were typed. If participants brought in photo albums, the response of the participants to the photos and memories they disclosed were recorded. After the interviews were transcribed, the researcher analyzed them individually with the themes, patterns, and meanings they ascribed to their experiences.

The researcher developed a coding system and log that allowed her to compare and contrast the information received not only from the questionnaires and written

information of the participants, but also from their thoughts and feelings. Throughout the interview process, the transcription of the data and the data analysis, the researcher reflected on and began to categorize responses. The data was organized in tables, so that the researcher could easily access the comments for use in the data analysis. The tables were: 1) the categories being studied (obesity, treatment, and weight loss), 2) the perspectives of the primary participant, partner participant, couple or researcher, 3) emergence and context of themes and 4) a comparison of the data from the perspective of the primary participant, his or her partner and the couple.

All data collected were treated as having equal value. Whether a statement came from an interview, questionnaire or member check, the data were given the same scrutiny. The context of the data for this study was also of equal value. For example, disclosure made in the individual session and ignored in joint sessions was noted. The context of the participant's weight was extremely important and taken into consideration during data analysis.

Horizontalizing of the data was accomplished by making notations of themes throughout data collection. Comments regarding content and context were handwritten on the interview transcriptions. Observations and comments were reviewed from multiple data sources and lists were developed. The data was not assigned any value during the process of listing. As the researcher completed the next steps of data analysis, other themes were also identified.

The next step, clustering of meaning and meaning units, was completed by taking the lists of comments and observations and beginning to label them as themes. The meaning units and themes were categorized. The frequency of the theme from the

multiple perspectives was noted on a separate summary sheet for each theme. Notations about possible connecting or overlapping themes were recorded.

Next, textural descriptions of the data were organized as the data emerged. Interpretations, observations, comments and meaning units from the data were followed by accurate descriptions of the data. Quotations from the data sources were preserved in a detailed textural form for future reference, for data verification, and to develop structural descriptions.

The themes, textural descriptions, and interpretations were all used to develop structural descriptions of the data. The structural descriptions of the data used terminology from Family Systems Theory. The meta-themes and FST terms were supported again by the horizontalized data, textural descriptions, and meaning units.

The four steps used in the data analysis did not always result in clearly defined meta-themes. Nor were these steps done in chronological order. While Moustakes' steps in data collection were followed, completion of one step would sometimes take the researcher back to a previous step of data analysis. Like Moustakes, the researcher found that the essence of the experience or data analysis is never totally exhausted and can be an unlimited process.

The researcher came to end the data analysis when she reached the vantage point of clearly identifying and supporting meta-themes with structural and textural descriptions. The analysis reached a place where the researcher determined that the analysis contributed to a better understanding of couples' experiences with obesity, treatment and weight loss.

### *Summary*

This study explored the phenomenological experience of obesity, treatment and weight loss from the perspectives of the formerly obese individual and his or her partner and their experience as a couple. The design utilized a qualitative, phenomenological method in which the researcher collected the data and conducted the analysis.

The sample consisted of six couples in which the obese spouses had lost at least 50% of his or her goal weight. All of the couples completed the study and voluntarily disclosed their experiences through separate and joint semi-structured interviews.

Internal validity of this study was demonstrated by triangulating of the data, bracketing the biases of the researcher, consulting with the chairperson and conducting telephone member checks. The instruments that were developed enhanced the validity of the data. Notations of the researcher's observations and perceptions guided this effort.

## Chapter 4 – Results

### *Introduction*

The purpose of this study was to better understand the experience of obesity, treatment and weight loss from the individual perspectives of the formerly obese individuals, their partners and their experience as a couple. Data was collected from the instruments developed for the study and semi-structured interviews. The use of multiple data sources produced complementary and conflicting results. For example, participants may report their weight(s) differently on the various instruments and/or in the interviews. Rich descriptions of the experiences described by the participants, individually and as couples, became the meta-themes of this study.

The methods of data analysis described in Chapter Three were used to identify seven meta-themes that emerged in the data. These themes sometimes overlapped, blended into each other, and were intertwined with subsequently described sub-themes. The order of presentation of the themes follows the similar patterns of recursive circularity as reported in the individual and couple sessions. The patterns of interaction and reaction to weight gain, treatment and weight loss described by the participants were similar. Furthermore, these patterns were almost universal in which the sequences presented. These patterns contained linear and recursive circularity features.

The first theme, “Fluidity of the experience,” emerged in response to the participants’ complex descriptions of their experiences with obesity, treatment and weight loss. The three voices, primary, partner and couple, most often blended into one harmonious voice. For one couple, their three voices resounded frequently with harmonic dissonance. Experiences merged between each other, time, and comorbidity of obesity,



weight fluctuations and interactions with multiple systems. Treatment of obesity usually involved multi-disciplinary treatment teams that also overlapped, and were sometimes fragmented.

The second meta-theme, "Family of origin: weight metaphors, childhood stories and obesity fear factors," emerged in the first joint genogram interviews. Participants' understanding of their experiences with weight began with their families of origin.

The third meta-theme, "Weight gain, role changes and social isolation," seemed to evolve as the couples began experiencing weight as a medical illness. The primary participants entered treatment and as the effects of comorbidity emerged, role changes became necessary. Weight then became an unspoken issue between the couple.

The fourth meta-theme, "Weight communication: perceived boundaries and inadequacies," occurred when the couples made attempts to talk about what was happening to them as individuals and as a couple. When weight resulted in role changes, becoming difficult to talk about, and weight loss goals were not met, the couple perceived their communication as ineffectual. Anxiety increased and communication decreased.

The fifth meta-theme, "First-order/second-order changes," emerged at several levels. Initially, weight gain was a first-order change that resulted in decreasing health of the primary participant. When roles and responsibilities shifted to the partner participant, second-order changes, or change in the system, occurred. Later, as goals of weight loss were established and achieved (first-order change), the subsequent second-order changes in the individual and couple relationships often did not occur.

The sixth meta-theme in this process was "Body image dysphoria." With weight gain, especially after successful weight loss, primary participants did not always have a

better body image. In fact, some of the partner participants continued to hold negative body images of their spouses.

Finally, the seventh meta-theme, “Weight as the third person in the relationship,” emerged as a circular transition back to the first meta-theme, fluidity of the experience. The couples had a lingering sense of doom that weight, “the third person,” was a shadow following them.

### *The Research Participants*

The participants’ names have been changed to protect their identity. The researcher selected names to honor the participants and her family and the loved ones who have supported this research. The names are combinations of these individuals to be anonymous for the person being honored and the participant. As one reads any complex novel, the reader may be challenged to integrate the characters with events and the roles they play. In qualitative analysis, reporting of dialogue in multiple contexts can be confusing to the reader. The primary participants are printed in bold and the partner in italics for reader convenience in parts of Chapter IV.

The following “raw” and unedited descriptions are the initial impressions of the researcher. They have been reviewed and approved by each of the participants

### *Narrative Descriptions*

*Couple One: **Rachel** and David.* David was a short, balding, overweight, pot-bellied man who didn’t care that his appearance was disheveled. David spoke loudly, almost as if he were hard of hearing, in a deep staccato voice that gave him an air of authority, belying the sensory impression that registered if you just looked at him. David’s voice noticeably softened throughout the individual partner interview. At times,



his confidential self seemed to appeal for corroboration of his assessment of Rachel. He emphasized to the researcher that he really had an *understanding* [italics added] of his wife's concerns, and he wanted the researcher to understand his predicament. David had an air about him that stated very loudly that he wasn't at all concerned about his attire or his appearance. He wasn't color coordinated and looked as if he had just tumbled out of the spin cycle. Despite David's lack of style, he was an honest look-you-in-the-eye sort of man who had been working two jobs most of his life in order to make ends meet.

Rachel was also overweight, but more so, and offered a more harmonious picture due to the fact that she did have sense of style. Her clothes were well chosen and color coordinated even though she shopped the extra large racks. Her hair and nails showed that she was meticulous about her appearance, and since money was very tight, she had that confidence and self-reliance that is possessed by those who are able to make a lot out of a little because of attention to detail.

This couple's description of their positive experience with weight loss in both joint sessions had undertones of uncertainty, which the researcher, would not have connected with, had she not interviewed them separately. In individual sessions, both David and Rachel described examples of distance, misunderstanding, and separation as Rachel immersed herself in exercise, social connectedness, and healthier eating. David's interpretation of Rachel's commitment to her morning exercise group was, "I thought she must be having an affair." Rachel described David's reaction to her weight loss/walking group as "trying to hold me back." Rachel described examples of how he would say "honey, just snuggle with me a little longer....it's too early and cold to go walking." She sadly said the walking group dis-banded. In the last joint session, both expressed

concerns about their experiences of Rachel's strong commitment in the walking group. David stated, "I was worried she was going to fall and hurt herself; she would walk when there was ice and snow on the ground....I couldn't understand her obsession." Rachel agreed, "I can see that he was just concerned, and sometimes I would walk when there was ice on the ground....I was just afraid to stop walking."

*Couple Two: Vicky and James.* Vicky and James arrived in separate vehicles, he coming from work and wearing his uniform shirt and she coming from their latex-free home via her latex-free vehicle, which they attempt to keep free of latex contamination. The lists of latex items that needed to be avoided were so numerous and pervasive that not only were the daily newspapers and magazines not allowed, but sometimes James's work clothes were shed before entering the home.

Vicky's weight had yo-yoed and was presently at the high mark once again. During the eight year battle since latex-disability had sidelined her from a health care professional position at a major hospital, she has, by necessity, become semi-reclusive. Vicky was dressed for comfort, not even a weak nod toward fashion. Her hair was cut short and it spoke to practicality. She wore no make-up or jewelry and carried her water in a glass jar. Vicky surveyed the office and directed James to where he should sit. Vicky was excited about the interview and eager to talk. James dutifully sat where directed, appeared very tired and yawned frequently throughout the interview. James was one of two participants who did not complete the Weight Timeline; he said, "I'm sorry, I was just too tired."

The couple seemed to know each other's family of origin and family histories in detail. When constructing the genogram each would sometimes remind the other of a

detail that had not been included. It was as if each could have told the other's family history with the same accuracy. As the couple talked about issues related to weight Vicky did most of the talking with James nodding in agreement. However, when the topic was not about weight, James was very engaged. He spoke eloquently and with feeling about her medical history which eventually led to her disability and social isolation. He expressed empathy for her physical plight brought about by external factors but expressed little empathy about her weight. James acknowledged and described in great detail the connection and interaction between her physical illness and her weight gain. During the individual partner interview, James spoke softly and, at times, appeared sullen about the current state of their relationship and the negative effect it has had on him. He seemed at a loss about how to support Vicky better and he appeared sad about the loss of shared activities.

Several issues experienced by the partner and affecting the relationship were noteworthy. James described the gradual decline in the couple's relationship, as his wife gained weight and became more ill; he talked at length about the effect it had on him. He stated that as she became more depressed and increasingly more limited by what she could do physically; he also became depressed and gained weight. He talked about dropping educational classes and about how he was no longer pursuing career goals. Without further exploration, it was difficult to assess if he was hiding his limitations behind his wife's problems or if there was a spillover effect of her experience. What was significant and noteworthy was that they both felt isolated and very sad that they could no longer pursue and engage in activities (i.e. canoeing, backpacking, and social outings) that had brought them together and were the mainstay of their first five years of marriage.

*Couple Three: Cathy and Joe.* Joe and Cathy, the youngest couple, in the study were also the most recently married. Their plain-spoken answers were refreshing because there was no hint of holding back, dishonesty or excuses. They appeared to speak just the plain unvarnished truth, candid and simple.

Joe was a straight talker who looked right at the researcher while speaking. His no-nonsense honesty was reflected in his vocabulary as well as his demeanor. His plain spoken charm was enhanced by a maturity that came from a rural upbringing where hard physical labor was expected and self-sufficiency the norm.

Cathy was older, better educated, and more sophisticated than Joe, but shared his qualities of honesty, directness and openness. She was meticulously groomed and organized, gave credit to those who supported her weight loss, had valuable insights, and gave believable descriptions of how weight gain and loss affected herself and her relationship with Joe. They were careful not to be negative about each other, but would openly make negative remarks about each other's family of origin and about each others' relatives. They were in tune with each other's needs and expectations and had a more difficult time talking about her weight gain than her weight loss. It was as if the suddenness of the gain was an embarrassing mystery, while the gradual weight loss was a shared journey that had a comfortable ending. Joe's willingness to speak openly about his own family members and their problems was not carried over when he spoke of his spouse.

Cathy was more sophisticated and could converse on several levels, while Joe exhibited a surety and confidence that comes from the knowledge that the accomplishment of a job was nothing more than doing each individual step in the proper

order until all the steps were completed, like putting a motor back together. Despite these differences, each listened to the other with respect. Joe was reluctant to place blame on his spouse for gaining weight, but was willing to point out his dissatisfaction with her attitude and her unwillingness to continue to be social in spite of her weight gain. He was not happy to stay at home or avoid contact with friends. He did not comprehend her fear of the ridicule she thought would come her way. Cathy feared losing the edge that she enjoyed in their relationship. She thought that she would be exposed as not sophisticated, not in control, and not worthy of the pedestal that he had placed her on. Joe never seemed to grasp nor understood Cathy's struggle with body image and avoidance of going out socially while obese. None the less, Joe was proud of her effort at weight loss and gave her much credit; "she did it the hard and right way, exercising and watching what she ate....She didn't have gastric by-pass or use Nutri-system." He took pride in understanding why his wife gained the weight, e.g. medical reasons, depression, and antidepressants. In the joint session he seemed to still be reassuring Cathy that he understood, and especially normalized her weight gain during pregnancy which, in reality was the beginning of her weight loss.

*Couple Four: Becka and Bobby.*

Bobby and Becka entered into the research study with eagerness and a passion about their experiences. Becka frequently stated that they had a lot of experience with weight gain and treatment and could provide good advice for others. Bobby agreed, but with noticeably less enthusiasm. While this couple seemed to talk more openly than others about marital issues related to weight, it was with palpable anger and hostility that they described many areas around which their lives were interwoven and connected.



Bobby was tall and thin, whereas, Becka was much shorter and heavier, with an obvious difference in their BMIs. Becka was quick to point this out and recited the childhood poem "Jack Sprat could eat no fat...." While Becka recited the poem, Bobby just stared straight ahead. Bobby stated, "I can't help it if I'm not attracted to fat women....I still love and care for you, but I can't get sexually excited when you are overweight." Becka passionately said to Bobby, "If you really loved me, it wouldn't matter how much I weighed." There were several circular statements about their relationship, sex and weight throughout the interviews.

At the time of the interview, Becka had lost a significant amount of weight, yet the couple talked as if she were still at her highest weight. The lost weight did not seem to move the couple beyond their negative experiences of obesity, yet this negativity around weight did not spill over into all areas of the couple's relationship. The couple described significant stressors in their family through which they believed that they had successfully navigated.

Bobby remained very serious throughout most of the interviews. He would often become defensive of his own honesty when Becka was upset with his answers. "Well, she [referring to me] wants us to be honest, and it isn't anything that hasn't already been said." He did not complete the Weight Time Line, but did completely answer a set of journal questions. Bobby expressed frustration at himself for not foreseeing the probability of his wife gaining weight like the other short and overweight people in her family; "the apple doesn't fall far from the tree."

Bobby was defensive about issues related to his past alcohol abuse, and would respond with statements supporting his success with quitting alcohol, while his wife was

still struggling with her "food addiction." Bobby stated that he believed that his wife was overweight due to the genetic predisposition from her family of origin. However, he stated that just as he was predisposed to chemical dependency and he had to receive treatment and give up alcohol to stay in their relationship, his wife had a responsibility/obligation to lose weight. Bobby believed that it was as important for her to lose weight as it was for him to quit using alcohol. This researcher sometimes experienced him as not being flexible and understanding of Becka's weight gain. As these experiences were noted, the researcher consciously tried to put these aside in order for the phenomenon of his experience were better understood. Bobby talked about feeling sad, hurt, and disappointed that his wife didn't love him enough to try and do something about her weight, and said: "I don't understand how she could let herself go." He was concerned about health issues that ran rampant in her family and he was afraid that she might succumb to these illnesses as well.

In the individual interview, Bobby was much more open about his sadness and fears, about the effect of his wife's weight upon each of them individually and as a couple. He stated several times that he felt guilty about his lack of sexual attraction toward his wife when she was overweight. "I just can't help myself be more attracted to her when she is so overweight."

Becka presented herself as an expert in gaining and losing weight and was not nearly so concerned about the extra pounds that still remained. She expressed confidence in her personal treatment plan based on Weight Watchers' meals and an exercise program with co-workers. Becka's experience of obesity, treatment and weight loss pretty much mirrored her husband's viewpoint, inasmuch as they both still seemed to be immersed in

and merged to the experiences with obesity and alcoholism, but unable to differentiate the past from the present.

The couple scheduled interviews around the puppy training class they were taking. Becka and Bobby spoke with pride about this shared event. The new puppy seemed to invigorate the couple.

*Couple Five: Mark and Joanne.*

Mark and Joanne were the most enthusiastic, vibrant and connected couple in this study. It was apparent from the moment they entered the researcher's office. They seemed to envelop the office and infuse it with an energy that mirrored the excitement that passed between them. They sat closely and frequently reached out to touch each other. The physical connectedness of this couple was evident immediately, but not far behind was the zest that each had not only for each other but for the moments that they shared.

Both were casually dressed in sportswear and gave the impression that, if asked, they would not only play a game of mixed doubles, but would both beat you handily. Mark, who was carrying a photo-album, began to speak about the photos before sitting down. Both Mark and Joanne were enthusiastic about participating in this study and eager to share their story.

Mark was the only male who was a primary participant in this study and had a swagger about him that said confidence in capital letters. During the interviews there were shared glances and frequent touching that spoke to shared intimacy and understanding. It was very evident that these two individuals enjoyed each other's



company and that each was enthusiastically rooting for the other and for themselves as a couple.

They both talked about their chemical dependency recovery which is now three and a half and two and a half years for Mark and Joanne, respectively. The researcher thought how sad it would be for these energetic, enthusiastic young people to have put their licensures and careers in jeopardy by substance abuse. The researcher decided not to explore how chemical dependency had affected them individually and as a couple; this was not the focus of this study. The researcher refrained from exploration of chemical dependency with one exception. The couple was asked to describe how their experiences with substance abuse may or may not have affected their experiences with weight gain and weight loss.

Through the interviews and follow-ups their enthusiasm never flagged, even when they spoke of some of their life stressors. They were confident and self-assured and exuded an aire of genuineness that is as rare as a no-hitter is in major league baseball.

*Couple Six: Louise and Stephano.* This interview was the only one not conducted in the researcher's office. The interviews took place in the couple's mobile home in a well-maintained mobile home park. The house was meticulously cared for, every wall was filled with pictures and every space was filled with knick-knacks. Each room was carefully color coordinated and tastefully furnished. Throughout the interviews, Stephano attended to every need: served delicious coffee, calmed the barking dog, answered his daughter's questions, and refilled his wife's water glass. Stephano was a Greek immigrant who spoke softly in broken English and was ten years older than his wife. He was difficult to understand at times, but his face glowed when he spoke about

being a famous soccer player in his home country. Stephano has never had a problem with his weight and stated that he had not seen many overweight individuals, especially women, until he came to America.

Stephano became tearful when talking about his wife's weight. He repeatedly stated and emphasized to the researcher as he walked to her car, "I'm afraid I am going to be old and the only one who can take care of my wife and our daughter.... If she doesn't lose weight I fear for what will happen to her." Stephano expressed regret about moving to Missouri. "Things were good in Colorado; we come to Missouri and they are not good." Stephan went on to talk about her weight gain. "She gained so much weight; she cannot even walk very far and sometimes has to use oxygen." He spoke with passion, love and concern. Present was the sense of helplessness, "I don't know what to do."

Louise was seated for both interviews at the kitchen table with her medicines lined up in a neat row on the table. She never used her oxygen during the interviews, but there was oxygen tubing that hung close to the chair and extended into the bedroom. Louise's personal appearance was very neat, with coffered hair and painted manicured nails.

Louise often interpreted what Stephano was saying when he was searching for the right word to use. This did not appear to be an attempt to control what was being said, but a way to manage Stephano's anxiety. Louise and Stephano both frequently stated that he wanted to participate in the study, but may have a hard time understanding the questions. Perhaps the questions were difficult to understand and not directly answered in full by Stephano, but he certainly had no difficulty expressing his concerns about his wife's weight and his role as a supportive partner. Stephano did the cooking and

attempted to control the portions of food his wife ate. Louise said that she very much needed Stephano's "portion control." Stephano verbalized some feelings of guilt about his wife being overweight, because he was responsible for the shopping and cooking.

