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Weight Loss Maintenance: Women's Experience During Perimenopause

Karren B. Liebert

The Graduate Center, City University of New York

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WEIGHT LOSS MAINTENANCE: WOMEN'S EXPERIENCE DURING PERIMENOPAUSE

by

KARREN BROWN LIEBERT

A dissertation submitted to the Graduate Faculty in Nursing in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

2017
Weight Loss Maintenance: Women’s Experience During Perimenopause

A Dissertation

by

Karren Brown Liebert

This manuscript has been read and accepted for the Graduate Faculty in Nursing in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

____________________  Steven Baumann, RN, PhD, PMHNP, GNP
Date  Chair of Examining Committee

____________________  Donna Nickitas, RN, PhD, FAAN
Date  Executive Officer

Supervisory Committee:

Linda Perez, PhD, RN, NPP
Arlene Spark, EdD, RD, FADA, FACN

THE CITY UNIVERSITY OF NEW YORK
ABSTRACT

Weight Loss Maintenance: Women’s Experience During Perimenopause

A Dissertation

by

Karren Liebert RN, MSN, CNS

Advisor: Steven Baumann

Women’s health may be at risk during middle age, a time when women in the United States often gain weight. Being overweight or obese during perimenopause increases a woman’s vulnerability to disabling health sequela in later life, such as cardiovascular disease, diabetes, depression and osteoarthritis, all of which increase morbidity, mortality, health care costs and decrease quality of life. Stigma and discrimination related to overweight and obesity are associated with delay and avoidance of health care, and with poorer quality health care. Weight loss often is followed by weight regain within three to five years. This qualitative study was designed to understand the meaning of successful weight loss maintenance during perimenopause.

The philosophical framework that guided this study was Merleau Ponty’s interpretive phenomenology. Individual in-depth interviews of a purposeful sample of women collected narrative stories of their own experiences of maintaining an intentional weight loss during perimenopause. The study utilized van Manen’s phenomenological method with the six procedural activities and the three thematic approaches to determine the meaning of weight loss maintenance for this group of women.

Key words: weight loss maintenance, perimenopause, nursing, qualitative method
Acknowledgements

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Chapter I

Statement of the Problem

The literature shows that for most Americans, the ability to maintain a healthy weight as we age, and avoid being overweight or obese remains a challenge. The Centers for Disease Control (CDC) lists nutrition, physical activity and obesity as top public health concerns (2016). The prevalence of obesity among middle-aged (40-59) adults in the U. S. was 40.2% in the National Health and Nutrition Examination Survey (NHANES) 2011-2014 (CDC, 2015).

Data from 2011-2014 also show a rise in prevalence of obesity among U.S. women to 38.3% (Flegal, Kruzon-Moran, Carroll, Fryar, & Curtain, 2016; Ogden, Carroll, Fryar, & Flegal, 2015), which exceeds the Healthy People 2020 obesity target of 15% or less (CDC, 2010b; Trust for America’s Health, 2010; WHO, 2016). Furthermore, women aged 40–59 had a higher prevalence of obesity (42.1%) than women aged 20–39 (34.4%) (CDC, 2015).

Women are prone to weight accumulation as a result of aging, perimenopause and post menopause for a myriad of hormonal, psychological, social or cultural factors (Fine et al., 1999; Keller et al., 2010; Lee, et al., 2010; McVeigh, 2005; Nabi et al., 2008; Soares, 2008; Wing et al., 1991). Existing research has demonstrated significant morbidity, mortality and decreased quality of life due to excess weight during perimenopause and post menopause (Flegal, Graubard, Williamson, & Gail, 2009). Perimenopausal women who do not engage in weight loss maintenance often develop comorbidities, thus further endangering their health.

Compounding the problem of health risks related to middle age weight gain, women this age may develop physical mobility limitations related to excess weight making them twice as likely
to be inactive (Gray-Stanley et al., 2009). A decreased ability to be physically active is problematic for perimenopausal aged women since research has demonstrated that physical activity is crucial to weight loss maintenance (Catenacci & Wyatt, 2007; WHO, 2011). This heightens the need for better understanding of how perimenopausal women experience themselves, especially in regard to being overweight or obese.

Obesity has a significant economic impact on the U.S. health care system because of diagnostic and treatment services for associated health issues (CDC, 2016). Excess weight challenges society’s ability to afford health care (Lee et al., 2010). Reducing obesity may be the most cost-effective way of addressing the many chronic illnesses that are driven by excess body weight. Indirect costs to the U. S. economy include absenteeism and decreased productivity at work (CDC, 2016).