Neither one drove. Both were dependent upon others for transportation: Louise's children, friends and their church family. Economics and access to health care were described as major contributing factors to Louise's weight gain. Louise frequently stated that the couple faced many difficulties upon arrival in Missouri. The more disappointed she became, she began to feel more depressed and returned to earlier eating habits. One disappointment cited was, "Our house wasn't ready for six months and we had to live in my daughter's home." Demarcations for the couple's experiences seemed to be related more to where the couple lived than weight itself. However, weight changes were present in each of the places the couple lived. The couple talked in longing terms about their life in Colorado.

### *Demographics*

All twelve (six couples) of the participants were Caucasian (one participant was a Greek immigrant), middle- to upper-middle class, with an average age of 43.17 years ranging from a low age of 26 years to a high of 70 years. Of the ten religious preferences reported, one participant belonged to the United Church of Christ, three were Catholic, two were Methodist, one was Baptist, and a couple described themselves as "Christians." In addition, one participant subscribed to the Greek Orthodox Church. A majority of the participants were either college graduates or had at least attended some college or trade school; the oldest couple reported having a high school education.

The occupations of the participants included three disabled individuals (secretary,

health care professional, and service industry), a customer service representative, two mechanics, two stay-at-home mothers, an education professional, two active health care professionals, a law enforcement officer, and retired sports professional.

A summary of the demographics is provided in Table 2.

Table 2: Participant Demographics

Participant	Age	Sex	Education	Ethnicity	Religion	Combined Annual Income	Occupation
<b>Couple One</b> <b>Rachel</b>	<b>43</b>	<b>F</b>	<b>Currently College (CPA)</b>	<b>Causation</b>	<b>None Stated</b>	\$30-50,000	<b>Disabled Secretary</b>
<i>David</i>	<i>46</i>	<i>M</i>	<i>Some College</i>	<i>Caucasian</i>	<i>None Stated</i>		<i>Customer Service</i>
<b>Couple Two</b> <b>Vicky</b>	<b>41</b>	<b>F</b>	<b>BSN</b>	<b>Caucasian</b>	<b>UCC</b>	\$50 – 60,000	<b>Disabled Health Care Professional</b>
<i>James</i>	<i>42</i>	<i>M</i>	<i>AA &amp; Trade School</i>	<i>Caucasian</i>	<i>Roman Catholic</i>		<i>Mechanic</i>
<b>Couple Three</b> <b>Cathy</b>	<b>31</b>	<b>F</b>	<b>AA, 1 class to complete BSN</b>	<b>Caucasian</b>	<b>Catholic</b>	\$30-40,000	<b>Health Care Professional, Stay at Home Mom</b>
<i>Joe</i>	<i>26</i>	<i>M</i>	<i>AA</i>	<i>Caucasian</i>	<i>Catholic</i>		<i>Mechanic</i>
<b>Couple Four</b> <b>Becka</b>	<b>42</b>	<b>F</b>	<b>Some Graduate</b>	<b>Caucasian</b>	<b>Methodist</b>	\$50 – 70,000	<b>Social Services</b>
<i>Bobby</i>	<i>43</i>	<i>M</i>	<i>Some College</i>	<i>Caucasian</i>	<i>Methodist</i>		<i>Law Enforcement</i>
<b>Couple Five</b> <b>Mark</b>	<b>38</b>	<b>M</b>	<b>BSN</b>	<b>Caucasian</b>	<b>Christian</b>	\$50 – 60,000	<b>Health Care Professional</b>
<i>Joanne</i>	<i>35</i>	<i>F</i>	<i>BA</i>	<i>Caucasian</i>	<i>Christian</i>		<i>Education, Stay at Home Mom</i>
<b>Couple Six</b> <b>Louise</b>	<b>61</b>	<b>F</b>	<b>HS</b>	<b>Caucasian</b>	<b>Baptist</b>	\$20 – 40,000	<b>Disabled Service Industry</b>
<i>Stephano</i>	<i>70</i>	<i>M</i>	<i>HS</i>	<i>Caucasian (Greek immigrant)</i>	<i>Greek Orthodox</i>		<i>Retired Professional Sports Player</i>

### *Weight Histories*

An understanding of the context from which people tell their stories is always significant. Of particular importance to the study of obesity, treatment and weight loss is the context of one's current weight (BMI). Themes around the context of weight are discussed later in the chapter

The partner participants' BMIs were not a criterion for this study. While some of the partner participants met the BMI criteria for overweight, there was still a substantial difference between the primary participants' BMIs and their partners' BMIs. In addition to making note of the current BMI, the fluctuations of the primary participants' BMIs were examined more closely.

Rachel, at the time of this study, had BMI of 46. As an adult, her BMI had ranged from 26 to 58. The most weight she had lost and maintained was 133 lbs. Rachel had one "serious weight loss attempt" and six to eight attempts less than 20 lbs. Rachel had childhood obesity and was the only one who was taken by her parents to a professional weight loss clinic. Prior to the study, her physician informed Rachel that she would most likely never reach a BMI in the normal weight range. Endocrine diseases contributed to her weight.

Vicky, at the time of this study, was at her highest BMI of 46. As an adult her BMI ranged from 28 to 46. One year prior to the study she had maintained a 52.5 lb. weight loss for two years. Interestingly, Vicky had been considered "fat" by her childhood classmates. At home, her parents disavowed the comments of her classmates. As a result of entering this study, Vicky looked at her childhood pictures and compared her childhood weights with growth records. She told the researcher, "I wasn't



overweight then; I was in the 99<sup>th</sup> percentile.” Vicky was trying to get herself motivated again to lose weight at the time of the study. She stated, “every time I lose weight, I regain it with another five lbs....I’m scared to try again, who knows how much I’ll end up weighing?”

Cathy, the youngest of the primary participants and most recently married, had a BMI of 28 during the study. She had one weight gain of 46 lbs., had recently lost around 20 lbs., and continuing to lose weight during this study by portion control and exercise. Cathy’s described experiences were not much different than those of other primary participants who had been married longer, experienced more weight fluctuations and less success at weight loss.

Becka had a BMI of 36 at the time of the study. She had the most weight loss attempts, “too many to count,” and the greatest weight fluctuation of all the participants. Her most recent weight loss was around 50 lbs. The longest Becka had maintained her weight loss was 18 months. Her adult BMI has ranged between 23 and 44. Becka was active in Weight Watcher’s and worked out at the gym during this study. She was the most enthusiastic about her weight loss program that she was doing with her co-workers.

The only male primary participant, Mark’s BMI was 31 at the time of the study. He appeared lean and muscular. Using a different measurement of weight may have changed Mark from an overweight category to a normal weight range. Mark had a history of childhood obesity and had lost considerable weight during adolescence. His BMI ranged from 21 to 41. Mark was not involved in a formal weight loss program; however, he described himself as trying to live a healthier lifestyle. The most weight he

had lost was 50 lbs. Mark had been able to maintain a normal weight, as an adult, for more than ten years.

Louise was the oldest participant and currently had the highest BMI, 62. Louise was the only participant in a second marriage. She blamed obesity for the demise of her first marriage. Over the years her BMI had fluctuated between 23 and 70. Several years ago she had lost 120 lbs and maintained this weight loss for 2 ½ years. Louise had regained this weight and is currently losing weight by following a diabetic diet with portion control. She has many comorbid illnesses and is not able to exercise. Of all the participants, Louise had been through the most comprehensive weight loss program. This included medical management, aqua and physical therapy, supervised meal plans by a registered dietician, group therapy and individual therapy. These services were available to her in Colorado. These services, including transportation, are not Medicare covered services in Missouri. Louise's husband was the spouse who was most involved in her weight loss program.

Several additional noteworthy facts were provided regarding weight. Each of the primary participants (corroborated by their partners) was in a normal weight range before marriage. Each of the primary participants gained weight after marriage, but in different time frames. Rachel, Vicky, and Louise began gaining weight immediately after marriage. Cathy's weight gain began during the onset of depression three years after her marriage, Becka gained weight during each of her pregnancies. Data regarding the onset of Mark's weight gain was not shared. Mark, Rachel and Louise had childhood obesity. Vicky reported that her classmates perceived her as being overweight, but not her parents. These three participants lost a significant amount of weight during



adolescence. It was difficult to know for certain if Vicky had childhood obesity. She did report losing weight during college, but not adolescence.

Since this study included multiple interviews, journaling and additional methods for data collection, the references to weight were not always identical. Data reporting may appear to be inconsistent; however, the data provided was inconsistent. The researcher determined the percentage of the weight goal met, by reviewing weights reported in the multiple data sources. The highest weight and lowest weight were recorded for the table. The percentage of weight loss goal met was determined by subtracting the most recent weight loss, from the most recent weight gain. This provided an approximate weight loss which could then be compared with the goal weight. Pounds were converted to BMIs.

Table 3: Primary Participants' Adult Weight Loss Goals

Primary Part.	Current BMI	Highest BMI	Lowest BMI	Goal BMI	% of Goal Met
<b>Rachel</b>	46	48	26	35	80
<b>Vicky</b>	37	37	28	28	65
<b>Cathy</b>	28	31	23	25	52
<b>Becka</b>	36	44	23.5	35	60
<b>Mark</b>	31	41	21	27	70
<b>Louise</b>	62.2	70	23	35	50
Averages	40.03	45.17	24.08	30.83	62.83

### *Genogram Analysis*

The following two tables depict important information about the participants gathered primarily from the genograms; however, some of the data was gleaned from demographic data and interviews. While most of the data is self-explanatory, the researcher brings to the reader's attention the following significant data, particularly as it relates to the participants in this study: 1) Age of weight gain, 2) all of the primary participants were still at an obese or overweight BMI, 3) five of the six primary participants had at least one episode of depression, 4) one primary participant had a history of substance abuse, 6) five of the six partner participants had a history of substance abuse, and 7) five of the six primary participants have personal health concerns, whereas in the partner participants, only one of six had health concerns. This data emerged from the genogram interviews, journal entries and self-report inventories.

The data that emerged from these sources are pertinent to the experiences of the primary participants and their partners. Several of these salient concerns were not part of the semi-structured interview questions. The additional data disclosed by the participants reflects the complexity of obesity and the relationships of obese individuals. The significance of select data in the tables on the next page is further discussed in relationship to meta-themes.

Table 4: Primary Participants' Genogram Summary

**Primary Participants N=6**

	Average	Range
<b>Age</b>	44	31-61
<b>Sex</b>	5 female/male	
<b>Education</b>	1 High School 0 some college 1 AA 4 BS/BA	
<b>Current BMI</b>	40	28-62
<b>Highest BMI</b>	45	31-70
<b>Lowest BMI</b>	24	21-28
<b>Onset of First Weight Gain</b>	2 elementary 3 in their 20s 1 in their 30s	
<b>Length of Weight Loss Maintenance</b>	4 years	6 months – 10 years
<b>Personal Health Concerns</b>	5 of 6	
<b>Substance Abuse</b>	1 of 6	
<b>Depression</b>	5 of 6	

Table 5: Partner Participants' Genogram Summary

**Partner Participants N=6**

	Average	Range
<b>Age</b>	43	26-70
<b>Sex</b>	5 male/1female	
<b>Education</b>	1 High School 2 Some college 2 AA 1 BS/BA	
<b>BMI</b>	27	19-35
<b>Personal Health Concerns</b>	1 of 6	
<b>Substance Abuse</b>	5 of 6	
<b>Depression</b>	1 of 6	

## *Themes*

### *Fluidity of the experience*

Fluidity of the experience, as defined by the researcher, means that there are no clear demarcations between overweight, treatment and weight loss. In addition, it means that the experience(s) of one partner spills over or blends with the experiences of the other. This meta-theme is supported by the prevalence of similar themes between the primary, partner, and couple participants. Given the three subjects explored: obesity, treatment and weight loss, and the voices of these experiences from the formerly overweight individual, his or her partner, and the couple, a researcher might assume that data would naturally fit into a three by three chart. While some distinct features existed, participants did not talk about any one experience, without bringing in aspects of obesity, treatment and weight loss.

Primary participants, partners and couples seemed to have a difficult time describing these experiences in both *individual and joint interviews*. Primary participants most often focused on overweight experiences and weight loss failures, while their partner participants focused on the effects that obesity continues to have on their lives. Couples seemed to be overwhelmed by their experiences with obesity and attempts at weight loss.

Other factors support this fluidity of the experience. In many cases, the primary participants continued to tell their story from their overweight experience, even when they had lost a substantial amount of weight. At times, it seemed difficult for these participants to talk about their experiences prior to weight gain and after weight loss.

Some partner participants seemed reluctant to acknowledge the weight loss of their partner. They responded to their spouses as if they had not lost the weight, or

noticed the disappearing pounds. Bobby was withholding of his compliments to Becka. He voiced concern that she would not reach and maintain her weight loss.

When the primary participant had lost substantial weight, the couple seemed to fear a return of the weight gain. It was if they couldn't trust the weight loss. The couples seemed to have difficulty envisioning their relationship without weight as an issue.

Vicky stated that she was afraid to attempt weight loss because in the past she would regain and exceed her previous overweight high. Her husband, James stated that it was hard to imagine their lives changing, even with weight loss. Noteworthy, is the fact that Vicky also had a latex allergy which had also caused changes in the couple's lifestyle.

For some couples, their experiences with obesity were blurred with other stressors and comorbid illnesses in their lives. For others, such as James and Vicky, weight loss was on the back burner because managing other health concerns and stressors were of greater import. James changed life goals, became less outgoing and quit participating in events he enjoyed, such as canoeing. Of all the couples, James and Vicky seemed to have a reciprocal spillover effect on each other. James seemed both angry and devoted to his wife. Perhaps, this was related to having a younger sister with Spina Bifida and his own experience with Hodgkin's disease.

The blending and melding together of these experiences was not as present in two of the couples. However, in these couples, the primary participant in one couple relationship described fluidity of the experience as body image dysphoria. In the other couple, the partner participant, continued to describe his experience with his wife's weight fluctuation, as if she had never experienced weight loss.

Joe provided descriptions of his own and his partner's experience with very clearly defined demarcations and corresponding descriptions. In the joint sessions, Joe and Cathy described their experiences with weight gain, treatment and weight loss. The measuring stick Joe used to explain before, during and after experiences was primarily related to socialization. Having been party goers, Joe was surprised at Cathy's reluctance to go out. Both described how she would cry and rummage through her clothes trying to find something to wear.

Cathy said when she was at her highest weight "it [weight] made me very sad, made me feel lonely, but it also made me feel very unhealthy at the same time." She appeared sad as she began describing her experience with obesity. She disclosed additional thoughts and feelings about this experience, but seemed to always come back to describing the overall experience as sadness.

As Cathy began to lose weight, she did begin socializing with her husband again. However, what Joe didn't seem to understand was what a challenge it was for Cathy to socialize again even after weight loss. In a member check regarding this meta-theme, Cathy responded with this email:

It definitely makes sense to me. My husband and I both think that I tell my story more dealing with being overweight rather than treatment or weight loss. *I can tell that I focus all my energy on being overweight instead of the success that I had losing weight.* [italics added]

The other couple that seemed to have more clearly defined demarcations with weight fluctuation was Becka and Bobby. Becka was definitive about her experiences, as evidenced by her journal entries. During times of weight gain she inserted ☹, and when she lost weight she inserted ☺. Vicky also used these faces when journaling about weight fluctuation.



For Bobby, weight seemed to engulf him and he was not able to recapture the connection he had with Becky prior to her weight gain. Bobby appeared very sad and near tears when he talked about his lack of physical attraction to his wife. "I just can't help it....It's not like I don't want to be [intimate], I just can't make myself." Even though his wife had lost a substantial amount of weight and he believed that she was motivated to lose weight, Bobby still finds it challenging to be physically attracted to her.

Stephano and Louise did not define and describe their experiences according to weight fluctuation. For them, their experiences were defined by the different states in which they had lived. Stephano and Louise seemed to focus primarily on the experiences related to obesity. Louise was the most physically ill participant. One thing that Stephano made clear was that his wife had multiple physical problems with the weight gain: "It is difficult," he stated.

The spillover effect of the experiences of obesity in the partners was apparent in several participants, including Stephano. He stated that his wife's obesity had a significant impact on his outlook about the future. Stephano, in broken English stated: "Nervous and make me depressed."

In the individual partner interview, James said that his "wife's weight and just her general health" had changed his lifestyle significantly. He described several ways this had affected him.

I just give up on a lot of other things; I have just personal things I want to accomplish either on my own or within the marriage, improvements around the house. Like a couple of years ago when I went through treatment [chemotherapy for non-Hodgkin's Lymphoma], one of the first things I wanted to do when I got out was I wanted to take a study course and become certified in handling refrigerants. I had a lot of the knowledge and knew what to do and for the most part now it's the thing where you need to take a study course you're certified. I've given up on that. Things that are important to me or used to be important to

me that I would normally if I had problems with I could correct them and make sure I would do those things. I don't even care anymore.

As James saw his wife continue to gain weight he saw himself as becoming more despondent.

When asked about his perception of his wife's experience after weight loss, David responded: "You'd be amazed how much bubblier she was then." When the researcher further explored his wife's "bubbly" experience, he stated that he believed she was bubblier because "I think she felt better physically, felt better about her self, felt better all around." These were the same words Rachel used to describe her experiences after weight loss. Yet, Rachel and David also commented on how the experiences seemed to blend together and it was hard to describe their experiences.

Mark and Joanne had very little to say about the differences in obesity, weight loss and treatment during their marriage. At this time in their family life cycle, they were raising young children, pursuing their careers and education. Both were also in substance abuse recovery programs. Spirituality had become the focus and priority in their relationship, and they were placing emphasis on lifestyle changes. In the partner and joint interviews, substance abuse seemed to be a higher priority than weight management.

The individuals' experiences seemed to merge together. The merging of these experiences brought the couples into an emotionally charged system. Separateness of the individuals in this emotional and unstable system was sometimes hard to identify. Multiple levels of dependency and self responsibility existed in the overweight couples. This meta-theme was experienced by all of the participants. The three voices of the primary, partner and couple participants, blended into one harmonious mantra. The mantra seemed to be saying these experiences have changed my life, your life, and our



lives. We have tried numerous and different ways to remove ourselves from the life trap in which we have become ensnared. We have become blended and homogenized and are no longer individuals, we have become the fluidity of our experiences.

*Family of origin: weight metaphors, childhood stories and obesity fear factors*

The multi-generational transmission process was transparent in this second meta-theme. The experiences and examples given here that tumbled from the participants' mouths began in the first genogram interview and continued without let-up until the last interview. The interviews were replete with examples that showed how the second meta-theme was very present and very real for each and every one of the participants, sometimes covering three or four decades. Additionally, all five of the couples who had children (total of 15 children) were very concerned about giving to their children and grandchildren the weight metaphors, childhood stories and obesity fear factors given to them by previous generations.

One of David's early observations about Rachel's family was "that's their family trait, short and stocky." Rachel agreed with David's observation of her family, and compared her family to his. Rachel recalled her own father was overweight related to lack of exercise from being a truck driver. She recalled him making fun of extremely obese individuals. Rachel shared several memories of her father's comments:

Look at that pork belly or something like that. I can't really remember specific words, but he would turn it into a joke; he was always a kidder. My dad would look at the knee or elbow or some part of the flesh that looked funny to him; he would make it look like something else and turn it into a joke, like the arm looking like a sausage or something like that.

David said his mother, an RN, would question why fat people insisted on doing it to themselves. David said that an expression she used was "why do they keep shoveling

mashed potatoes down their throat?" David said his father was less critical and explained obesity in terms of poverty and lack of self-respect. David recalled:

I do remember one instance, a whole family of people who were all very heavy and they were very dirty. Looking back on it, they came out of this hillbilly cabin. I do remember how come they were all so big and dirty. My dad explained sometimes when people are real big they don't have any self-respect and they don't worry about themselves. He also explained just because a person was big he didn't have to be that filthy. Every one of them smelled!

Rachel and David both reported that "weight was not talked about, unless there was someone extremely overweight." They both regretted not being taught more about the importance of nutrition and exercise as children. David stated, "I think if we had talked about restriction and weight when I was growing up, we would probably be more weight conscious as an adult." Rachel added, "When you don't know it growing up, it's hard to learn, kind of instill it in yourself to start doing."

Vicky took the lead in describing families of origin for her own family and for her husband's family. James talked openly about interactions with overweight individuals since childhood. Most of the time, James was very serious and at times appeared to be very anxious talking about any weight related questions. On the other hand, Vicky was more jocular and seemed to enjoy her role as storyteller. Both related how early family and childhood experiences had influenced them. James reflected affectionately on one of his elementary parochial school nuns, "Sister Geraldine, hid candy for us....she was so large....her name was Sister Geraldine and we called her Sister Geronimo."

James described differences in his own reactions to people's weight, depending on what he knew about them. He provided the following examples:

You know what it really depends on how much I know that person. Really, yeah. If I see someone sitting down in a buffet type restaurant just shoveling it in, I just

automatically think well that's, you're to blame. If I see a really obese person sitting down in a buffet type restaurant and eating portions that they should be eating, I think maybe something else is going on or they're trying to make an effort. I really don't like going there because I see large people going in and just shoveling it in...it just sickens me.

Vicky did not respond to her partner's comments about weight. She laughed and told funny ice cream stories about her parents dating and how she and James continued the tradition. Of her own family, Vicky said unless someone was really overweight, "you just didn't talk about it....we enjoy food and it's not a problem." Vicky later disclosed more serious experiences as a child. She didn't see herself as being overweight as a child, but recalled being made fun of by classmates and being comforted by her mother. When asked to describe one of those experiences, she laughed and recalled:

I'm sorry; I have a really bad image in my mind. I don't know if you want to hear this or not. My brother had a picture of a woman who was horribly obese. She was nude and she had candy bars all over her. That's what I think of when I think of somebody that's really, really obese, that picture.

For Vicky, this imagery from childhood helped her during weight loss. "I don't want to be like that [horribly obese lady covered in candy bars].... I really could be like that."

Vicky told the researcher that instead of bringing pictures she wanted to talk about a voice recording of her father made when she was a little girl. Vicky brought the researcher a tape her father made for her when she was a small kid and didn't want to eat.

The researcher heard a deep masculine voice who Vicky said was her father repeating a mantra "Eat Vicky Vi eat....Come on, Vicky Vi, eat your mashed potatoes." Vicky said the tape was her dad's idea and he did most of the talking, her mother making one statement at the end. She noted, "I'd beg to hear the tape again."

Vicky and James believed this tape had a significant impact on Vicky's preoccupation with food. She said, "I think it scarred me for life....It has programmed

me to eat.” James described how he would have reacted if had been given this tape by his own father.

If it was my father I would never have forgotten it and I would have taken it pretty serious and it would have reminded me every time I ate to eat or not to eat too much as you get older. I wouldn’t have liked it, I wouldn’t have liked it.

Other participants also described how some early childhood experiences had a lingering effect on them. Mark talked about how his father bribed him to lose weight. He would be rewarded with gifts, even if his goal weight was not met. He noted:

It really hurt my feelings, it hurt my self esteem, it already wasn’t too great, it reaffirmed that all these kids were right, that I wasn’t okay, that I was overweight, and that wasn’t okay. My own family doesn’t even think I’m okay. I remember thinking that.

I don’t want to overstate that because it wasn’t something that was a daily thing where he was like an ogre, it was kind of like under the surface, it wasn’t a daily thing where he would berate me about my weight, it was more like every once in a while he would make a comment about my eating, or that bribe thing I was talking about, that happened once, but it was significant because it totally stands out in my mind today. It’s like it happened yesterday, so it’s pretty intense.

Since three of the six primary participants, Mark, Rachel, and Louise had childhood obesity, they had many experiences to share about their experiences at school and at home. The partner participants were not unaffected by stories about weight from childhood. One partner participant, Joanne, described what it was like growing up thin with overweight siblings. How then could a child with an idealized weight experience shame and guilt related to her own weight? Joanne poignantly told of her early weight related experiences.

I never had weight issues until I was older. My sister was always a little overweight and my dad used to call her thunder thighs and he would make derogatory comments towards her and really kind of publicly shame her and humiliate her and I was a witness to that.

While the primary participants had many school experiences to share, Joanne's experience at school with her sister and then as the partner of an overweight man had many similarities. Joanne described herself as being very empathic and having compassion for people who were "fat." She said that she would never do anything to make them feel bad. The description was replicated by other participants' school experiences similar to the one Joanne had with her overweight sister:

My younger sister Becky struggled with obesity most of her life; 30 pounds or more because she's real short, too. She also was born with a disability and was ridiculed a lot. I remember children ridiculing her in the cafeteria. I would defend her. I felt powerless. I wanted to protect her. I remember sitting in the cafeteria and being so bummed out seeing it happen. I left my friends to go protect her.

Other participants also expressed anger about the teachers ignoring the teasing. Mark said the teachers just ignored the teasing and said, "I think they enjoyed it."

As participants recalled their experiences with their families of origin, weight metaphors were used in their stories. Most of the primary participants were careful not to use weight metaphors regarding their spouses or in-laws.

Bobby looked at the contrast between the couple's families on their genogram and stated "well, it is true; the apple sure doesn't fall too far from the tree." Becky commented on the contrast between her family and the thin family members on Bobby's side of the family. "Boy, I sure have a lot of short, stocky people in my family." During several subsequent interviews, the meaning of this metaphor was talked about in both individual and couple sessions.

In the individual session with Bobby, he said, "Boy, I should have known that the apple doesn't fall far from the tree." He went on to talk about his disappointments with Becka's weight gain. During the individual interview with Becka, she also referred to this same metaphor. She was confused about her husband's lack of understanding about the obesity and genetic pre-disposition.



In the joint session, when the metaphor was brought up again, the discussion was more intense and heated. The couple began to talk about Bobby's recovery from alcohol abuse. Bobby became defensive and stated that he had a genetic predisposition for addiction. "I don't understand, if I can give up alcohol, why can't she change?" Becka responded:

For example, when you quit drinking and we go out together, I'm expected not to drink because if I do that gives you an excuse to drink. However, if we went out to dinner tonight and you got a big ol' dessert, you would not feel like you could not get a big dessert because I'm on a diet, and that would bother me.

Primary participants talked about some of the metaphors with which they were teased. Louise recalled memories of being teased as a child. "Oh, they used to tease me because I was the chunky one." The other kids would say, "Fat pig, oink oink....here comes the elephant."

The participants seemed guarded about repeating metaphors they heard growing up. They seemed to become more nostalgic and a notable increase in moments of silence. The metaphors that did come up were slang words, poems, and descriptors of behavior. Additional metaphors included: 1) Jack Sprat could eat no fat, 2) food addiction, 3) fat and dirty, 4) fat and lazy, 5) fatty, fatty two shoes, 6) shoveling it down, 7) move your fat ass so I can sit down, 8) chubby kids, 9) blimpie, 10) fat as a tick ready to burst, and 11) Twinkie Toes.

The weight fear factors, as defined by the researcher are those apprehensions that smaller children have that they can and will acquire the disease or illness that will make them fat or be like the fat person. Although completely unfounded many children "believe" that they will "catch" this malady by being too close to obese people or eating the wrong foods that that causes one to become obese. They learned these fears listening

to others, behind closed doors or in the school yard. Weight fear factors changed with maturity, life experiences and interactions with obese individuals.

Weight fear factors began to emerge from the genogram interviews. The participants reflected on their genograms and diseases present in their family history. They also recalled stories of what happened to overweight people they knew. Their biggest fear was developing diabetes and heart problems. For example, Stephano was extremely fearful for his wife's health. "I'm old and I don't know what to do." In desperation he said, "I can't take care of my special needs daughter and a sick wife."

Primary participants described fear factors which had motivated them to lose weight. Becka said, "I don't want to be fat and get MS." Vicky said, "I had to lose weight because of a yeast infection and my diabetes." Louise said that she had to lose weight so she could exercise and control her diabetes. Cathy said that she lost weight because "It was hard to tie my shoes....I didn't want to be like Granny, who could hardly work on the farm because she was so fat." Rachel stated that her high blood pressure and diabetes scared her. She also couldn't afford the medications.

#### *Weight gain, role changes, and social isolation*

The third meta-theme seemed to become apparent near the time weight gain was accompanied by medical illness for the primary participants. Their physical inability to perform previously defined tasks and fulfill their roles led to role changes in the couples' relationships. As the effects of comorbidity emerged and the primary participants developed health problems, they sought medical treatment. For some, this was enough to motivate weight loss treatment. Others continued to gain weight.

For the partner participant, these role changes were accompanied by increased responsibilities and tasks. Three of the six primary participants were placed on social security disability. As they left their careers, most of their spouses began working second jobs and the overweight couples experienced significant lifestyle changes. Weight then became an unspoken issue between the couple.

Weight gain had a significant impact on couple socialization and was often expressed as a poignant loss by partners. Some partner participants said, "I love her (him) no matter how much they weigh." While the weight gain itself was challenging, it became even more confusing to partners when weight gains were accompanied a significant change in socialization. The "war against social isolation" taken on by some partner participants was perceived by the obese/overweight participant as not being very understanding. The partner participants often felt as if they were in "no win, double-bind" situations. If they stayed home with their spouses, they felt bored and angry; yet, if they continued to socialize, they were lonely.

It is noteworthy that two partner participants, Joe and David, continued attending events within the couples' social networks, and tried to stay connected to their spouses. For these two couples, the overweight individuals began to lose weight and go out more with their partners. Another participant, Bobby, continued socializing with his wife, including puppy training classes. Becka and Bobby reported no changes in socialization related to weight. Primary participants, James and Stephano decreased their socialization as their spouses became more isolative. For some couples, increased weight and decreased couples socialization was a turning point for them to begin living more parallel lives.



Five of the six partner participants reported some embarrassment about being seen in places of public with their overweight spouse. Another partner, Joe, stated he was embarrassed to be seen without his wife.

The feelings related to weight gain and decreased socialization were intense. The partners spoke of grief, loss, anger, hopelessness and helplessness. The degrees of intensity with which partner participants talked about their experiences were poignant. This meta-theme seemed all encapsulating of the experience of weight gain and the effect on couple socialization.

Upon closer examination, while social isolation was prevalent in varying degrees with each of the couples, several nuances were observed. These included differences in partner perceptions around socialization, socialization being replaced with other ways of being connected (medical care), a welcome relief by some participants, and most significantly the emotional isolation experienced by the couples.

While Mark and Joanne were very active together and with their children, each talked of personal responsibility. On the surface it appeared as nothing changed with weight fluctuation. Joanne stated that she never spoke of her husband's weight gain. Yet, Mark said very quietly and sadly, "She's never said a word to me about it as far as you're putting on some pounds, she's never encouraged or discouraged me." He hesitantly said, "If anything, I think she kind of works against me a little bit." For example, when Joanne grocery shopped, he would like for her to make healthier food purchases. Mark shrugged his shoulders and said "I guess it is unrealistic to have separate grocery lists." He stated that he had never asked this of Joanne. "When I'm serious about losing weight, I do my

own shopping.” Mark also wanted more support in his weight loss efforts. “I think it would be cool if she got into it as well.”

With Louise’s most recent weight gain, she and Stephano didn’t go out as much as they did in the past as a couple. The social occasions were also limited by lack of transportation. “Sometimes we go. Somebody having a party, you know, big family here, my daughter is here. Sometimes you know we have a party.”

There was a discrepancy between the couple descriptions of a decrease in socialization, and their perceptions of how much the socialization had changed. Emotional isolation seemed present in all of the couples during these experiences. As primary participants gained weight, became unhappy with their body image, they would withdraw from their spouses. Many participants seemed to respond to these changes and distanced themselves from their overweight partners. Their perception of the social isolation represented emotional isolation, as the partner withdrew from couple relationships, the social and emotional isolation increased in a recursive circular pattern.

Joe strongly believed that weight gain affected the couple relationship. While quite lengthy, Joe’s description aptly depicts what other participants said about the process and connections between socialization, emotional isolation and couple interactions.

I think our relationship struggled a little bit. We were just newly married and the whole time we were dating, the four years we dated, she maintained a steady weight. She was not overweight by any means. Then after we got married, a lot of the issues started; onset depression, she gained a lot of weight, and she did not want to do anything.

We were kind of aggravated with one another because I want to go do something and she doesn’t want to go do something. It’s just not fun to sit home every Friday and Saturday night. Granted there are some Friday and Saturday nights

you want to sit home but just not every Friday and Saturday night or whatever weekday it is.

Then she's made mention several times that our sex life was terrible during that point in time, I think we kind of discussed it, she was under the impression that because she was fat I didn't want to have sex with her. I don't think that has anything to do with it at all. She's my wife I love her very much, but if you're active together and go out and do stuff or even if you're active together at home there's something about doing stuff together you're more than likely to end up in a romantic mood and have sex.

But if you're going to lie around the house all day and she never fixes herself up and she's just lying in bed, I'm just going to go to bed. I love her, don't want her to weigh 300 pounds, I'm going to be married to her, be with her, whatever she weighs.

Joe and James talked about the double-binds they found themselves in. If they went out, they felt guilty about not taking their wives and had to answer a lot of questions about the whereabouts of their wives. If they stayed home, Joe and James reported feeling bored, angry, resentful and bitter.

When Joe found a balance between socializing and staying home with his wife, Cathy gradually began to become more socially active with him. On the other hand, James stayed at home with his wife and their socialization continued to decline. James said, "It took me two years to get up the nerve to go on a canoe trip without her."

The decrease in socialization was not always attributed to the primary participants' increase in weight. The comorbidity of physical changes that occurred with weight gain very much affected the capacity to participate in previous activities. Three of the six primary participants were on social security disability. Rachel, Vicky and Louise had major physical limitations.

Some of the partners focused on changes in terms of socialization. Other partners talked more about the changes in roles and increased responsibilities. James and

Stephano did all the grocery shopping. Not only was this a change in roles, they felt increasingly more responsible for their wives' weight gains. They made the choices in what to buy, and whether to buy or not buy what their spouses put on the list. Stephano especially felt increasingly more responsible for his wife's weight. "I do the grocery shopping....I do the cooking....Sometimes she doesn't like it."

David and Joe had taken on second jobs which they attribute to their wives' weight gain and depression. Rachel was on disability and Cathy suffered from depression, had increased fatigue and an infant. Cathy had resigned from her professional position due to depression and prior to pregnancy. David said that his second job paid for his wife's medications.

The patterns of change, role changes and isolation seemed to be acted out, or responded to, before the couple began to communicate about these experiences. The onset of weight gain was often insidious and the couple relationship gradually shifted roles and responsibilities. The couples took many different roads, as individuals and as couples, as they tried to change their relationship and/or lose weight.

*Weight communication: perceived boundaries and inadequacies*

The fourth meta-theme, "Weight communication: perceived boundaries and inadequacies," seemed to develop as the couples either avoided or made attempts to talk about what was happening to them as individuals and as a couple. Many couples noted it was particularly difficult to talk together as weight led to role changes. Some couples perceived their communication as ineffectual, especially as weight loss didn't occur. As anxiety increased, communication decreased, which added to the anxiety in a circular process.

All of the participants reported infrequent and brief conversations about weight. They also reported during the member checks how thankful they were for the research interviews and the “opportunity” to talk about weight with a “neutral person” during research interviews. Most couples learned something new about each other and some individual participants had new insights about themselves. Participating in this study was a reflective process that was both painful and welcomed.

As mentioned in meta-theme three, changes in roles and responsibilities occurred. Many of the changes in roles and responsibilities caused the partners’ lives to become more stressful. They were working longer and harder, even those with working spouses. The partners would come home late and tired. What the partners found the easiest to talk about was socialization. In reality, with increased responsibilities within the home and longer work hours, the partners didn’t have as much time for socialization. The partners spoke of these changes in their individual interviews, but frequently did not talk about these experiences in the joint interviews.

Parallel to the partner participants’ experiences, difficult communication, many primary participants described examples of begging for compliments. The primary participants described a greater need for reassurance about many aspects of their relationships, including dependency upon their partners for selection of clothing prior to social events.

Cathy described experiences of rummaging through her closet and changing clothes multiple times before finding an outfit she felt comfortable wearing. Not only did she seek her husband’s approval during these times of “clothes modeling,” Cathy stated

that she wanted and need more sexual intimacy. Joe's perception was quite different. He associated her decreased initiation of sexual intimacy with decreased interest.

As Cathy talked about her need for intimacy with weight gain, other primary participants also disclosed the need for more sexual intimacy during weight gain, but wanted their partners to initiate sexual contact as they were experiencing more isolation from their partner. Also several primary participants said they wanted to know that their partners were still attracted to them.

Perceived boundaries in the couple relationship are understandable in the context of the above relationship experiences. The primary participants began to initiate sexual contact less often, talked less about their weight, and felt more dependent upon their partners to initiate closeness. The partner participants may, in turn, may have perceived this as withdrawal in the relationship and decreased interest in sexual intimacy. This systemic pattern of relating added to the decrease in couple connectedness. Individuals then began to attach different meanings to these experiences and reactions, than their spouses had anticipated. When the realities of these experiences were not voiced the negative assumptions about their relationship and the inadequacies of it were more pronounced and more problematic.

Mark said, "Seems like since we're both sober and in recovery we're more goal oriented we can talk about that....We're more on the same page so to speak." Both agreed that in the early years of their marriage, insobriety affected their marriage negatively, including weight related experiences.

As with all primary participants, Rachel was asked to describe how her husband responded to her weight gain. "I don't think he said a word to me; he accepted it.... I



don't think he said anything." She went on to describe intense feelings of loneliness and depression as she gained weight, "especially when I had to start wearing my husband's clothes." Again, the couple did not discuss weight changes.

All of the partners in the study said they had been reluctant to bring up the subject of weight. Past experiences of approaching this subject had been met with tears, anger, and frustration. They were afraid to bring up weight because "I don't want her to cry or get upset with me." This fear of discussing weight was magnified by those partners who felt as if they had a responsibility to share their health concerns about their loved partner.

David described not talking about weight as being irresponsible and likened it to having an alcoholic spouse.

Interestingly, most of the primary partners saw their spouses as being supportive and actually quoted statements of support their partner did not remember saying. James said, "I never knew what to say, so I didn't say anything." Rachel, in the individual interview, mentioned several compliments her husband made about her appearance. She smiled and said, "He would just give me that special look, you know what I mean.... He didn't have to say anything." These discrepancies concerning support were most often described during individual interviews. Overall partners of obese individuals did not perceive themselves as having the skills and knowledge necessary to broach the subject of weight with their partner.

Becka felt supported by Bobby in other ways. They agreed they had excellent problem solving skills and had together survived several family crises. Although the couple had the communication skills, but the issues related to weight were too conflictual and difficult to discuss. Becky and Bobby talked about how well they handled the sale of

their business, career changes, and their teenage daughter's pregnancy. As a couple and as family they were able to make this transition. Their daughter and grandchild live with them. Becka looked at Bobby and asked, "It's worked out well, hasn't it?" Bobby nodded his head yes.

Partners often described strongly defined boundaries for communication about weight. They seldom initiated talking about their partners' weight, because they believed that he or she "would talk about if he or she wanted to." These boundaries included weight, attractiveness, intimacy, sexuality, food choices and lifestyle.

Where there were deeply defined boundaries related to talking about weight related issues, the partners stated that they began communicating less with their spouses. Couples described their understanding of these defined boundaries in several ways. Some partners would say, "She cried every time I barely mention anything about her weight." Later, conflicts, arguments and sarcasm accompanied comments about weight. Examples given were, "Do you really want another brownie....Why are we going to a smorgasbord?" Important topics related to work and family were sometimes neglected. Seemingly, less significant topics were not talked about either. Some partners perceived this as an unspoken agreement with their spouse; however, the primary participants disclosed that they would like to talk more about weight with their spouses. Both primary and partner participants described feeling lonely at times, partially due to this perceived boundary about weight communication. These communications patterns did not seem to be gender related. Mark also reported that he didn't discuss weight with Joanne, but had wanted her to be more involved with his weight loss.



The systemic dynamics described by the partner participants in these areas of reduced communication accentuate the fluidity of the experiences. As one partner withdrew and became less intimate, his or her spouse might respond in like manner. This led to more distance in the relationship. Couples later began to communicate less about other important aspects of their relationship which were not weight related.

Some partners did bring up issues related to sex with each other. Four of the six male participants felt sexual initiatives were rejected, so they quit talking about and initiating sexual intimacy. In the individual interviews with the primary participants, Vicky, Cathy and Becka stated they actually wanted to have sex more frequently when they were overweight. Cathy's desire for increased intimacy and sex during weight gain was emphasized, with one caveat.

I didn't want to initiate it [sex], I was hoping he would. Okay, I'm in the mood to or I just want to because I want to feel close to him but yes, I definitely wanted him to initiate it.

Joanne, a partner participant who also talked about her own weight gain said that she tried to not allow her feelings "to ever create distance but I wouldn't be as eager to reach out." Mark (primary participant) said he noticed that during Joanne's time of weight gain, she was "less self-confident." Joanne described herself as "more reserved" and didn't feel comfortable initiating sex. As Mark agreed with Joanne's assessment of the effect of weight gain on sex, he concurred "You would wait for me to initiate rather than you initiate."

These desires for more sexual intimacy and closeness were not communicated to their spouses when the primary participant was overweight. As David said, their husbands thought "she just doesn't want it."

Feeling sexually rejected was devastating for Vicky and Becka. Vicky's husband, James, just avoided sex with her. The couple had not had a sexual relationship in over five years. This was confusing to Vicky, because it didn't seem to matter how much she did or didn't weigh. Vicky called her doctor to get a prescription for Viagra. "He's never used it." Bobby openly talked to Becka about his loss of physical attraction to her. These vignettes were poignant and overlap with many other meta-themes, first/second order changes, body image dysphoria, fluidity of the experience and social isolation.