The increased prevalence of overweight and obesity among midlife U.S. women presents a health risk as well as a dilemma for society in general, due to the shared burden of cost. These factors indicate a need to decrease excess weight in midlife women. The medical model for addressing excess weight and the diet industry’s message have been insufficient to change behavior of most women to successfully lose weight and maintain the weight loss. Considering there are more than 40 million female baby boomers in the United States (born 1946-1964) now experiencing either perimenopause or post menopause, it is imperative that the stakeholders have a better understanding of weight loss maintenance in perimenopause to decrease health risks and disability, as well as improve life expectancy and quality of life for women who are overweight or obese. There is a need to understand what is involved in weight loss maintenance in addition to dietary and exercise considerations. This study will contribute toward understanding more
about a relatively unknown phenomenon in health care research, the meaning of weight loss maintenance in perimenopausal women.

The use of a qualitative humanistic interpretive research approach will help uncover the nuances and complexities of a participant’s existence in everyday life. The significance of phenomenological research lies in “the implications for change that emerges from the interpretation we glean from our participants on the meaning of various experiences” (Munhall, 2007, p. 154). There is a need to understand what it is like to experience weight loss maintenance for perimenopausal women, each in her situated context with different reference points (Sandelowski & Barroso, 2003), before larger studies can be meaningful and findings applied to practice.

The Phenomenon

Maintained weight loss

The phenomenon of interest in this study is maintained weight loss. This study will look at women who were overweight or obese entering perimenopause according to the National Health and Nutrition Examination Surveys (NHANES) body mass index (BMI) guidelines (Centers for Disease Control (CDC), 2003), and achieved an intentional weight loss during perimenopause of at least 10% of baseline weight, which was sustained for one year or longer. Intentional weight loss means through diet and exercise and not related to a disease, illness, medication or bariatric surgery. The National Institutes of Health (NIH) recommendation for weight loss states that an initial weight loss goal should be a 10% loss from baseline followed by a one–two pound
loss/week over six months, rather than attempting to enter into a specific BMI category (United States Department of Health and Human Services (USDHHS), 1998).

**Definition of Terms**

Two terms used in this study that are related to weight loss maintenance are BMI and perimenopause, which are described and defined in Appendix A. A person’s BMI is a calculation based upon height and weight. Perimenopause in this study refers to a woman’s subjective report in midlife (ages 42-62) of a natural change in her pattern (frequency, duration, or amount of flow) of regular menses, and includes the time up to one year beyond the final menstrual period (FMP). This study will not include women who have had surgical menopause.

Participants for this study will be overweight or obese women who intentionally lost 10% or more of this weight during perimenopause and maintained at least a 10% weight loss for one year or longer.

**Aim of the Study**

This is a study of women who were able to intentionally lose at least ten percent of their baseline weight during perimenopause, and maintain the loss for one year or longer. Maintenance of a significant weight loss remains elusive and is especially difficult for women as they age. A woman’s body weight normally increases 1-2 pounds per year beginning in her late 20’s to early 30’s through her 60’s (Hankinson et al., 2010; Panotopoulos, Raison, Ruiz, Guy-Grand, & Basdevant, 1997; Wing, Matthews, Kuller, Meilahn, & Plantinga, 1991). Also, some women tend to gain additional weight during middle age for a variety of reasons, so it becomes
more difficult to maintain a normal body weight in later middle age. (Fine et al., 1999; Hankinson et al., 2010; Lee, Djoussé, Sesso, Wang, & Buring, 2010; Keller et al., 2010; McVeigh, 2005; Nabi et al., 2008).

More salient data show that generally, overweight or obese adults who intentionally lose a clinically significant amount of weight (at least five %) (Hollis et al., 2008) tend to regain one third or more of it back within one year, and all of it back within three to five years (Calle & Kaaks, 2004; Katan, 2009; Wing, Tate, Gorin, Raynor, & Fava, 2006).

**Prior studies of weight loss maintenance among perimenopausal women**

A systematic review was conducted of studies in the U. S. between 1990 and 2015 that demonstrated one year or more of weight loss maintenance among midlife women. Literature searches were conducted using six electronic databases, including CINHAL Complete, Cochrane Library, Medline Complete, Proquest, Psych Info and PubMed. One study found that 55% of the healthy premenopausal women (ages 44-50) in an intervention group sustained weight loss maintenance at a five year evaluation point, and controls did not. Compared to the control group, the intervention group consistently exercised more and ate fewer calories (Simkin – Silverman, Wing, Boraz, & Kuller, 2003). These women are not the norm, and are therefore important to study. They are a subset of mid-life women who have obviously modified their dietary and physical activity behaviors to make informed choices about their weight, but little is known about what it is like to lose weight and be able to keep it off (Brantley et al., 2014), and what meaning the experience of weight loss maintenance holds in their lives.

Only two qualitative studies were found that addressed weight maintenance among women, but not exclusively perimenopausal women. One focused on weight loss maintenance and
relapse in obesity (Byrne, Cooper & Fairburn, 2003), and the other was a grounded theory approach about maintenance of healthy eating behaviors after a weight management program (Zunker, 2009). A recent study (Jull et al., 2014) concluded that “high quality studies evaluating the effectiveness of interventions targeting body weight changes in women during their menopause transition are needed.” This underscores the lack of research in this area. Therefore, a qualitative interpretive study is proposed to understand participant defined meanings of the experience of maintaining an intentional weight loss during perimenopause. The aim of this qualitative study is to develop an understanding of the meaning of the experience of maintaining an intentional weight loss during perimenopause. The understanding may illuminate the structure of the lived experience of overweight women, rather than generate causal explanation.