Talking about weight was a taboo. Many of the participants talked about how it was easier to not talk, or to talk about other issues in the relationship. Although Vicky volunteered for this study, she said "I'm not ready to talk about my own issues with weight." She then brought up the issue of her husband's substance abuse. Other couples also seemed to be more comfortable talking about alcohol than weight. In the joint interview, Vicky was shocked by her husband's lack of "admission" about his side of the family during genogram construction. She talked about the chemical dependency on his side of the family, and the divorces. James did state in that interview that he was a recovering addict. As she continued to talk about these omissions by her husband, Vicky began to compare chemical dependency and being overweight.

For two couples, each with a history of substance abuse recovery, (Bobby and Becka; Vicky and James) rarely did they use the communication skills learned through recovery with weight. In four of the six couples, alcohol seemed easier to talk about than weight. Being comfortable talking about any one of these issues was not an indicator of how comfortable couples were in talking about another issue.

Stephano's and Louise's early childhood experiences were similar. Louise was very open and expansive when describing the alcoholism in her family, while Stephano said very little, but became tearful when talking about the alcoholism in his family. He stated, "My father was an alcoholic.... Brother died of alcoholic, all three brothers drink.... My father, too; yeah, drinks too much, too much."

#### *First-order/second-order changes*

The fifth meta-theme, "First-order/second-order changes," emerged at several levels and different times for the participants as individuals and as couples. An example of a first-order change would be an increase in sexual activity after weight loss. This first-order change could become a second-order change. In this example, a second-order change would include the couple talking about relationship and both feeling comfortable initiating sexually intimacy.

First-order/second-order changes were usually not a parallel process. Recursive circularity was more evident. Initially, weight gain was a first-order change that resulted in decreasing health of the primary participant, shifting of roles and responsibilities for the partner participant and became unwelcome second-order changes.

Vicky's weight fluctuated throughout her relationship with her husband. She attributed her largest weight gain to a crisis with her husband's substance abuse. "That was when I ballooned up." After her husband had treatment for substance abuse, she once again became motivated to lose weight because:

I feel better when I don't weight as much. It's a lot of work carrying extra weight around you know right now I'm carrying around more than what my dog weighs. She weighs 40 pounds and if I pick her up and I'm carrying her and my back is and I'm carrying around that much extra. My dog weighs more than I need to get rid of, and then some.

Vicky was further motivated to lose weight because she couldn't physically do things she had done in the past. She also was concerned about the effect of being overweight on her health. "I was on insulin, off it for a while, and when I lost weight this last time I as able to go off it again....Being off insulin was wonderful and it's rare to do that."

During her first weight gain, James took on more chores and changes were made in their roles. When Vicky lost weight loss desired second-order changes in their relationship remained unchanged. James was disappointed that this weight loss did not bring about a second-order change (shifting of the responsibilities). Vicky was also disappointed that their sexual relationship did not improve (second-order change).

Likewise in the other participants, as individuals and as a couple, the accompanying goals of weight loss were established and achieved (first-order change), the subsequent second-order changes in the individual and couple relationships often did not occur. The consequential goals of weight loss were not something most couples talked about. There were exceptions. Weight loss did bring about positive second-order changes for some couples.

Rachel and David, Mark and Joanne, Stephano and Louise, and Joe and Cathy reported several desirable secondary changes. David said, "If she's happy, then I'm happy." Mark and Joanne were pleased with the changes in lifestyle they were experiencing. Louise, when in treatment, learned to perceive comments by Stephano as helpful and not meant to be hurtful. Joe was just happy that Cathy was going out again!

Weight loss goals (*first-order change*) did not necessarily produce the anticipated and desired changes in the couple relationship (*second-order change*). Sometimes both the primary and partner participant had hopes that when the weight was lost, the formerly

obese partner would be ready to socialize. Yet, weight loss, self-esteem, and socialization do not change precipitously at the same time. This was very confusing for some partners.

For primary participants who had lost a substantial amount of weight, and they did not perceive their partner as being attracted to them, they described feelings of loneliness, frustration and rejection. Yet, when the primary participants were overweight, they came to rely on their partner to initiate closeness. In fact, some partner participants felt confused by their own lack of attractiveness and/or sexual desire for their spouse, after weight loss.

For partner participants who described themselves as being supportive of their spouses' weight loss treatment, their self-esteem decreased. Some felt as if their attempts to help their spouse lose weight were a poor reflection on them. These partners began to feel more inadequate about themselves and within the couple relationship. This was especially important for Stephano, who did the cooking. Bobby couldn't understand why his wife wouldn't lose weight "if she really loves me." It was as if he was flawed in some way. Bobby's self description "I'm cavalier" seemed to reflect this. Some partners became less supportive as their attempts to help their spouses lose weight failed.

Weight fluctuation in the primary participant also influenced the weight of their spouses. For example, James began to gain weight along with Vicky. Joe began to experience anxiety about his own BMI. David frequently told Rachel, "You're weight loss, is my weight gain." Bobby remained angry regardless of his wife's weight. Joanne was envious of Mark's weight loss; she couldn't lose weight after having two children. Stephano reported some initial weight gain with Louise, and quickly lost the weight.

Rachel provided a comprehensive overview of her experiences with weight fluctuation from childhood through her adult life. Many first-order/second-order changes are readily apparent. For example, after weight loss in adolescence she described a favorable increase her high school experiences. However, the second order changes of better self-esteem, improved confidence and overall enjoyment of life were neither consistent nor persistent with later weight gains. It is very important to note that of all the participants with weight fluctuation, Rachel “bounced back” more and described more second order changes with weight loss.

While Rachel was motivated to lose weight during high school to “be noticed by the boys,” her reasons for losing weight were different as an adult. Rachel’s obesity affected her ability to conceive. Her desire to have children motivated her to lose weight. Later, comorbidity of insulin resistant diabetes, hypertension and decreased abilities to perform tasks motivated her to lose weight. Through each of her weight losses, Rachel had medical care, a support group and “someone to walk beside me.” Rachel perceived her husband as being supportive. “I could tell just by the way he looked at me.”

#### *Body image dysphoria*

The sixth meta-theme was “Body image dysphoria,” which was present in all of the primary participants and was a major impediment to socialization, intimacy and to their partial inability to function. The anxiety and unease produced by body image dysphoria served to further remove the primary participant from the hope of weight loss treatment and contributed to the emotional isolation suffered. Some of the partner participants also experienced body image dysphoria.



As described in Chapter Two the choice of the word *dysphoria* [italics added] was deliberate and added to the literature review, after data collection. Dysphoria can and does mean many things, but is not specific. It implies a heightened emotional state, most notably characterized by anxiety, restlessness, unease, abnormal depression and discontent; body image dysphoria is more than the opposite of euphoria because it also connotes a malaise and a discomfort that contributes to the isolation suffered by the one suffering from dysphoria. The added, extra-hard-to-bear quality resulted in partial or sometimes total inability to function.

Cathy felt self-conscious about her appearance, both with her husband and others. "I didn't want to be out in public because I felt like everyone was probably staring at me....That might not be the case, but I felt like I was a spectacle or something." She stated that her desire for intimacy with her husband increased as she gained weight; "I still wanted the intimacy part and probably even more so at that time just because I wanted to feel like he still wanted me." Cathy recalled, "I feel like we had sex less, and I feel like it's because of my weight." She was sure that her husband will "give you [the researcher] a different point of view; but I feel like it was because maybe he's just not attracted to me and that's how I felt." Cathy felt self-conscious about her appearance without clothes on or even when she was dressed in her best. She required constant reassurance about her appearance and attire.

The segments in the sessions when the primary participants talked about their body image both with and without the presence of their partners were most often tearful. One observation made by the researcher was how often each of the primary participants became tearful at the end of the individual interview. The primary participants who

seemed to experience body image dysphoria most intensely were those who had a childhood history of obesity and secondly those with a history of depression.

Mark had one of the most poignant descriptions of body image dysphoria. When he began to cry, he talked about another aspect of this study or recovery from substance abuse. Mark began again talking about his experience of weight, from his early childhood experience of obesity.

When I was aware of it [overweight], when I was made aware of it, it was painful. You can't crawl out of your own skin. You are what you are and if you're overweight, you're an easy target. Whenever you have conflict as a kid, [weight] is the first thing they're going to tease you about....I was only really aware of it [my weight] when people pointed it out. I didn't walk around every day going on about being fat. I wasn't depressed.

There were times when Mark didn't even want to attend school.

Some days I did, in elementary school I was scared to go to school because I knew what was coming. It went in waves, like for a while a certain kid would decide to focus on me and it was like every day and that's when it got really hard, but generally speaking it was more of a situational thing one of my friends would start in on me, my brother, but during my adolescence, elementary school or early childhood I wasn't depressed and I don't think I had a poor self image yet, I think it developed over time but generally speaking I think I was a pretty happy kid, real active, if I wasn't who knows how big I would have gotten.

Mark came to the first interview session with class photographs and sports uniform pictures. The pictures seemed to represent and depict the body image Mark wanted to internalize.

Rachel described her childhood obesity experience and the early onset of puberty, including the challenge of finding in-vogue clothes:

Well, I was very self-conscious, I would be in class and I felt like I was the heaviest one in class, maybe I wasn't, but I felt like I was thinking back on it. I would go to the store and try to find clothes and I felt like nothing fit that I wanted to buy. Things that did fit weren't fashion clothes, like grandmother clothes and things that were in style that other kids wore in school didn't fit me. Of course, I



had already filled out, wore a B cup bra. Whenever I started developing I grew right away, all out there.

Rachel's experiences as an adult were similar. As individual the interview was coming to a close, and Rachel knew that I would be interviewing her husband, she began to cry.

Well, I'm crying because of the way I am now since I gained all of it [weight] back, some of it back then I lost some. I'm not back the way I was before when I lost 115 pounds. Part of [the reasons] was because of the illness I have, insulin resistance. I didn't know that's what part of the problem with my weight gain until I gained all my weight back.

Rachel started talking about issues related to intimacy and her weight. Intimacy is not something Rachel and her husband talk directly about. She felt very embarrassed by her recent weight gain.

My relationship with my husband now I think is probably, as far as a personal relationship or intimate relationship, I have a hard time enjoying myself because I feel like my weight hinders our enjoyment and I don't always want him to see me so it's probably he wants to have it more than I do and he doesn't understand my lack of wanting to.

He just says come to bed early and I'll usually want to say no, I'm not ready to come to bed yet. He wants something more and I'm not ready to give anything more because *I don't want him to see me* [italics added].

Vicky, who said she was described by her classmates as "fat," denied being overweight until after college. While being perceived as overweight at school, her weight was normalized by her parents. She even brought in the "Vicky Vi" with her father telling her to eat more. Vicky did share the following about her experience with being overweight as a married woman:

I'm uncomfortable with my own self image, especially when I'm overweight. I don't like looking at the mirror at myself when I get out of the shower I avoid looking in the mirror. Sometimes I mean, I had lost so much weight and now I've gained it back and then the extra ten pounds on top of that there are times I don't

even want my husband to see me after a shower or something just because I hate the way I look.

With weight gain, especially after successful weight loss, primary participants did not always experience their pre-weight loss anticipation of a better body image. In fact, some of the partner participants continued to hold negative body images of their spouses. With weight regain, primary participants used very self deprecating language and metaphors to describe these experiences.

Five of the six primary participants described self-directed anger about weight re-gains. Rachel had gained and lost weight once thus had not experienced re-gain. Louise was tearful and appeared sad as she talked about her most recent weight gain.

When you have a beautiful body, which I had at one time and you don't have it any more, it's depressing. It's sad and you know, it's like why did I let myself get this bad, why did I let myself get this out of control. Then I'd put it off and put it off cause you really intend to start it you really intend to do it, then it's like I'm not ready to do this yet.

In describing her experiences with weight gain and re-gain, Becka said,

I think when you are overweight there's a lot of baggage that comes with that. Guilt, embarrassment, and negative feelings about yourself, and I don't see how that can not affect the person you're married to. I'm sure it's like that self-fulfilling prophecy if you feel that way about yourself, or that's how others see you, or how you view yourself and feel about you.

Becka then spoke longingly about desiring her husband's support, approval, and sexual attraction for her. Sensitivity to her husband's remarks about her weight often had a negative effect on their relationship. She reported that he was either making negative remarks, was silent, aloof, or worked extra long hours. Becka was asked to explain how she experienced her husband's comments.

I think it's because I know how he feels about overweight people, and I know it's a negative thing for him. Therefore, in my striving to be a good wife, I'm not because I'm fat. Therefore, I'm failing; I'm not doing what I should be doing. He

doesn't know how to give a compliment, or if does, he sure doesn't give them. I really resent his lack of support.

Becka didn't trust or have confidence her husband's support. Even when her husband seemed to try being supportive, Becka stated "he always follows up the compliment with something negative."

Disturbances of self and/or body perception emerged throughout the interviews. When a participant lost weight, as an adult, body image dysphoria lingered. Body image dysphoria did not decrease proportionately with weight loss; it also intensified even more immensely with weight gain. The researcher wonders if body image dysphoria would emerge less intensely in a population of obese participants without a history of depression.

There were some partners who shared in their partners' experience of body image dysphoria. Even after their spouses lost weight, they still had a negative perception of their spouses' body image. While this is also a partner and couple experience, disturbances in body image were not always present in the partners, nor was their necessarily a connection between the primary participant and their partner.

Bobby was both sad and defensive as he talked about not supporting Becka during weight loss. He began talking about how weight interfered with the intimacy in their marriage, much to his dismay.

Well, if you're attracted to heavy people, or whatever you're attracted to, you can't really help what you're attracted to. Still, her argument is if you love me unconditional no matter what. Well, that's all part of it but there's also that attraction, it's not that I wasn't attracted but I mean.

Bobby appeared very sad and near tears when he talked about his lack of physical attraction to his wife. "I just can't help it....It's not like I don't want to be....I just can't

make myself.” Even though his wife has lost a substantial amount of weight and he believed that she was motivated to lose weight, Bobby still found it challenging to be physically attracted to her. “I love my wife and I will always love her, but that doesn’t mean I am physically attracted to her.” Bobby and Becka seemed to mirror their experiences of her body image. This may have been present in more participants, but was not directly described.

#### *Weight as the third person in the relationship*

“Weight as the third person in the relationship” listed as the last meta-theme, is listed last because it completes the circular transition back to the first meta-theme, “Fluidity of the experience.” Weight is always present, acknowledged or not, and is unrelenting. Weight never takes a holiday! Participants, especially, the primary participants believed innuendoes to weight were present in every conversation, every purchase of clothing, every decision at the grocery store, every where, all the time, without surcease. It fosters new ways of communicating, and new patterns of not-talking. It complements and completes the seven meta-themes by returning to the “Fluidity of the experience” and reinforces the themes identified in this study. Weight will not cure itself by ignoring the long list of reasons that brought one to overweight-ness. Communicating effectively, without rancor and blame is the first, most important step in ridding the relationship of the unwanted third person.

Alcoholism is often described as the white elephant in the living room everyone sees but no one wants to talk about. Weight as the Third Person in the relationship may be even more intense. The weight is ever present in the primary participant, the partner participant and the couple. Two couples actually used the metaphor of “weight as the

third person.” Becka talked about this in an interview and Vicky wrote about it in her journal.

During sex, the excess weight was problematic. Vicky said, “I felt like there was a big pillow on my tummy and it was always between us.” This is noteworthy, since she and her husband have not had sex for years. Other participants described weight as “always there.” The alcoholic had times of sobriety, even when not seeking treatment. The overweight person never gets away from the extra weight. It was also described as “a shadow” that followed them every where.

When weight was lost, the Third Person still hovered nearby. When weight was gained, the third person contributed to increase in distance between the couples. As weight fluctuated, the third person was ignored in communication, but precipitated changes in the couple relationship.

Weight as the Third Person can begin to take on a life of its own. As more meaning is attached to weight/the third person more distance is created in the couple relationship. The third person can come to represent different meanings for each of the participants. For some participants, the potential destructiveness of this third person was feared. The third person brought depression, social isolation, threat to survival, diabetes, heart problems, strokes, and physically incapacitating to some individuals. The results of this third person’s presence were expensive and costly to the relationship.

Some primary participants had expensive medical bills, which required their partners to work two jobs and/or substantially change their lifestyles. One primary participant required oxygen, and most required expensive medications. Both primary and



partner participants talked about the changes in roles and increased responsibilities for the partner participants, as the third person began to sit at the head of the table.

Weight gain and weight re-gain after weight losses were negatively perceived by five of six the primary participants who had experienced weight fluctuation. Increasingly discouraging remarks about their bodies and weight were made after a weight gain. Two primary participants, Louise and Becka still talked about “my beautiful body.”

In talking about her re-gained weight Vicky, spoke of being fearful that it would be harder to lose weight the next time, and she could never reach the formerly reached weight loss goals. If she tried to lose weight and wasn’t successful, “I would end up weighing 10 lbs. more.” Louise advised everyone to have a scale. “You have to watch your weight every day.” “If you don’t watch your weight every day, it gets away from you.”

Primary participants who re-gained their weight experienced more helplessness and hopelessness. Their partners’ also seemed to reflect these experiences, and were less supportive with each new diet. These primary participants perceived them as not giving their partner credit for the weight they lost, not sharing in their happiness, and some saw their partners as becoming more critical of their weight. Apathy about weight was also experienced with weight fluctuation.

When Rachel lost a substantial amount of weight and was committed to her walking group, regardless of weather conditions, David began to think she must be having an affair. He began to gain the weight she was losing. Rachel perceived David as holding her back and preventing her from losing weight. With relief, the couple finally

talked about their different perceptions. It was as if this was complimentary for both of them.

Weight becomes triangled between the couple; interlocking triangles emerge as the couple interacts with other systems. Some of these systems include their nuclear family, family of origin, friends, work, treatment and clinicians. Patterns of triangulation were apparent when talking about weight loss attempts and partner support, or lack thereof. It seemed as if once weight became an issue, it remained so with the couple. Weight had influenced the couple relationships, primary and partner participants roles, responsibilities and positions in their relationships, and primary participants continued to have health consequences, which they attributed to weight.

In couples with substance abuse issues, it seemed much easier to talk about substance abuse than weight. However, one still has to eat to live while alcohol isn't necessary for survival. When participants were in recovery from substance abuse, it seemed easier to talk about something substance abuse in the past and weight in the present.

Many participants referred to the presence of food (potential weight gain) at every social event. Family patterns of eating were triangulated with weight. Some couples managed to change lifestyles and share meals. Other couples cooked separately. Primary participants sometimes attributed weight gains to their spouses' restaurant choices or the fattening foods brought home from the grocery store.

Even when weight was lost, comorbidity of other diseases were lingering reminders of weight gain and the fear of weight gain. Primary participants spoke of weight re-gain in a self-deprecating manner. They also experienced an increase in body



image dysphoria with weight gain and lingering effect after weight loss, and even more intense dysphoria with weight re-gain. Their partners had additional and sometimes different experiences. For many of the partners, it was not the body image that concerned them, but they were very fearful of health consequences on their partner. The interpretations of these fears were like a shadow of death hovering close to the couple. These fears were expressed by all of the participants. This fear was most apparent in the interviews with Becka and Bobby; their genogram personified these fears. Bobby's anger at Becka and their children's obesity may be just what he says, "I'm afraid of what is going to happen to her if she doesn't lose weight....she will probably get MS and not be able to take care of herself...just like her mother." Certainly, looking at his genogram he has experienced the deaths of his parents and other family members at a young age.

### *Summary*

The researcher interviewed six couples in which at least one spouse had been obese and lost at least 50% of his or her goal weight. Five of the six primary participants were women and were currently in the overweight to obese BMI categories. Some of their partners were overweight but none were in the obese range. There were twelve Caucasian participants and one partner was a Greek immigrant. It was the first marriage for all but one primary participant who was in her second marriage. Most of the participants came from rural communities. The participants had varying degrees of education and a variety of careers. Each had education beyond high school. Some had college and others technical education, and some were still pursuing educational interests.

Depression was prevalent in five of the six primary participants, and one of their partners reported depression. One primary participant was in recovery from substance

abuse. Five of the six partners were in recovery from substance abuse. Five of the six primary participants had health concerns and were on disability. One of the six partners had a major health concern. Both primary and partner participants had concerns about the health issues in their families of origin.

The seven meta-themes that emerged from the data included: fluidity of the experience; family of origin: weight metaphors, childhood stories and obesity fear factors; weight gain, role changes and social isolation; weight communication: perceived boundaries and inadequacies; first-order/second-order changes; body image dysphoria; and weight as the third person in the relationship. These meta-themes interlocked with other meta-themes, contained sub-themes, and a number of minor themes with small distribution prevalence. Sometimes the couples' experiences were polarized and others seemed to mirror the other. The data presented by the participants in their individual and joint interviews echoed similarities of their experiences. In describing their experiences with weight, the data content differed at times, yet the process seemed similar to their other experiences and those of other participants.

In Chapter Five the themes will be compared and contrasted to the findings of similar research that exists. The themes have implications for many disciplines, including physicians, nurses, physical therapists, educators and mental health professionals.

## Chapter 5 – The Findings

### *Summary of the Findings*

The findings of this study, which were presented as new data in Chapter Four, were more complicated and varied than the researcher had anticipated. The six couples who participated in the study had experiences with weight fluctuation, significant differences in couple BMIs, life stressors and comorbidity which added to the uniqueness of this sample. Primary participants also had experiences with depression, hypertension, diabetes, lifestyle changes, chemical dependency, career changes and being on social security disability. The partners also had experiences with chemical dependency, career changes, and family of origin health concerns. The prevalence of comorbidity of physical illness and other stress in the couple relationship contributed to the unique experiences of this sample. The interpretations of findings, implications of the study, and recommendations were influenced by the characteristics of the sample.

It is not the intent of the researcher to reinforce the medical model and/or pathology of obesity. However, the sample from which data was gathered closely resembled medical model perspectives on obesity. Concerns of the Health at Any Size are still applicable in this study, but may not seem evident.

The experiences of the primary participants, partner participants and couple participants did not always line-up with the expected categories of obesity, treatment and weight loss. Sometimes there were no clear demarcations between the experiences of obesity and weight loss or the treatment of weight loss by the partner participant versus the primary participant. The meta-themes which emerged from multiple data sources

also presented from multiple perspectives which further complicated the data that was presented.

The family systems theory lens used to explore the experiences of overweight couples proved to be an effective perspective for interpreting the findings of this study. FST created a broad inclusiveness to better understand the phenomena described by the participants. The systemic perspective addressed many environmental influences on overweight couples, including physical, psychological, family of origin, social, academic, career, and healthcare systems.

Analyzing the meta-themes as revealed by the primary, partner and couple participants revealed significant patterns of circularity in the occurrence of *significant* [italics added] changes related to weight fluctuation and other life experiences. Participants had different perspectives about weight gain from their families of origin. The stories heard about their families of origin were painful or hurtful to the overweight partner. The family of origin was where the participants learned to fear the consequences of weight gain. Weight gain, the first-order change was accompanied by second-order changes of roles, dynamics and often social and emotional isolation. These changes occurred out of medical necessity or embarrassment about weight gain. Weight loss goals, both achieved and not achieved, brought additional second-order changes. When the second-order changes brought anxiety, loneliness, tension and strain on the relationship, the overweight couples attempted to talk about weight. They quickly became discouraged and weight conversations became taboo. Decreased communication, increased tension and weight gain resulted in body image dysphoria. For some, body image dysphoria became rejection of sexual and emotional intimacy. Partner participants

sometimes mirrored the body image dysphoria. The couple literally felt the existence of a third person in their relationship. The shadow of the third person brought the couple back to the fluidity of these experiences.

The circularity of patterns presented above and multiple variations that could and did present themselves during this study reinforced the need to find a new way to explain how the obese and non-obese partners interact as a couple when trying to bring about weight loss.

This researcher was also impressed by the extraordinary effort that is required by the partner participant to accommodate the needs of the primary participant and to sublimate their own needs. One example might be, to not only do the grocery shopping and prepare the meals, but to take on a second job to pay for the increased medical expenses due to comorbid diseases and the inability of the primary participant to work. The amount of devotion and commitment to the primary participant, in this example is extra ordinary. Underlying reasons for the devotion and commitment of these partners, in a divorce-prone society, are not fully understood. Is the devotion and commitment out of love for their spouse, religion, a way to fulfill an unmet need, resigned indifference or someplace in between?

### *Discussion of the Findings*

This phenomenological study which explored the experience of obesity, treatment and weight loss from the perspectives of the formerly obese individual, his or her partner and their experience as a couple added a better understanding of overweight couples' experiences to the existing literature. This study was the second of only two known qualitative studies on obesity that interviewed both partners individually and together.

Overweight couples cannot be fully understood with interviewing and understanding their experiences as individuals and as a couple. Furthermore, understanding the couple system in the context of their family of origin system through joint construction of a genogram further enhanced the richness of this study.

The results of the study indicated the importance of researching overweight couples from a systemic perspective. Identification of the couples' interactional responses and patterns to the experiences of obesity, treatment and weight loss were enhanced by studying individual and couple perspectives. During individual interviews primary and partner participants described their experiences with weight fluctuation. The joint interviews further contributed to understanding of the systemic dynamics by direct observation. The systemic effect was a unique experience for each participant as an individual and as a couple.

Each of the participants talked openly about the intimacies of their experiences. Their need to talk about and better understand their experiences was overtly expressed. Some couples noted that they gained new understanding of their partners through their joint interviews. The seven meta-themes are described below.

#### *Fluidity of the experience*

The fluidity of the experiences with obesity, treatment and weight loss accurately depicted the complexity of obesity and couples, and the multiple systems within which they interact. With weight gain, primary participants became less autonomous and more dependent upon their spouses. The couple and weight fluctuations seemed to merge and affect multiple aspects of their lives. The impact of the overweight couple's experience



systemically affected other systems, parents, children, co-workers, employers, healthcare and economic systems

In many respects, weight gain was similar to a trauma or a serious ongoing medical disease. Both imply intensifying of symptoms, changes, and difficulty describing and remembering what one's experience was like prior to an event. The comorbidity of the primary participants contributed to the chronicity of the couples experiences.

*Family of origin: weight metaphors, childhood stories and obesity fear factors*

Participants' fears of obesity often began at home. They learned lifestyles that affected their weight, heard stories about obesity from their families of origin, and some observed the negative health effects of weight gain on family members. Several participants learned harmful weight loss methods from their parents and weight loss clinics.

When the participants entered the school system, they learned more about "being fat." Some came home from school crying about the painful comments made at school. Others were teased and became confused. The school system did not intervene on the behalf of the participants; some participants reported that teachers stood by and watched the teasing; others stated that their peers were more apt to tease them when adults were not present.

A small number of participants described feeling confused by the differences in messages received by their peers and their parents. When some were told they were overweight at school and then told their parents about being teased, their parents said that



they were not overweight. Other participants reported that their parents tried to help them lose weight and one participant was taken to a weight loss clinic.

In the interviews, the participants told childhood stories and mentioned weight related metaphors with amusement and embarrassment. The metaphors learned from their families of origin and childhood experiences, continued to echo in the couple relationships.

#### *Weight gain, role changes, and social isolation*

Weight gain experiences resulted in role changes. Partners often had to take on additional responsibilities and sometimes second jobs. When a partner breaks a leg and can't mow the lawn or go up and down the stairs to do the laundry, the spouses openly talk about the temporary adjustments to be made. However, with weight gain, the changes are not temporary, unless treatment is effective, and the partner has many new roles to take on.

There is a stigma related to talking about weight gain. These overweight couples often didn't talk about these changes. In an attempt to hide their weight, they began to isolate from each other, and this usually extended to other systems as well.

In the overweight couple relationships, both partners, regardless of weight, had significant life changing experiences. Perceived absence of partner support in actuality was more about being exhausted from working two jobs and/or taking on more chores and tasks. Feeling lonely, isolated, ashamed of one's body, and with few offers of encouragement, made it very difficult to enter weight loss treatment and be "compliant." A cycle of turning more to food than to one's spouse for comfort developed. In turn, the partner felt less connected and more isolated.

*Weight communication: perceived boundaries and inadequacies*

When one of the partners in the overweight couple became *unbearably miserable* [italics added] communication was initiated. Partners willing to initiate communication about weight gain often stated this “backfired” and made matters worse. Other partners believed it was a marital responsibility to confront the weight gain, the same as one would do an intervention for chemical dependency. Some partners who held this belief and did not *intervene* [italics added] said they felt guilty. Several partners said that when they brought up concerns about weight, their spouse would cry, became angry, or refused to talk about weight loss treatment.

Several primary partners brought up their need for more sexual intimacy, yet as they gained weight, they expected their partners to initiate intimacy. These primary participants felt embarrassed about their bodies, didn’t want to be seen, and yet wanted the reassurance from their spouses that they were still sexually attractive. The decreased initiation of sexual intimacy was perceived by the partner participants as decreased interest in sexual intimacy. This often resulted in both primary and partner participants feeling less connected sexually frustrated. The couples, particularly the partners, stated this was a boundary they couldn’t cross.

Most partners believed weight was a taboo subject, especially when some attempts to discuss weight gain were met with hostility. They also felt inadequate and believed they didn’t have the skills to discuss weight “without someone getting all upset.” Interestingly, the primary partners perceived their spouses to be supportive, while their partners did not. Of course, occasionally sarcastic comments about weight were expressed by both partners.

Couples described communication as being their first attempt to resolve weight issues in their relationship. When communication attempts were uncomfortable, or perceived as upsetting, their first attempts at weight loss were seen as failures.

#### *First- order/second-order change(s)*

One of the major contributions to this study is the prevalence of and manifestation of first-order/second-order changes in the overweight participant, the partner participant and the couple. This study identified positive and negative first-order/second-order changes. First-order/second-order changes were initially identified with weight gain. Weight loss attempts and weight re-gain brought about additional first-order/second-order changes. These first-order/second-order changes were not necessarily experienced by both partners simultaneously. The partners in this study provided many insights into better understanding their partners' experiences with weight gain. Sometimes partners had been perceived as angry, aloof, and even saboteurs of their spouses' weight loss. In reality many partners were feeling lonely, isolated, inadequate and overwhelmed.

#### *Body image dysphoria*

Body image dysphoria was described by each of the primary participants. Affected not only by how they felt about themselves internally, these overweight individuals became lonelier, more isolative, and more disconnected while, at the same time, less involved in many important systems. Some had experienced job losses and were on disability.

Even when some primary participants became more involved in life after weight loss, they still described a lingering body image dysphoria after weight loss. The dysphoria intensified with each weight gain. Noteworthy was the spouse's responses to

weight loss. Several reported that they continued to feel sexually unattracted to their wives after weight loss. The partners seemed to mirror or internalize their overweight spouses' body image dysphoria. The lack of attraction, especially with weight loss was very confusing for the partners.

#### *Weight as the third person in the relationship*

Throughout the interviews, examples of weight as the third person in the relationship were present. The third person represented many experiences of the phenomena of weight fluctuation.

The third person was akin to an invisible person, a person that projected emotional processes of the overweight couples. This third person seemed to be behind how the couples communicated and how they expressed their conflicts.

Several primary participants were reluctant to attempt additional weight losses. They believed they would temporarily lose weight, and then gain back more than they lost. The third person held them back. Some partner (and perhaps, some primary) participants hid behind the third person and became less productive. Issues related to mortality were discussed. It seemed like the third person was an ever-present and evil shadow following the overweight couple.

These seven meta-themes were interlocked with other meta-themes and included a number of minor themes with small distribution prevalence; the experiences were sometimes polarized and other times seemed to mirror the other. The data presented by the participants in their individual and joint interviews echoed similarities of their experiences. In describing these experiences with weight, the data content differed at times, yet the process seemed similar to their other experiences.

### *Comparison of the Findings with the Literature*

Practically no qualitative research included joint and individual interviews with overweight couples, as individuals and as a couple. There were very few studies of couples in which the non-obese individuals had a voice. There were still fewer studies that purported to examine overweight couples' experiences with treatment for obesity. Considering the prevalence of obesity, the research for overweight couples is grossly disproportionate to other issues for which couples seek treatment. Most of the studies completed to date have been quantitative and were gleaned from research conducted within the past two decades. All of this supports the need, not only for this particular study but also for future research into this area of qualitative study of obesity.

The comparison of this qualitative research study with the literature reviewed supports some similarities of earlier research, regardless of the source. These included both qualitative and quantitative research studies with a myriad of samples ranging from questionnaires completed by college students, interviews with school children, examination of public statistics, overweight individuals and those seeking treatment for psychiatric disorders. This study further identifies noteworthy areas of differences and new considerations for the treatment of overweight couples.

### *Childhood Obesity*

Four of the six primary participants reported their first experiences with being overweight during childhood. While these participants spoke retrospectively of their childhood experiences with being overweight, the findings of this study are consistent with other childhood studies. Many of the references to early childhood experiences were

similar to the ones reported in the study by Sobal and Maurer (1999). For example, teacher ambivalence and dislike for overweight children.

As described by Clinton and Smith (1999), the families of these overweight participants were the first ones to make comments about their weight. One partner participant was strongly committed to partner support because of early childhood family and school experiences of their overweight siblings. Three of the four primary participants reported having fewer friends as a child because of their weight.

It is notable, regardless if the primary participant was overweight as a child, all of them had regrets about not learning more about healthy food choices as a child. They reported feeling confused about their weight and didn't know how to lose weight. The lack of information promoted a sense of helplessness and intensified guilt. The eating habits learned as children made it more challenging to change these habits and live a healthier lifestyle. Several couples with children have a strong commitment to both live and to teach their children about healthier lifestyles.

Bribes to lose weight were consistent with the findings of Sobal and Maurer (1999). The primary participants received rewards, even though they did not obtain the weight loss goal set by their parents. One of the primary participants in this current study, reported difficulty in letting-go of an embedded childhood memory of his father's bribe for him to lose weight. He described continuing feelings of guilt when he received his reward and didn't meet the challenge of weight loss. This participant and others described feelings of disapproval by their parents, especially their fathers.



### *Adolescence, Early Adulthood and Obesity*

Consistent with studies on adolescence and obesity, the participants who were overweight as children reported a lower self esteem in adolescence (Adams-Curtis, Forbes, Jobe, Pokrajac-Bulian, Revak, White & Aivcic-Becirevic, 2005; Hoyt & Kogan, 2001; and Wiederman & Hurst, 1998). It is not known if the participants in this current study were also depressed during their adolescence. Consistent with the findings of Tiggermann and Lynch (2001), four of the six primary participants reported experiencing depression as adults.

Adults who reported being overweight as children and/or adolescents felt less popular, believed they had less friends, and were not attractive to the opposite sex. Being overweight with the onset of puberty was particularly painful for both the male participant and female participants. This was consistent with findings of other researchers (Davison & McCabe, 2005; Neumark-Sztainer, 1999; Rodin, Silberstein, & Striegel-Moore, 1985; and Tantleff-Dunn & Thompson, 1995).

All of the primary participants lost weight during adolescence. As adults, reflecting on and describing these adolescent experiences said they felt better about themselves and had more confidence after weight loss. They stated that their relationships improved, they were noticed by opposite sex and had more friends after weight loss. This finding is consistent with the literature on adolescence, early adulthood and obesity (Anderson, Durkin, Norris, Paxton, & Wertheim, 2005; Damhorst, Littrell, & Littrell, 1987; Lieberman, Gauvin, Bukowski, William & White, 2001; Nichter, Nichter & Vuckovic, 1995; and Wertheim, Paxton, Schutz & Muir, 1997). This study did not



explore, nor did participants disclose information about adolescent and pre-marital sexual relationships.

### *Obesity and Self/Body Image Dysphoria*

The literature strongly suggests that poor body image or self-worth plays a role in the manifestation and perpetuation of obesity (Anderson, et. al, 2003; Areton, 2002; Foster, Wadden, Vogt and Brewer, 1997; Shapiro, 1980; and Spiegel, 1988). Still, the reverse may be more accurate in that obesity can result in low self-esteem. Low self-esteem and poor body image was prevalent among all primary participants in this study. The poor body image persisted after weight loss. Two partner participants reported a lingering poor body image of their spouse, even after weight loss.

Body image dysphoria, a term embraced by the researcher for experiences related to body image, body dissatisfaction and low self-esteem, seemed to be even more intensified when the partner participant was not perceived as complimentary towards the primary participant's weight loss. Body image dysphoria seemed to be increased with each weight gain.

The "Weight and Significant Events Timeline" supported the findings in the literature that self-esteem was lowered with each weight gain, as cited in studies of the "yo-yo" phenomenon (Foster et al., 1997; Friedman, Schwartz, & Brownell, 1998; Hayes & Ross, 1986; and Maurer & Sobal, 1999). While the studies cited were blind studies with recorded weights, it would seem this study supports earlier findings. This qualitative study explored the experiences of participants, which included their perceptions of their own weight.

The intensity of the experiences of the participants in this study supported findings in the literature review. Body image dysphoria may have been intensified in this study, which included the primary, partner and couple participants. Exploring weight in the context of one's marriage may be more intensified than studying overweight participants only, as other studies reported in the literature.

### *Obesity and Sexuality*

A comparison of this study with studies cited in the literature review may be less accurate, because this study actually interviewed the primary, partner and couple participants. This study did not replicate the stigmatization of obese women compared to their obese male counterparts reported by Regan (1996) in which participants found obese women less attractive, less skilled, cooler, less responsive, and not as likely to experience the same desire and sexual behaviors as a normal weight woman or obese males. In this study primary participants reported the same sexual desires regardless of their weight. One caveat being, that when the primary participant was overweight, they were reluctant to initiate intimacy, yet these women wanted their husbands to initiate sexually intimacy. Some reported that they wanted to be more sexual when overweight.

The findings in the study by Werlinger, King, Clark, Matthew, Pera, et al., (1997), in which significant increases in the frequency of sexual activity, as well as improved body image, was observed in pre and post-treatment evaluations, is not as clearly replicated in this research study with couples. Overall, the participants in this study reported an increase in sexual activity with weight loss, yet there were significant exceptions. Two partner participants still found their partner unattractive after weight loss. Some partners wanted to have sexual activity, regardless of the weight. This was

echoed by some primary participants. When overweight, the primary participant desired more sexual intimacy. The overweight partner wanted to feel more connected to her spouse, despite their poor body image and reluctance to be seen by their spouse. Furthermore, the overweight partners wanted their spouses to initiate sexual relationships because they wanted “proof” that they she was still sexually desirable.

#### *The Marital Relationship and Psychological Distress*

The findings of this current research were most similar to a qualitative study performed by Keicolt-Glaser and Newton (2001). The findings of the current study were significantly substantiated by Keicolt-Glaser and Newton who reported that mental functioning [mental imbalance] is consequential to the couple's health. Their study and others also indicated how negative marital quality was correlated with poorer health, including bad health habits, which could include overweight/obesity, as well as depression (Beach & O'Leary, 1993; Biglan, Hops, Sherman, Friedman, Arthur, & Osteen, 1985; Gottman, 1999; and Markey, Markey, & Birch, 2001). Indirect physiological effects of poor marital functioning were also identified (e.g. cardiovascular, endocrine, immune, neurosensory, and other physiological mechanisms). While four of the six couples in this study, presented very few concerns about their marital relationship, a distinguishing finding in this study was the monumental focus on poor health, the tremendous deficits in lifestyle and the overall dissatisfaction with their lives.

The findings of this current study were similar to the findings of another qualitative study (Faricy, 1990). This researcher also found that obesity did affect the marriage due to the poor self-esteem of the obese member and the socialization of the

couple. While Faricy (1990) saw obesity as a secondary influence on the relationship, this current study indicated that influence was different for each couple, and also each individual within the couple. Obesity was described as a primary and secondary influence on the relationship and or the partner.

#### *The Marital Relationship and Depression*

While the focus of this study was the experience of obesity, treatment and weight loss, issues related to depression were present. In consideration of the FST framework of this current study and the prevalence of depression, the systemic view of depression is worthy of further study in contrast of the work done by Coyne (1976). He maintained that the depressed person's behavior is maintained or increased in part by his or her social environment. Without knowing the onset of weight gain and depression of the participants in this current study, a direct comparison cannot be implied.

The findings of Gotlib and Colby (1987), are also worthy of further study in relationship to obesity.

When the depressed individual observes these negative or discrepant messages, she or he becomes increasingly symptomatic in an attempt to regain the initial support (p. 17)

There are some similarities to the findings of this study. With each attempted weight loss, the primary participant experienced lowered self-esteem; and some partners felt increasingly hopeless and helpless in providing support to their partner. The partner participants also seemed to have more psychological difficulty with their partner's weight gain. These partners were less engaged and connected during subsequent weight loss treatment.

### *Marital Satisfaction and Obesity*

The prevalence of depression among the obese participants and chemical dependency issues in their partners is consistent with the findings of other research studies cited in the literature review. Findings of this study and the literature remain clear about the need to thoroughly evaluate psychological functioning and assess for depression, body image disturbance and binge eating disorders when obese persons seek treatment (Ledyard, 2004; Sobal & Maurer, 1999; and Sobal, Rauschenbach & Frangillo, 1995).

The current research study supports these findings. Couples frequently stated that they recognized weight as a very important issue in their marriage. Some couples reported that weight loss treatment was placed “on the back burner” due to what they considered more pressing issues. Sobal, Rauschenbach and Frangillo (1995) gathered and analyzed data on obesity and marital quality. Weight and five other variables (age, race, socioeconomic status, employment status, and presence of children) were reviewed and the impact of these variables on marital quality showed that body weight was not one of the major variables associated with the quality of the marriage.

This study and Ledyard (2004) conducted individual and joint interviews with the participants. Family of origin similarities between alcoholism and obesity and/or the comorbidity of alcoholism and obesity were identified in both studies. The metathemes in this studied differed significantly. Ledyard described meta-themes and the couple dynamics separately. This current study described and associated meta-themes with couple dynamics and systemic theory. This study and Ledyard both identified the

importance of couples as a team, the influence of family of origin and the great fear of weight re-gain, or as Ledyard stated, "fear of change: change back!" (p. 67).

#### *Obesity, Marital Relationships and Partner Support*

Consistent with the analysis of thirteen studies by Porter and Wampler (2000), this study also identified the need for partner support and also the waning of partner support over time. Couples in this study reported decrease support with each new weight loss attempt. Congruent with the findings of Porter and Wampler, upon review of the data of the study, this researcher agrees the partner is not able to provide the needed support, engaging the support of others outside of the marriage may be an important alternative.

Research regarding the importance of partner support in weight loss has been studied and the findings of this study are consistent (Black, 1988; Brownell, Heckerman, Westlake, Hayes, & Monti, 1978; Cohen, Schwartz, Bromet, & Parkinson, 1991; Dubbert, 1982; Dubbert & Wilson, 1984; Kagan, 1983; and Margolin & White, 1987). Perceptions of partner support were explored in this study. Similar to other studies, the primary participant were very conscious of the support or lack of from their spouse. The descriptions of partner support seemed conflicting at times. Some partners were able to specifically state what they needed and/or received from their partner. Others hoped their partner would understand and respond to their needs without directly asking for partner support. Partner support was an area of confusion, miscommunication and misunderstanding for some couples.

This qualitative research study which interviewed both primary and partner participants identified very important aspects of the experiences of obesity, treatment and



weight loss in connection with couples. The patterns identified in the overweight couples from the beginning onset of obesity and through weight fluctuations have not been described in previous studies. The descriptions of the participants' experiences of the seven meta-themes and how these meta-themes developed in their relationships contribute substantially to the systemic understanding of weight fluctuation. For example, primary participants described needing more intimacy to feel loved, but waited for their partner to initiate intimacy. The partner, in turn, believed his or her spouse had lost interest in intimacy and sexual relationships. Not communicating these experiences with each other left both partners feeling rejected, lonely and increasingly isolated.

Finding related to partner participants was rarely discussed from the partner perspective in the literature, and was limited to dissertation studies (Ledyard, 2004 and Faricy, 1990). The findings of this study contributed to a better understanding of the partners' experiences. Several of the partners took on second jobs to support the family. The majority of them took on additional responsibilities in the home and within the family. The partners felt physically exhausted and unable to provide more support to their overweight spouse. The partners of overweight individuals are significantly affected by the weight gain of their partners and are sometimes in dire need of support. The partners are often conflicted regarding differences in goals, socializing and change in their relationship due to the physical limitations of their obese partner. Furthermore, partners stated that they began to feel responsible for their spouses' weight gain (especially if they did the cooking), and they had an impending sense of doom regarding the medical complications of obesity and that they felt inadequate about their ability to effectively support their spouses' weight loss treatment.



Cunningham (1986) identified that one of the largest predictors of how well an obese person will do at achieving his or her weight loss goals appears to be the support that is received, especially from the partner. Perception of partner support was also identified as an important factor in weight fluctuation. This study further identified the need to educate and provide support to the partner of the overweight spouse. The overweight individual may require guidance in recognizing and receiving partner support.

### *Limitations of the Study*

Fulfilling the purpose of this study was challenging in light of the far reaching individual, systemic nature of the subject; to better understand experience of obesity, treatment and weight loss, from the individual perspectives of the formerly obese individual and his or her partner and their experience as a couple. The use of multiple data sources from these three perspectives was cumbersome and unwieldy at times. While the meta-themes were prevalent and easily identified through FST lens, less prevalent themes were also identified. Exploration of less prevalent themes were not fully explored, may be significant and deserve a better understanding than provided in this study.

The use of standardized instruments as used in previous studies would have enhanced comparisons with other studies. This is also a criticism of couples' research in general. This researcher would recommend inclusion of additional instruments such as body satisfaction/inventories, quality of life assessments and marital satisfaction scale, such as the popular Locke-Wallace.

Another major limitation of this particular study was the sample size. The small sample of twelve participants (six dyads) is too small to generalize the findings of this study to other populations. Even though this study had some diversity in gender, culture, education and success in weight loss, a larger sample with a more diverse population would discover if themes are similar to this study and/or identify additional themes.

This was a sample of convenience, and the primary participants were not limited by treatment choice. Studying obesity and couples with contemporary medical treatment options would have enhanced this study. This study had prevalent issues related to depression, obesity and substance abuse, which would limit the generalizability to the general public. Overweight couples without depression and substance abuse may have significant differences from this current study.

#### *Implications of the Study*

This study, although small, provides important implications for the individual and the couple in overweight relationships. The participants in this study were considered the experts. Not only were they eager to tell their stories, but were very insightful and straightforward in shedding light on how best to treat overweight couples. The researcher specifically asked participants to provide recommendations for medical health care professionals, mental health care professionals and other overweight couples.

The voices of the overweight couples have a resounding effect on the implications for this study as described by this researcher. Implications of the study also arise from the researcher's clinical experiences; supervision she obtained from esteemed professionals and the supervision she has provided; numerous workshops and study groups for eating disorders; comprehensive professional reading; collaboration with other health care

professionals; being a managed care provider; her advocacy role for overweight individuals; and her own experiences with the systems in which she interacts.

Those who have contributed to the researcher's general body of knowledge are very much appreciated and honored by the researcher. It is with regret that many of these individuals and sources are not cited in the implications for this study.

The implications of this study apply not only to overweight couples but are important to mental health care professionals and the medical healthcare professionals who provide treatment to this large and growing sector of the population. The experiences of the overweight couples provide new insights into how these processes play out in real world settings and provide clinicians with some best practices approaches to comparable situations in the future.

#### *Implications of the Findings for Health Care Professionals*

Many health care professionals will find the results of this study, and others to follow useful specifically with regard to the perception of an obese person as a chronically ill person (American Obesity Association, 2002; Bray, 2003; and the National Health and Nutrition Examination 2002). The relationship between weight and disease(s) requires careful examination of both future and existing research, specifically in regards to the diverse beliefs related to weight gain causation and correlation with chronic illness (Daniels, 2006; Dennis, 2004; Frieden, Galvez & Landrigan, 2003; Gaesser, 2003; Robinson, 2003; Szwarc, 2003 and the World Health Organization, 2005).

Health care professionals need to better understand the sensitivity of weight (Dennis, 2005). The diseases related to overweightedness such as diabetes or hypertension widespread beliefs that the obese individual and weight itself are the

culprit(s) needs drastic re-evaluation (Boutelle, Neumark-Sztainer, Story & Resnick, 2002; Gaesser, 2003; Robinson, 2003 & Szwarc, 2003). A clear understanding of the etiology of obesity (and co-morbid diseases), defining of obesity, and available treatment options and goals must be fully explored with and understood by the obese individuals seeking treatment, their partners, physicians and health care professionals and mental health professionals providing services.

The obese individual and his or her partner need to be provided the same scope of services available to any other medically ill patient, and most importantly, with the same respect and empathy. Health care professional do not presently treat obese individuals as chronically ill patients, who have all sorts of medically diagnosed long term illnesses, and will have them until they die. Ironically, cancer is no longer considered a terminal illness, but a chronic illness with contemporary treatment. Further, the treatment of cancer continues to be supported by research, allowing cancer patients to benefit from remission of their illness, thus providing hope that a cure may come from the next research study. Obese individuals, on the other hand, do not have this hope. Research on obesity has lagged far behind the advances of the obesity treatment.

A wide range of support services for the obese individual and his or her partner need to be available in order meet the demands of what will be the largest acute care phenomenon to have ever hit the world. The impact will be nothing short of the most significant, long-term illness to have ever impacted health care professionals.

One recently televised financial planning panel enthusiastically advised viewers to invest in an Obesity Index Portfolio (Neal Cavuto "Cost of Freedom" 2006). In addition to investing in the usual and obvious suspects like diabetic equipment companies

and pharmaceutical companies, investors should also consider investing in manufacturing companies of all sorts of makers of extra large equipment such as beds, extra large wheelchairs, clothes and gowns, and special scales. The comments from the experts describing this as truly growth without let-up for the next two decades( Frieden, Galvez & Landrigan, 2003, p. 684; Kopelman, 2001 p. 30; WHO, 2001). Some public school systems are responding to changes in the school menu and providing more opportunities for students to exercise. The state of New York has banned restaurants from using trans fats in food preparation. Although everyone seems to be aware of the consequences of obesity and the rapid rise in the obese population, the medical profession and health insurance plans seldom respond to the needs of obese individuals.

Most insurance plans do not reimburse for nutritional counseling unless a strict criterion is met; unfortunately, nutritional counseling is not reimbursed by insurance companies. Yet, when the obese individual develops secondary complications, such as Type II Diabetes, nutritional counseling is reimbursable. Exercise is known to be one of the most effective treatments for weight loss, yet physical therapy is not reimbursable because one is overweight. Sadly, obese individuals are at great risk for physical injury when they exercise without proper guidance. An injury can be a major setback in weight loss treatment.

This is the first year (2007) most insurance companies have decided to reimburse for weight loss surgery, at lower BMIs and for adolescents. Patients are making choices without the knowledge of well researched health risks, especially the long term effects of new surgical procedures. Furthermore, the effect of rapid weight loss is not known. How will individuals respond to rapid weight loss? How will they react to rapid changes in



body size? These new surgical options open a whole new world of choices for overweight individuals. A new age of body image, without longitudinal research to anticipate the physiological and psychological health issues will become a new challenge for medical and mental health care professionals. Hopefully, services will be available to meet the needs of overweight individuals and their families.

Health care has become highly specialized. The primary care physician is being challenged to treat the whole person without use of specialist. What is already known about obesity and co morbidity of physiological problems (coronary artery disease, diabetes mellitus, hypertension, increased cancer risks and depression) is challenging. The dilemmas for health care professionals are profound. Will the primary care physician's role be to treat all of the above and the specialists will only treat advanced stages of these diseases? Will health care for obese individuals be so fragmented by multiple specializations that they begin to feel fragmented themselves? Will obese individuals continue to receive incomplete and inadequate services because of this specialization by physicians, clinicians and the health care system?

These twelve participants, as the experts and experienced with interacting in the healthcare systems, provided the following salient reminders for the healthcare professionals:

- 1) The stigma associated with obesity may deter patients from bringing up important weight related issues and/or seeking treatment. Educating about the risks of obesity and the benefits of a healthy weight loss program is indicated.
- 2) Confrontation must be given with support, hope and guidance.

- 3) Assessment regarding etiology of their weight is important. Why am I overweight?
- 4) Failed attempts at weight loss should be further evaluated. Instead of assessing a failed weight loss attempt as non-compliance, collaboratively explore for additional medical conditions impeding weight loss.
- 5) Educate and advocate for Weight Loss as passionately as smoking cessation
- 6) Use a variety of tools for measuring success. In addition to the pounds lost, measure muscle mass, use medical markers such as cholesterol, glucose levels, and lipid panels to identify progress with weight management.
- 7) Referral to a mental health professional may be necessary in order to support the couple and assist with developing health supporting priorities.

Therefore, until and unless, these recommendations are employed in order to get a comprehensive phenomenological look at the multifaceted complexity of obesity, a misunderstanding of these dynamics will continue to confuse and baffle researchers, therapists, and society in general. Furthermore, what remains hidden and obscure will very much hinder advancement in treatment of what has become the number one health problem in the United States and will soon become the number one health problem in the world?

#### *Implications of the Findings for Mental Health Professionals*

Individuals seeking treatment for weight loss requires a comprehensive assessment and collaboration with other medical healthcare professionals. At the onset of providing psychotherapy, referral to a primary care physician is important to determine etiology of weight gain and provide treatment of any medical co morbid diseases which



will effect mental health and the outcome of psychotherapy. Having a collaborative relationship with physicians who can provide specific recommendations and a specific plan of care and an encouragement for that plan is an absolute necessity if there is to be any progress and maintenance of long term weight loss. The devastating effect of recidivism on the overweight individual and their partner was poignantly described by the participants.

While not part of the literature review, the work of Patricia A. Fennell (2003) in *Managing Chronic Illness* is important to understanding chronically ill people. Fennell has conceptualized a four phase model for treating the chronically ill. The implications of this study present the need for mental health professionals to explore similar literature when treating overweight individuals and couples who have co morbid diseases.

A more educated mental health professional who has an understanding of the individual's etiology of weight gain, current health problems being treated and existing stressors will better support the therapeutic alliance with the overweight individual/couple seeking treatment. The mental health care professional can then work more effectively in collaboration with other health care professionals. An understanding of the obese individual's motivation for weight loss and if there is a medical necessity for weight loss needs to be identified. More realistic therapy goals and decisions regarding weight loss can be established. Instead of defining success by use of the scale, using other markers for progress in therapy may be useful. Additional goals (markers for success) may include an increase in physical mobility, lower blood pressure, glycemic balance, and overall improved quality of life.

The high incidence of depression and eating disorders may require referral to a primary care physician and/or psychiatrist for medication management. A high incidence of chemical dependency is found in obese individuals and their partners (Bray, 2003; Fairburn & Brownell, 2002; Kopelman, 2001; and Wadden & Stunkard, 2002).

The mental health professional needs to be comfortable talking about issues related to weight and weight loss in a nonjudgmental and empathic manner to facilitate establishment of a therapeutic rapport. Without the rapport, individuals may be withholding about issues related to their weight and present with increased feelings of shame and guilt, especially during times of weight gain.

Assessment of the family dynamics and appropriateness of including the partner in therapy needs to be determined. The obese partner's ability and willingness to support weight loss treatment is an important part of the therapy process. Is the partner willing and wanting to support weight loss treatment? Does the partner have unmet needs that prevent him or her from being a supportive partner. Does the partner lack the skills in being understanding and supportive? Does the obese individual have other important relationships with whom the individual and their weight loss goals can be supported?

Expanding the support system for the obese individuals and exploring potential resistances to increased support are important issues to explore. When partners are unable to provide support in weight loss, are there other areas where the partner is capable and willing to support the overweight individual?

Specific issues related to the relationship include: 1) relationships strengths, 2) relationship limitations, 3) educational needs, 4) previously navigated successes in the relationship, 4) secondary effects of weight gain on the relationship, 5) priority of the

couple (it may not be weight loss), 6) contributing stressors, 7) influence of family of origin, 8) partner's influence on treatment choices, and 9) potential roadblocks to successful weight loss.

Complex issues may emerge when providing psychotherapy for couples in overweight relationships. It is important for mental health professionals to understand the effect weight gain has had on the couple in several areas: 1) defining and/or re-defining roles due to physical limitations of the overweight partner, 2) change in socialization of the couple, 3) effect of weight gain on intimacy; the overweight partner may want more intimacy during weight gain, but wants his/her partner to initiate intimacy, 4) change in socioeconomic status, and 5) during weight gain communication may diminish. The experience with weight gain is not soon forgotten. Secondary expectations of weight loss may not occur. The supportive partner may have unresolved issues in the relationship which may or may not be related to weight gain. The partner may require support before the obese individual can make progress in treatment. Existential issues related to mortality may be prominent in the partner and the couple, as the consequences of obesity are considered and feared.

The lingering effects of weight gain on the relationship needs to be explored from the perspective of the overweight individual, his or her partner and as a couple. Body image dysphoria may persist after weight loss. When the overweight individual has successfully lost weight, his or her partner may still respond to the overweight partner as if he or she were still overweight. The images of the overweight individuals may linger in their partner and affect their sexual relationship.

Successful weight loss for the overweight individual can be enhanced when lifestyle changes are embraced by the couple. Building on past successes and successfully achieving weight loss may bring a stronger sense of “we-ness” to the relationship and further strengthen the relationship (Gottman, 1999).

#### *Implications of the Findings about Couples*

Given that the mental health care and the health care professionals can put their own houses in order as outlined above, the couples have their own agendas that will require an effort of extraordinary proportions. The total rethinking of the role of the health care professional in managing the assets of the hospitals and managed care companies, will not only be a necessity but will also allow the system to cope with the long term chronic illnesses that will visit this generation until their deaths. The mental health profession will profit from the reorganization of the health care profession and will need to be far more “hands-on” in their treatment role. The lessons learned from this qualitative research and others that will follow, and the benefits of learning from the couple themselves will pay huge benefits in dealing with the obese couple, their treatment and their weight loss.

Obese and overweight couples will need to have a more active role and become more participatory in their own diagnosis and treatment. The lessons learned from this study are almost universal in their applicability to couples in overweight relationships.

- 1) Obese and overweight couples seek weight loss relief from a whole myriad of symptoms they exhibit. Relief from any symptom or group of symptoms will not necessarily help other symptoms or issues.

- 2) Partners need explicit information and specific instructions on how to best support their spouse during weight loss.
- 3) Co-morbidity significantly increases complications for the obese individual and raises many more issues for the couple.
- 4) Special counseling and motivation is always necessary for the supporting spouse. The energy required in supporting their overweight spouse, while maintaining their own health, customary lifestyle and interests is necessary for success.
- 5) When the non-obese partner cannot provide support to his or her partner, forming a mutually acceptable support system for the overweight individual is vital for weight loss maintenance.
- 6) When the obese person can no longer physically perform activities and chores, there is a significant detrimental impact on his or her spouse and the couple relationship. Open communication about these changes may decrease the intensity of the feelings surrounding these shifts in roles.
- 7) Couples need education about potential weight gains and how to communicate concerns in a supportive manner.
- 8) All couples, especially obese individuals and their partners need to find that necessary balance between support, control and personal responsibility.
- 9) Providing a structure to talk about weight in the relationship may normalize the experience for the couple and enhance communication in other important areas of their relationship.

The lessons learned from the couples about healthcare professionals were

very important and need to be explored in future studies. When approaching individuals and couples about the health risks of obesity, providing hope in the treatment of obesity, and providing the necessary treatment resources are prerequisites for any weight loss to begin. When this hope is not provided, the obese individual may feel guilty, inadequate or lost. The impact of this experience not only affects the obese individual, but also his or her partner and very significantly the couple relationship.

### *Recommendations for Future Research*

Empirical and quantitative research studies most often analyze treatment outcome with very specific protocols to define success. The protocols established by professionals and treatment providers may not lead the desired treatment outcome of the participants. Successful weight loss is frequently defined by the amount of weight lost and the length of time the weight loss was maintained. Research needs to include additional parameters for measuring success beyond the scale; these include increase in physical mobility, stamina and flexibility, increase in productivity (e.g. work attendance), better quality of life and improved health as evidenced by glycemic balance, normal blood pressure and supporting laboratory blood work.

The participants in this study valued and wanted weight loss to be a positive outcome; nonetheless; in reality they deemed other factors to be just as important. At times, their perceived priorities put weight loss on the back burner. The questions raised in focus groups conducted with psychotherapists in the field, accurately reflect questions raised by and experiences of the participants.



Replication of the current study is recommended with a larger and more diverse sample. The themes emerging from this study could then be compared and contrasted with new themes emerging and the different populations being studied.

Using the themes which emerged in this study and developing semi-structured interviews to further explore, understand, collaborate and validate these findings is recommended. Exploring less prevalent themes with a larger sample may also support better understanding the phenomena of overweight couples.

A concurrent study with the recommendations and the implementation of interventions with overweight couples, based on the themes identified in this study, is highly recommended. This is highly recommended due to the increased prevalence of overweight couples and the resulting disproportion to available research.

More phenomenological studies regarding obesity, treatment and weight loss, with a “grand tour question” approach are needed. In order to elicit more detailed information regarding select categories and themes, the researcher would also suggest adding questions.

Since the early 1990s obesity has sky-rocketed among children, as well as adults. Expanding the study to include children and families is paramount.

### *Conclusion*

A better understanding of how the dynamics of obesity emerge and affect overweight couples will be significant for the clinicians providing treatment. The findings of this study offer a better understanding of the experience of obesity, treatment, and weight loss. The seven meta-themes followed a parallel process with family systems theory. It would be an enhancement to the general level of knowledge to



learn about obesity, treatment and weight loss with a massive study of overweight couples and families. That knowledge and understanding can then begin to serve as the foundation and platform from which mount a creditable, sustained and realistic offense against what has become the largest, yet least understood, concern of the 21<sup>st</sup> century.

The physicians, the health care professionals, the mental health care professions and the health care providers need to collaborate in the largest coordinated study of the single most important health care problem of the 21<sup>st</sup> century. Without a coordinated effort by all of the above and, of course, the voices of obese individuals and their partners, cost will continue to spiral out of control, the health care structure will collapse, and fully one-third of the population will be without adequate help nor hope for the biggest health problem of the 21<sup>st</sup> century.

## Appendix A: Body Mass Index

Healthcare professionals often use body mass index (BMI) to classify levels of overweight and obesity. A BMI of less than 25 indicates that you are at a weight that is healthful for you (less than 18.5 is considered underweight, however). If your BMI is between 25 and 29.9, you are considered overweight. A BMI of 30 or more indicates obesity.

Find your height in the left-hand column in the chart below and see whether your weight falls into either range listed.

If you prefer to calculate your exact BMI, multiply your weight in pounds by 705. Divide by your height in inches; divide again by your height in inches.

Height	Overweight (BMI 25.0–29.9)	Obese (BMI 30.0 and above)
4'10"	119–142 lb	143 lb or more
4'11"	124–147	148
5'0"	128–152	153
5'1"	132–157	158
5'2"	136–163	164
5'3"	141–168	169
5'4"	145–173	174
5'5"	150–179	180
5'6"	155–185	186
5'7"	159–190	191
5'8"	164–196	197
5'9"	169–202	203
5'10"	174–208	209
5'11"	179–214	215
6'0"	184–220	221
6'1"	189–226	227
6'2"	194–232	233
6'3"	200–239	240
6'4"	205–245	246

Source: American Medical Association (2003). Roadmaps for Clinical Practice, Assessment and Management of Adult Obesity: A Primer for Physicians.

## **Appendix B: Telephone Screening Interview**

1. Thank the caller for inquiring about the research being conducted on "The Experience of Obesity."
2. Introduce myself as the Principal Investigator, conducting dissertation research for my Ph.D. in Marriage and Family Therapy at Saint Louis University.
3. Inquire as to how they found out about the research and what his or her particular interest in the research is.
4. I will describe the research study and explain that couples will need to commit to two confidential interviews, complete questionnaires and participate in 2 follow up calls. Participants may bring photographs of themselves at different weight levels, if they choose. Journaling about their experiences is optional, but will be encouraged. The couple can expect to spend up to 4 hours with the PI over a period of one to two months. The caller will be informed of the \$25.00 per session, reimbursement for his or her time. A photo album will be given at completion of the final interview. If the caller is still interested, I will ask him or her to have his or her partner call me.
5. Participants will be asked if they have recently experienced excessive stress or marital discord. The participants will self define stress and marital discord. The PI will not ask for specifics over the phone, because this would precede participant signature of the Informed Consent.
6. Participants will be informed that they will not be a candidate for the study, if they have a history of anorexia or bulimia.
7. When the partner calls and states he or she is willing to participate in the study, I will set up an appointment to meet with them within the next two weeks. The caller will be informed that they will receive a packet in the mail that contains a consent form, a copy of the Body Mass Index Scale, and a description of what is required for participation. They will also be informed that I cannot discuss any health concerns, including his or her height and weight, without his or her written consent. The caller will be encouraged to look at the information to make sure that he or she meets the study criteria. Directions to the office will be enclosed.

## Appendix C: Flyer and Website Advertisement

# WEIGHT LOSS RESEARCH FOR COUPLES:

**One partner must have lost substantial weight;  
*Even if it has been regained.***

### Overview

This research seeks to identify those factors within a relationship that contribute to successful weight loss and those factors that may contribute to weight loss setbacks. The goal is to gain better insight for treating overweight/obese individuals and to better understand what works and what does not work in achieving weight loss and then maintaining the weight loss.

**You and your spouse/partner** will commit to two appointments; separate and joint interviews will include questionnaires, a photo album review, and optional journaling. The study will not exceed 4 hours. You will be contacted twice by phone for follow-up questions, lasting 10 minutes or less. Your participation in this important research will be compensated.

### About the Researcher

Brenda Kieffer is a Licensed Professional Counselor and a Registered Nurse. She holds a bachelor's degree in nursing and a master's degree in counseling. This research study will fulfill the requirements for Brenda to receive her doctoral degree in Marriage and Family Therapy. Brenda has many years of professional experience treating a wide spectrum of clients, including eating disorders, involving individuals, couples and their families. Brenda believes obesity is a medical condition which may or may not have psychological implications. Brenda plans to use these research findings to better understand the relevance of weight to a relationship; furthermore, Brenda believes that this study may provide insight to health care professionals on how to be more supportive of couples who seek treatment for weight loss.

### Contact Information

**Any questions concerning participation in this research may be answered by Brenda Kieffer. She may be contacted at 636-239-5588 or 314-808-2382 or by email: [CouplesWeightStudy@yahoo.com](mailto:CouplesWeightStudy@yahoo.com).**

**Thank you for your time and consideration!**

## Appendix D: Press Release

St. Louis, MO: Post Dispatch and Suburban Journals  
Washington, MO: The Missourian

Brenda Kieffer is seeking participants for a research study to better understand formerly obese individuals and their non-obese partner's experience with obesity, treatment and weight loss. This research seeks to understand the relevance of weight to the relationship and to identify those factors within a relationship that contribute to successful weight loss and those that do not. Couples will need to commit to two appointments, during which separate and joint **confidential** interviews will be conducted. These research appointments will also include a Photo Album Review, Questionnaires, and optional Journaling. The study is designed to not exceed 4 hours, to be conducted in two appointments and to be completed within 2 to 3 months. Some couples may complete the interviews in less time. Couples will be contacted twice by phone for follow-up questions, lasting 10 minutes. Reimbursement for your participation in this important research will be provided.

Brenda Kieffer is a doctoral student at Saint Louis University working towards completion of her degree in Marriage and Family Therapy. This study will fulfill the requirements for her dissertation research project. Brenda is a Licensed Professional Counselor and RN. She holds a bachelor's degree in Nursing and a master's degree in Counseling. Brenda has a number of years of professional experience treating a wide spectrum of clients, including eating disorders involving individuals, couples and their families. She plans to treat obese patients using her combined counseling and nursing background. Brenda believes obesity does not imply that the participant has psychological problems; obesity is a medical condition, which may or may not have psychological implications. Any questions you may have concerning participation in this research may be answered by Brenda Kieffer. She may be contacted at 636-239-5588 or 314-808-2382 or by email: [CouplesWeightStudy@yahoo.com](mailto:CouplesWeightStudy@yahoo.com).

## **Appendix E: Public Announcements**

### **Local Radio Stations: KSLQ and KWMO**

Brenda Kieffer is seeking participants for a research study to better understand the formerly obese individual and their non-obese partner's experience with obesity, treatment and weight loss. This research seeks to understand the relevance of weight to the relationship and to identify those factors within a relationship that contribute to successful weight loss and those that do not. Couples will need to commit to two appointments during which separate and joint confidential interviews will be conducted. These research appointments will also include a Photo Album Review, Questionnaires, and optional Journaling. The study is designed to not exceed 4 hours, to be conducted in two appointments and to be completed within 2 to 3 months. Some couples may complete the interviews in less time. Couples will be contacted twice by phone for follow-up questions, lasting 10 minutes. Reimbursement for your participation in this important research will be provided.

Brenda Kieffer is a doctoral student at Saint Louis University working towards completion of her degree in Marriage and Family Therapy. This study will fulfill the requirements for her dissertation research project. Brenda is a Licensed Professional Counselor and RN. She holds a bachelor's degree in nursing and a master's degree in Counseling. Brenda has a number of years of professional experience treating a wide spectrum of clients, including eating disorders involving individuals, couples and their families. She plans to treat obese patients using her combined counseling and nursing background. Brenda believes obesity does not imply that the participant has psychological problems; obesity is a medical condition, which may or may not have psychological implications. Any questions you may have concerning participation in this research may be answered by Brenda Kieffer. She may be contacted at 636-239-5588 or 314-808-2382 or by email: [CouplesWeightStudy@yahoo.com](mailto:CouplesWeightStudy@yahoo.com).

## **Appendix F: Recruitment Letter**

To Whom It May Concern:

I am conducting research for my PhD. in Marriage and Family Therapy at Saint Louis University and I need your help in providing qualified couples for the study. If you are able to provide candidates/couples for this research or are agreeable to distribute flyers about this research, please sign the enclosed agreement. Please copy the Recruitment Agreement onto your letterhead and fax it to me at **636-239-2275** or mail it in the envelope provided.

If you have questions about the research or are interested in receiving the results of the research, please contact me. Thanking you in advance. I am

Gratefully yours,

Brenda S. Kieffer, B.S.N., M.A.  
RN and Licensed Professional Counselor  
Saint Louis University Research Protocol # 13549



## **Appendix G: Recruitment Agreement**

### **Recruitment Agreement**

As representative for \_\_\_\_\_, permission is given to Brenda S. Kieffer, Saint Louis University Doctoral Student, to have potential research candidates contact her from our facility. We will distribute flyers and she may also distribute flyers to our staff and/or clients. Participation in the research is completely voluntary. Research participants will be compensated for their time and may withdraw from the study at any time.

I understand that the results of this study may be published in scientific research journals or presented at professional conferences. However, neither name nor identity will not be revealed. There are no foreseen risks to participation in this research.

Please list any special instructions and/or limitations for recruitment.

\_\_\_\_\_  
\_\_\_\_\_

I have read the flyer about the research and all of my questions have been satisfactorily answered.

\_\_\_\_\_  
Name (printed)

\_\_\_\_\_  
Position

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Saint Louis University Research Protocol # 13549

## Appendix H: Informed Consent for Participation in Research Activities

3750 Lindell Boulevard  
St. Louis, MO 63108-3413  
Phone: 314-977-7108  
Fax: 314-977-3214  
www.slu.edu

SAINT LOUIS  
UNIVERSITY

Counseling and Family  
Therapy Department

College of Public Services

### INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES

Participant \_\_\_\_\_ IRB Number 13549

Principal Investigator (PI) Kieffer, Brenda S., R.N. and L.P.C. 636-239-5588  
PI's Phone Number  
Last First Credentials

Title of Project: The Experience of Obesity, Treatment and Weight Loss:  
A Qualitative Study of Overweight Couples

"You" refers to the participant

You are being asked to participate in a research study conducted by Brenda Kieffer, a Ph.D. student at Saint Louis University conducting dissertation research. You have been asked to participate in this research study because you have responded to an advertisement or heard about the study from another source. After you have signed this consent, you will be given a brief screening interview, which includes questions about your height, weight, and variances in your weight to see if you meet the criteria to participate in this study. You and your partner will participate in two interview sessions with Brenda. Interview One will not exceed 2 hours. Interview Two will not exceed 2 hours. The study is designed to not exceed 4 hours, to be conducted in two appointments and to be completed within 2 to 3 months.

Any questions you may have concerning participation in this research may be answered by Brenda Kieffer. She may be contacted at 636-239-5588 or 314-808-2382 or by email: couplesweightstudy@yahoo.com.

This consent document may contain words that you do not understand. Please ask Brenda Kieffer to explain any words or information that you do not clearly understand. If you and/or your partner are receiving psychotherapy, you may wish to discuss participation in the study with your physician and/or therapist.

## **1. PURPOSE**

The purpose of this study is to better understand the formerly obese individual and his or her non-obese partner's experience with obesity, its treatment and weight loss. You will be interviewed and asked to describe you and your partner's relationship at various stages of weight loss. You will be asked to describe your relationship at prior, mid, and post obese levels. The interviews and questionnaires are not considered therapy and are not meant to take the place of professional therapy.

## **2. PARTICIPATION AND STUDY PROCEDURES**

Your participation in this research requires an individual interview with you and an individual interview with your partner. During the first appointment, individual and joint interviews will be conducted. Interview One will take up to 2 hours. Interview Two will also take up to 2 hours and will include joint interviews. The formerly obese partner will always be the first one to have the individual interview. Both of you will be asked to complete two questionnaires. In addition you will be asked to do some writing about your experiences and to bring in photographs taken during the weight loss, for review.

You will be asked to schedule with your partner two appointments approximately two to four weeks apart. A 10 minute telephone call will be scheduled between interviews and at the end of the second interview. All interviews will be audio taped.

The questionnaires will ask questions about how you feel about your relationship, how you communicate with your partner, and to describe any changes in your relationship you believe may be related to weight. Specific questions will be explored about the experience of obesity, weight loss, and treatment from both your perspective and your partner's viewpoint.

You will be encouraged to keep a journal of you and your partner's reactions to the interviews. This part of the study is optional. Between sessions and as the interviews are being transcribed, the Principal Investigator may call for verification and to clarify that the transcription and interpretation is accurate.

Both you and your partner are to be present during the interviews. In the first appointment a genogram, or a diagram of the family tree, will be drawn by the PI with information provided by you and your partner. Next, you will be interviewed, while your partner is in another room filling out questionnaires. Questions will be asked about the history of your relationship, weight gain and loss and its effect on you and your partner.

During the second interview, you and your partner will review with the Principal Investigator your photo album or photographs that you and or your partner brought in. You will be asked to talk about the photographs and to describe your relationship at the time the photograph was taken. After the photo album is reviewed, you and your partner will continue to be interviewed together. Questions will be asked about your experiences with obesity, weight loss and its treatment.

### **3. DURATION**

Your participation in this study will be completed in 2 to 3 months. It is anticipated that the time spent with the Principal Investigator will not exceed 4 hours. This includes two interviews, completion of questionnaires and telephone calls. However, you may call the Principal Investigator between appointments. The amount of time spent journaling is up to you.

### **4. RISKS**

Once you have signed this Consent for Participation in this research, you will be assigned a special code that will be used on all interviews, questionnaires and tapes. At the conclusion of the study, the list with the names and numbers will be destroyed. Only the Principal Investigator will have access to the list of names and corresponding codes.

There are no anticipated major risks for participation in the study. Minor risks include the possibility of loss of confidentiality. Important steps have been taken to ensure confidentiality. There is always a minimal risk of breach of confidentiality. Participants may benefit by better understanding their experiences and actually feel closer. However, there is the potential risk that as you answer questions about your experience with obesity, weight loss, and treatment on yourself and your relationship, you and/or your partner may become more aware of feelings of dissatisfaction. If any particular question makes you uncomfortable, you may discuss its importance and the need to answer it with the specially trained mental health professional. You may choose not to answer any questions with which you still feel uncomfortable. If you experience severe anxiety as a result of your participation, you will be encouraged to explore these issues with a mental health professional.

### **5. BENEFITS**

a.) Potential benefits to you include:

- 1) You may benefit by a better understanding of your and your partner's experiences and actually feel closer to each other. The semi-structured interviews and instruments may facilitate communication about changes in weight between you and your partner.
- 2) It is possible you may not benefit from being in the study.

b.) Potential benefits to society include:

- 1) Shedding light on how couples cope with obesity and weight loss may provide therapists with insights on how to be more supportive of couples who seek treatment for obesity and weight loss.
- 2) Discovering and examining problems associated with obesity and weight loss can provide therapists with useful insights for treating and educating individuals, who can then become more successful at achieving and maintaining his or her weight loss.

### **6. ALTERNATIVES**

You may choose not to participate in this research study. Your participation is voluntary. You may withdraw from this study at any time without penalty or prejudice.

## **7. CONFIDENTIALITY/PRIVACY**

The results of the research study may be published but your name or identity will not be revealed and your record will remain confidential. In order to maintain confidentiality Brenda Kieffer will not use your name; your information will be combined with other participants' to further protect your confidentiality. During the study your data will be assigned a code number. A master list linking the code number and your identity will be kept separate from the research data. The master list will be kept in a locked file and only the Principal Investigator and designated members of the research team will have access to the master list. Brenda Kieffer will be the only Investigator who will have access to the confidential information.

The Saint Louis University Institutional Review Board (the Board that is responsible for protecting the welfare of research participants recruited to participate in research), may review your research study records.

The study records will be kept in a locked cabinet in the Principal Investigator's office. She will be responsible for them. The audiotapes will be destroyed when the study is completed.

### **Protected Health Information**

The privacy law, Health Insurance Portability & Accountability Act (HIPAA), protects your individually identifiable health information (protected health information or PHI). The privacy law requires you to give the research team your authorization to use and/or disclose your protected health information in order for you to participate in this research study. Protected Health Information in this study will include your Height and Weight. During the interviews, issues concerning health may be brought up by you. By signing this form, you authorize the Brenda Kieffer and her research staff to use and/or disclose your protected health information for the purposes described in this form.

Brenda Kieffer agrees to protect your health information by using and/or disclosing it only as authorized by you under the Protected Health Information section of this form and/or as required by state and federal law. However, if you choose to share your PHI information with others outside of the study, your information may no longer be protected by the federal HIPAA privacy regulations. Your identity will not be revealed in any publication and/or presentation that may result from this study. Please note:

- 1) Your authorization to use and/or disclose your PHI does not have an expiration date.
- 2) You do not have to sign this form. If you decide not to sign this form:
- 3) You can choose to not participate in the research study.

After signing this form:

You can change your mind and not let the Principal Investigator use and/or disclose your PHI (revoke your authorization). If you revoke your authorization, you will send a written letter to: Brenda Kieffer at 864 Elizabeth Anne Lane, Labadie, MO. 63055, to inform her of your decision. If you revoke your authorization, Principal Investigators may only use your PHI already collected for this research study. If you withdraw your authorization, you will not be allowed to continue to participate in the study.

If you have questions or concerns regarding your privacy and the use of your personal health information, you may contact the Dr. Nancy Morrison, Chairperson of this Committee at 314-977-7114 or the University Privacy Officer at (314) 977-5545. You will also be given a copy of the Notice of Privacy Practices (a separate document).



## **8. COSTS AND PAYMENTS**

**Cost:** There will be no additional costs to you as a result of participation.

**Payment:** You will receive a photo album and photo preservation supplies and \$50.00, for the time and inconvenience you incur as a result of your participation in this research study. If you should decide to stop your participation before completion, you will receive a prorated amount of \$25.00 per interview completed.

## **9. RESEARCH RELATED INJURY**

If you believe that you are injured as a result of your participation in the study, please contact the Principal Investigator and/or the Chairperson of the IRB as stated in section 10. The University will provide treatment in the event that injury results because of your participation in this research. A "research-related injury" means injury caused by the procedures required by the research that are different from the treatment you would have received if you had not participated in the research. The University reserves the right to make decisions concerning payment for treatment for injuries solely and directly relating to your participation in the research; however, this does not mean you have waived your legal rights by signing this form.

## **10. CONTACTS**

Any questions you may have concerning participation in this research may be answered by Brenda Kieffer. She may be contacted at 636-239-5588 or 314-808-2382 or by email: [CouplesWeightStudy@yahoo.com](mailto:CouplesWeightStudy@yahoo.com).

If you have any questions about your rights as a research participant or in the event you believe you have suffered an injury as a result of participation in the research project, you may contact the Chairperson of the Saint Louis University Behavioral and Social Sciences Institutional Review Board (314-977-2029), who will discuss your questions with you or will be able to refer you to the individual who will review the matter with you, identify other resources that may be available to you, and provide further information as how to proceed.

If you have questions or concerns regarding your privacy and the use of your personal health information, please contact the University Privacy Officer at (314) 977-5545.

## **11. VOLUNTARY PARTICIPATION AND DISCLOSURES**

Your participation in this research is voluntary and refusal to participate will involve no penalty to you or loss of any benefits to which you are otherwise entitled. You may withdraw from the research study at any time without penalty or loss of benefits to which you are otherwise entitled. You will be informed of any significant new findings developed during the course of participation in this research that may have a bearing on your willingness to continue in the study. The Principal Investigator may withdraw you from this research if circumstances arise which makes this necessary.

The Principal Investigator may terminate your participation even without your consent when, in the Investigator's judgment, it is in your interest to do so, or under certain circumstances:

- 1) Extreme emotional reaction to questions.
- 2) Inability to keep scheduled appointments.

## 12. STATEMENT OF CONSENT

I have read this consent document and have been able to ask questions and express concerns, which have been satisfactorily responded to by Brenda Kieffer. I believe I understand the purpose of the study as well as the potential benefits and risks that are involved.

I will be given a signed copy of this consent document for my records. The Notice of Privacy Practices (a separate document) has been given to me. I authorize the use of my health information and give my permission to participate in the research study described above. I give my informed and voluntary consent to be a participant in this study.

\_\_\_\_\_  
Consent Signature of Research Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Participant

\_\_\_\_\_  
Witness to the Signature of Above Consent

\_\_\_\_\_  
Date

I certify that I have explained to the above individual(s) the nature and purpose of the study and the possible benefit and risks associated with participation. I have answered any questions that have been raised and the participant/patient has received a copy of this signed consent document.

Brenda Kieffer, R.N. and L.P.C  
Print Name of Principal Investigator

\_\_\_\_\_  
Signature of Principal Investigator

\_\_\_\_\_  
Date

(The Investigator signing here must be authorized in the protocol to obtain consent and must sign at the same time as the above signatures are obtained)

If there are any concerns about the treatment of research participants, please contact the Institutional Review Board at St. Louis University at (314-977-7744).

**This form is valid only if the IRB's current stamp of approval is shown below.**



## **Appendix I: Focus Group Questions for Preparation of Semi-Structured Interview Guides**

1. What stressors, besides obesity and its treatment, has the participant been dealing with?
2. What stressors, aside from the obesity issue, has the partner been dealing with?
3. How many attempts at weight loss or treatment has the individual experienced?
4. Has his/her partner ever been overweight? Please explain.
5. How does the subject feel about himself or herself presently? While obese?
6. During weight loss? After weight-loss treatment? How was the participant's self-image affected in each one of these stages?
7. Has the partner's expectations and desires affected the participant's weight? If so, in what way?
8. Has the partner's expectations and desires affected the subject's self/body image? If so, in what way?
9. How does the participant make his or her partner feel about him or herself? How does this affect the partner's self image?
10. How is the sexual relationship between the participant and his or her partner? How has the sexual relationship been pre-, mid-, and post-weight loss treatment?
11. How would the participant describe the marital satisfaction pre-, mid-, and post-weight loss treatment?
12. How would the participant describe a day in his or her life before, during, and after weight loss treatment?
13. Is there a history of obesity/overweight within the participant/partner's family?
14. Did the overweight person have treatment for weight loss because they really wanted to lose weight, or are they losing weight to please their partner?
15. What does being overweight mean to the participant as an individual and what does the participant believe it means for the marital relationship?

## **Appendix J: Bias Statement**

Having worked many years in a medical setting and having received additional training and supervision in both psychodynamic and group therapy, I have been influenced by the Medical Model for health, both physically and psychologically. Leaving the medical setting for private practice has brought a unique balance to my clinical skills. Using an eclectic approach when working with individuals, couples, families and groups, I quickly learned that working from and with multiple theoretical frameworks is most effective. A majority of my clients have depression, secondary to a medical condition. This has led to practicing more from systemic and strength perspectives, and with a greater emphasis on skills related to prevention, wellness and healthy lifestyle changes. As a student at Saint Louis University, I have taken research methods courses, including qualitative and quantitative. A pilot project was completed on the Experience of the Compulsive Gambler and his or her spouse. At Saint John's Mercy Medical Center, I was part of a team of researchers in a collaborative study with Washington University on Borderline Personality Disorders. I conducted Gunderson's Semi-Structured Interview for Borderline Personality Disorders and collected quantitative data. I also designed a study to evaluate the effectiveness of Outpatient Psychiatric Hospitalization Programs for St. John's Mercy Medical Center. I had experiences as a therapist and a program director in both quantitative and qualitative research. My passion for qualitative research comes from the invaluable knowledge gained through conducting semi-structured interviews. My respect for quantitative data and empirical studies comes from the reactions to presentations of the findings; when one research instrument (the SCL-90R) is used with hundreds of patients, the graphs, and tables are quickly presented

and well understood. I had the experience necessary to conduct interviews, which is the focal point of qualitative research (Patton, 1990). These experiences and education enhanced the trustworthiness of the data and the study.

The biases brought to the study come from working in a medical setting, psychopathological diagnoses, and from an understanding of patients. This bias was monitored through the literature review, through the use of a bias clarification interview and through the mentoring of the chair of the dissertation committee. These measures allowed for enhanced authenticity of this study.

I attended a two-day workshop presented by John M. Gottman, Ph.D., entitled *Marital Therapy: a Research Based Approach*, in order to hone marital assessment skills for research studies. This proved to be especially useful when describing the sample and the subjective responses arising out of the joint interviews. The information obtained from the workshop may have influenced my perceptions of the couple interactions related to their descriptions of the experience of obesity, treatment and weight loss.

The selection of topics to be researched, the rationale set forth in this proposal, and the interview questions developed all reflect both the bias and the knowledge of the researcher. For example, reviewing more literature on marital distress and the effect of depression on the marital relationship instead of a literature review of eating disorders reflects my belief that obesity needs to be understood in the context of the marital relationship. The consultations with the esteemed members of the research committee and revisions of the proposal helped to identify bias outside of the researcher's awareness. For example, defining obesity as a health problem with psychological and relationship implications brings a certain bias in the questions developed. There is also

the emphasis on understanding, showing insight, and identifying strengths of the couples that will also be present in the research. Believing that obesity is treatable and support through weight loss is important are other researcher biases. The selections in the literature review may also reflect bias in the researcher. Since the experience of obesity is not well researched, additional topics and related subjects were reviewed.

## **Appendix K: Semi-Structured Interview Guide for Genogram Construction**

1. The genogram is like drawing a diagram or map of your family. The genogram can provide a lot of information about your family on one sheet of paper, and help me to track the family members and events in your family. To protect the identity and privacy of your family members, please do not state their names, but state their relationship to you.
2. Let me begin by asking some questions about your relationship.
  - a. Are you married?
  - b. When did you first meet and decide to live together or get married?
  - c. Have either of you been married previously or lived with another partner?
  - d. Do you have children? Here, we will want to include all miscarriages, stillbirths, adopted and foster children.
  - e. Do either of you have children from previous relationships? If yes, what are the custody arrangements?
  - f. Does anyone else live in your home.
3. Next we will draw your family of origin.
  - a. Were you raised by your biological parents?
  - b. Are your parents still living?
  - c. Did either of your parents divorce and/or remarry?
  - d. What are the sex and age of each of your siblings? Include all miscarriages, stillbirths, adopted and foster siblings. List anyone else that lived your home growing up.
4. Now we will include your parent's family.
  - a. Please write Mom and/or Dad for your parents, so they remain anonymous.
  - b. How many brothers and sisters did your parents have?

5. For all those listed, indicate any of the following:
  - a. Serious medical, behavioral, or emotional problems; drug or alcohol problems, job problems.
  - b. Indicate any who were especially close; distant or conflictual, cut off from each other; or overly dependent on each other.
6. I would like for you to use this highlighter to highlight any other obese members of the family.
7. Next, I would like for you to highlight any other family members with weight concerns.
8. Growing up, what comments do you recall your parents making about these and/or other people who were overweight or obese?
9. What comments do family members currently make about obese individuals?
10. In what ways have your families of origin affected your beliefs about obesity?
11. How have these beliefs affected your relationship around obesity, treatment and weight loss?
12. Is there anything that you would like to add to your genogram at this time?

## **Appendix L: Semi-Structured Individual Interview Guides**

### **Primary Participant**

1. What was/is it like being obese?
2. How did you feel during that time(s) of your life?
3. What made you want to lose weight?
4. What was most helpful and most harmful to your efforts to lose weight?
5. What role did your partner play in your weight loss?

### **Partner Participant**

1. What was it like being married to someone who was/is obese?
2. How did you feel about yourself and your partner during that time of your life?
3. What do you think caused your partner to want to lose weight?
4. What role did you play in your partner's weight loss?



### **Appendix M: Telephone Member Check One Following First Interview**

1. Introduction; I'm calling in regards to your participation in the Couple's Weight Loss Study.
2. Please describe your comfort level in the last interview.
3. How would you describe your partner's comfort level in the interview?
4. Please describe your overall experience to drawing the genogram and questions asked about you and your partner's genogram.
5. Describe your experience as you were completing questionnaires and your partner was being interviewed.
6. Describe your experience of talking about weight without your partner being present.
7. Did you and your partner prepare for this interview?
8. Are there any areas which you wanted to talk about, but did not?
9. Are there any areas which you did talk about, but now regret?
10. Have you and your partner talked about the interview; and if so would you please describe your conversation?
11. Are there any additional thoughts or feelings related to weight you would like to share?
12. What was the ride home like?
13. Do you have any questions about the study and/or your participation?

### **Appendix N: Photo Album Review Explanation**

"I have asked you to bring in several photographs of yourself at different weight amounts and stages of your weight loss process. This includes photographs of you while obese, during weight loss, and after weight loss treatment."

"I would like for you both to look at each photograph and describe for me the experiences that you recall during this time in your relationship. This includes, but is not limited to, thoughts and feelings about yourself, your partner, and your relationship at the particular time of each photo reviewed. While doing so, feel free to include your thoughts and feelings concerning any aspect of your life."

"Reflections on these pictures may be the same for each of you. On the other hand memories and experiences of the picture representations of various times in your life may be very different. Both similar and different descriptions of experiences remembered by looking at the same photo are not uncommon."

"The photographs will be reviewed several times during the interviews. Please feel free to refer to them during any of the interviews or in your journaling between interviews."

The couple will then be asked to present the photos they have selected in any order they have chosen. Additional questions may include how the photos were selected, who was involved in selection of the photos for the interview, and why were any particular photos eliminated from their album.

### **Appendix O: Semi-Structured Interview Guide for Photo Album Review**

1. Describe how you selected the photographs to bring for the interviews. Does the photo accurately represent the way that you perceived yourself or your partner at the time when it was taken? Please explain.
2. What kind of memories do the photos bring back? Please elaborate.
3. If there are photos that you do not like, why do you keep them? Is there any kind of lesson or reminder in these photos that makes you retain them? Please explain.
4. How old are each of these photographs and who took each one?
5. Describe how you felt about yourself when the photograph was taken and any insights you may have about your feelings.

## **Appendix P: Semi-Structured Interview Guide for Couple Interview**

1. How do you communicate about being overweight and weight loss?
2. Describe strengths in your marriage that help you manage being overweight and weight loss within your relationship.
3. Describe any limitations in your marriage that made it difficult to manage being overweight and weight loss within your relationship.
4. How did obesity and/or the difference in you and your partner's weight affect intimacy present in the relationship?
5. How did the weight loss affect intimacy present in the relationship?
6. What do you think has been most beneficial to you, your partner, and your relationship, in terms of how each of you has participated in the issue of overweight/obesity and weight loss?
7. Describe any individual changes either of you has made and the effect on your relationship.
8. How does/did being overweight contribute to any difficulties in your relationship?
9. How do relationship issues contribute to being weight gain?
10. What other factors, if any, play an important role in your weight?
11. How is the effect that being overweight has had on your relationship similar or different from the effect that being overweight may have (or had) on other relationships (e.g. workers, individual friends, church)?
12. Describe any changes that have occurred in your relationships since weight loss treatment.
13. In what ways has being involved in this study affected how you and your partner look at being overweight and weight loss?

**Appendix Q: Couple De-Briefing Interview Guide Conducted  
at End of Joint Interview**

1. What was it like for you to participate in this study?
2. In what ways, if any was it helpful or harmful for you to participate in this study?
3. Have any intense feelings, emotions or issues surfaced as a result of your participation? If so, would you like to be referred to a mental health professional?
4. Do you have any further questions and/or concerns for me at this time?
5. If you have any questions and/or information at a later date, please call me.

**Appendix R: Telephone Member Check Two**  
**Following Final Interview**

1. Introduction; I'm calling in regards to your participation in the Couple's Weight Loss Study.
2. Please describe your comfort level in the last interview
3. How would you describe your partner's comfort level in the interview?
4. Did you and your partner prepare for this interview?
5. Are there any areas which you wanted to talk about, but did not?
6. Are there any areas which you did talk about, but now regret?
7. Have you and your partner talked about the last interview; and if so would you please describe your conversation.
8. Are there any additional thoughts or feelings related to weight you would like to share?
9. As a result of being in the study have you talked more about weight?
10. Do you have any questions about the study and/or your participation?

**Appendix S: Weight History and Significant Events: A Subjective  
Historical Timeline Questionnaire**

<b>Timeframe</b>					
<b>Weight</b>					
<b>Memories</b>					
<b>Events</b>					
<b>Stressors</b>					
<b>Feelings</b>					
<b>Reactions</b>					
<b>Observations</b>					



## Appendix T: Demographic and Treatment Information Questionnaire

Page 1 of 2

Participants Identification # \_\_\_\_\_

### DEMOGRAPHIC AND TREATMENT INFORMATION SHEET

Please supply the information below. We realize that some of this information is very personal and sensitive, and we are asking you to trust us and report honestly. All information will be kept completely confidential. This demographic information sheet applies to you as an individual, not as a couple.

1. Date the questionnaire was completed: \_\_\_\_\_

2. Address: Please include City, State, Zip Code: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Sex:            Male                                  Female

(1) Highest levels of education completed. Check all those that apply):

Less than high school

Some graduate education

Finished high school or equivalent

Master's Degree

Some college

Ph.D.

Two years of college

Ed.D.

Associate of Arts Degree

Professional Degree (e.g. Law)

Finished college (BA/BS Degree)

Other advanced degree            (13) please specify: \_\_\_\_\_

9. Ethnic or Racial Group Membership (check all that you feel apply):

Caucasian or Euro American

Native American

Black

Hawaiian Islander

African American

Asian American

Hispanic/Latino American

Other

Please specify \_\_\_\_\_

10. Please Specify Religious Affiliation (if any): \_\_\_\_\_

11. Current Personal Annual Income

Less than \$10,000

Between \$60,000 and \$70,000

Between \$10,000 and \$20,000

Between \$70,000 and \$80,000

Between \$20,000 and \$30,000

Between \$80,000 and \$90,000

Between \$30,000 and \$40,000

Between \$90,000 and \$100,000

Between \$40,000 and \$50,000

Between \$100,000 and \$150,000

Between \$50,000 and \$60,000

Above \$150,000

**12. Your Occupation(s):** Please briefly describe your occupation and what you do currently and note any changes you have made in your career:

---

Please describe the treatments you and/or your partner has sought for weight. Please include individual therapy, inpatient treatment, surgical intervention, nutritional counseling, exercise, physician prescribed therapy (including medication), self-taught program, support groups, and/or weight loss programs, such as Jenny Craig, Overeaters Anonymous, Weight Watchers the South Beach Diet, etc. Please use additional paper if needed.

## **Appendix U: Journal Questions for the Primary Participant: Option One**

**The following questions are to help you recall your experiences of obesity, weight loss treatment and loss of weight. Some of these may have already been asked in the interview. The questions are meant to give you ideas to write about in your journal and are not meant to limit what you write. Please don't be concerned about spelling and grammar, or complete sentences. Any information you provide will be helpful to others seeking treatment for obesity and weight loss. You may complete either set of questions or both of them.**

1. Describe your experience of being obese. Include your thoughts and feelings, at that time and presently, about the overall impact that being obese has had on yourself, your body image and your relationship with your partner, just to mention a few.
2. Describe your experience of weight gain and then loss. Include in your journal thoughts and feelings about the why and how of weight loss and the support (or lack of) you received from you partner. Write about your goals for the weight loss program you follow. Are you continuing this treatment? Be as specific as possible about weight, amount gained, amount lost, waist size, diet, exercise programs, etc.
3. How has your partner been supportive of your efforts, and if not supportive, how so? Again, be specific. Has your attractiveness to each other changed as a result of weight loss, or maybe just from the effort itself? Remember that this journal needs to give realism and insight into your own thoughts and feelings about what was/is going on during your experience of obesity, treatment and weight loss.
4. Detail your journal with several pages/paragraphs of discussion about your reflections on the weight gain/loss experience on both you and your spouse, individually, and as a couple. Point out how the process itself affected the effort. Are you continuing this program for weight loss and how will you apply the knowledge that has been gained already.

## **Appendix V: Journal Questions for the Primary Participant: Option Two**

1. Describe the main problems of being overweight for which you initially sought weight loss treatment.
2. Describe the impact that being overweight had/has on your self/body image.
3. Describe the impact weight loss treatment has had on your self/body image.
4. Describe the impact being overweight has/had on the overall relationship with your partner.
5. Describe the impact weight loss treatment has had on the overall relationship with your partner.
6. In what ways has being overweight affected intimacy with your partner?
7. What goals and/or expectations did you have during weight loss treatment? Describe the progress you have made towards meeting these goals. What has this experience been like for you?
8. What made you decide to loose weight? What weight loss program did you select and why?
9. How long did the program last and how many pounds did you lose?
10. Are you still involved in a weight loss program? If you are not, have you gained back any or all of the weight that you previously lost?
11. Has your partner been supportive of your weight loss efforts? If so, in what way?
12. Has your partner hindered your weight loss efforts? If so, in what way?
13. Has your partner considered you more or less attractive after weight loss, or has your partner's view of your attractiveness remained the same?

14. Describe any changes you have encountered as a result of the weight loss.
15. Describe the effects these changes may have had on your partner.
16. Describe a conversation you and your partner have had about your weight, weight loss, and your attempts to lose weight.

## **Appendix W: Journal Questions for the Partner Participant: Option One**

**The following questions are to help you recall your experiences when your partner was obese, in treatment for weight loss and after significant loss of weight. Some of these may have already been asked in the interview. The questions are meant to give you ideas what to write about and are not meant to limit what you write in your journal. Please don't be concerned about spelling and grammar, or complete sentences. Any information you provide will be helpful to others seeking treatment for obesity and weight loss. You may answer either set of questions.**

1. Describe your relationship with your partner since it began. You should include your observations about what attracted you to your partner, how weight gain and/or loss has affected that attraction, and what impact the gain and/or loss has had on the overall relationship.
2. Describe the progress that your partner has made in losing weight and how you view the efforts of your partner. Also, consider the ways you have been supportive of your partner's efforts. How do you feel about the support you did offer? Talk specifically about any difficulties in providing support and or your attempts to understand your partner's efforts.
3. Has being overweight or obese had any effect on intimacy with your partner? Has weight loss had any effect on the intimacy of your relationship? Describe how your attraction to your partner has or has not been affected by obesity and/or weight loss. Describe, if you know, the effects that the changes have had on your partner.
4. Describe the conversations that you and your partner have had about obesity and/or weight loss. Be as specific and detailed as possible.

## **Appendix X: Journal Questions for the Partner Participant: Option Two**

1. Describe any problems related to being overweight for which your partner initially sought weight loss treatment.
2. Describe in what way, if any, the impact your partner being overweight has/had on the overall relationship with your partner.
3. Describe the impact weight loss treatment has had on the overall relationship with your partner.
4. Has being overweight had an effect on intimacy with your partner? Has weight loss had any effect on your intimacy in the relationship? If yes to either of these questions, please describe the effect.
5. Describe the progress your partner has made toward resolving the overweight/obesity.
6. In what ways have you been supportive of your partner's weight loss efforts? Describe a time when you felt the best about the support you provided. Describe the most difficult time you had providing support.
7. Have you in any way hindered your partner's weight loss efforts? If so, in what way?
8. Describe how your attraction to your partner has or has not been affected by obesity and weight loss. Describe any changes you have encountered as a result of the weight loss.
9. Describe the effects these changes may have had on your partner.
10. Describe a conversation you and your partner have had about the overweight/obesity and/or weight loss.



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### **Vita Auctoris**

Brenda Sue Potz Kieffer was born Brenda Sue Melton in St. Louis, Missouri in 1954. After completion of primary and secondary education in the St. Louis County School system, Brenda enrolled in Lutheran Medical Center School of Nursing, and matriculated in 1975 as a Registered Nurse. While working as a Registered Nurse and raising two daughters, Brenda acquired a B.S. in Nursing and a Master of Arts in Counseling, both from Saint Louis University. In 1992, Brenda enrolled in Saint Louis University once again, this time as a doctoral student in the Department of Counseling and Family Therapy and is anticipating conferral of Doctor of Philosophy degree in the Spring of 2007.

During a thirty plus-year career as a registered nurse—mostly at St. John's Mercy Medical Center—Brenda has received extensive first hand knowledge and both formal and informal training in many disciplines. These experiences have allowed Brenda to work closely with many of the most renowned psychiatrists in the region and receive personal training in therapy and counseling in the hospital and clinical setting. In addition to supervisory responsibilities in an Emergency Room and serving as Nursing Supervisor of the Chemical Dependency Unit at St. John's Mercy Medical Center, Brenda has also served as Clinical Coordinator and Program Director for the Behavioral Health Outpatient Programs, the Medical Stress and Mood Disorder Unit, the Anorexia and Bulimia Treatment Education Center, and the Comprehensive Treatment Unit for the treatment of sexual and abuse and personality disorders, also at St. John's Mercy Medical Center.

Since 1997, Brenda has also maintained a private practice in which she provides individual, couples, family and group psychotherapy. While practicing in a rural community, health care providers tend to be “generalist,” Brenda has specialized in the treatment of eating disorders and compulsive gambling.

Brenda’s professional memberships include the American Counseling Association, the American Group Psychotherapy Association, the National Eating Disorder Association, and the Academy for Eating Disorders, the Saint Louis Eating Disorder Network, The St. Louis Psychoanalytical Institute and the Missouri Group Psychotherapy Society of which she served on the board for ten years and is Past President, (1999-2001).

Brenda has also presented numerous lectures and seminars at Saint Louis University and the University of Missouri-St. Louis, has been interviewed and published by the *Missourian* and *St. Louis Post Dispatch* and has appeared numerous times on televised panels and interviews. Brenda developed the No-Suicide Agreement which is used by many therapists and hospitals, and presented a formal presentation on “The Ethical, Legal, and Therapeutic Uses of a No-Suicide Agreement,” at Saint Louis University in 1994. She also lectured on topics related to Group Psychotherapy, Compulsive Gambling and Eating Disorders. Her specialty certifications include, but are not limited to, Registered Nurse, Licensed Professional Counselor, Certified Master’s Addictions Counselor, Certified Group Psychotherapy Supervisor, and Certified Eating Disorders Specialist.