**Conceptual Framework**

The ecological model of behavior suggests that health risk perception is related to overweight and obesity in perimenopausal women. The model was derived from Bronfenbrenner’s (1994) work about ecological influences on human development, and has previously been adapted and applied for the study of diabetes prevention (Fisher et al., 2002), and for the study of physical activity and weight management (Richards, Riner, & Sands, 2008). An ecological model looks at influences on health behavior from several perspectives: individual, familial, and community groups including cultural, organizational, and governmental and policy influences (Smedley & Syme, 2000).

The ecological model has some relevance for this qualitative study in that it tries to understand human behavior within a specific context. This framework applied to this study appreciates that human beings in a specific time and place may choose health behavior that has
been influenced by family, community groups and greater society. Phenomenological research tries to understand the meaning of lived experience within social, cultural and historical contexts as it is interpreted by the person who lives it (Wojnar & Swanson, 2007). In contrast, the ecological model tends to see behavior as influenced from external forces (Fisher et al., 2002; Stokols, 1996) and does not address existential ideas found in hermeneutic phenomenology such as responsibility, freedom and choice.

**Relevance to Nursing and Health Disparities**

Nursing has a social mandate to serve the public good in the area of health and to use its autonomy and authority to safeguard the public trust (American Nurses Association, 2010). There are several reasons for nurses to study weight loss maintenance, which involve scope of professional practice, an overweight or obese woman’s access to healthcare, the quality of care provided, and the present state of knowledge and understanding about weight loss maintenance. Nurses strive to promote the health of individuals through provision of holistic person centered care that appreciates peoples’ experiences of their own health as well as their own values and beliefs (Wojnar & Swanson, 2007). Therefore, many forms of knowing and understanding are relevant to holistic nursing practice. Holistic nursing is an attitude, a philosophy and a way of being that has a goal of healing the whole person in nursing practice, by recognizing the interconnectedness of body, mind, emotion, spirit, and relationship, social, cultural and environmental contexts (American Holistic Nurses Association, 2011). Thus far, knowledge about overweight and obesity stems primarily from a positivistic paradigm of research which has generated correlations of some variables to help inform our practice. However, nurses and other
healthcare providers realize that current knowledge is insufficient to effect behavioral change for most overweight or obese women, or to predict which women will be successful at weight maintenance. A need exists to understand the lived experience and life-world of successful perimenopausal weight maintainers from their perspective.

Maintenance of weight loss is not well understood or documented (Brantley et al., 2014) so understandably, most women and health care professionals lack understanding of women’s experiences of perimenopausal weight loss maintenance. This interpretive phenomenological study will explicate the subjective experience of each woman’s life-world. A look at a phenomenon from an inside perspective, such as human science phenomenological research does (Munhall, 2007), is germane and central to nursing, since a person’s experience is the focus of clinical nursing practice. Understanding elements that seem necessary and sufficient to the essence of weight loss maintenance in perimenopausal women will enhance understanding of the subtleties and complexities of the experience of this phenomenon, knowledge that could enable nurses in their clinical practice roles to better promote the health of mid-life women.

Qualitative research best answers questions that involve “knowing” from a holistic perspective- “knowing patients’ preferences, experiences, concerns, and priorities” (Zuzelo, 2007, p.486). The temporality of age is something we have little control over; but women’s lifestyle choices do affect their health status, experience of aging and longevity. Therefore, there is a need for nurses and other providers of health care to know more about weight maintenance for women is this age group.

**Research Question**
The research question that guides this study is: What is the meaning of the experience of intentionally maintaining a weight loss of 10% or more for one year or longer during perimenopause? Participants will be asked, “Can you tell me about your experience of maintaining weight lost during perimenopause?”

**Chapter Summary**

Chapter I stated the problem and introduced the study. Justification for the study was presented in the context of a current national obesity epidemic, rising rates of obesity in women, and the increased risk for weight gain during perimenopause, which contribute to chronic illness, disability, decreased quality of life and premature death in women. The phenomenon of weight loss maintenance was explained and terminology defined. Other issues discussed were the current large number of perimenopausal and postmenopausal baby boomer women, and the health care costs related to being overweight or obese. The relevance of this study to nursing and health disparities and a conceptual framework were identified. The chapter concluded with a statement of the research question, which will guide the study through exploration of the experience of weight loss maintenance during perimenopause. A qualitative study in the tradition of interpretive phenomenology will guide this study to learn more about this experience and how nurses may play a role in helping midlife women to maintain a weight loss. The next chapter will examine the evolution of the study from an historical context.
Chapter II

This chapter discusses what is known about the experience of weight loss maintenance during perimenopause. The experiences of perimenopause and women having excess body weight during perimenopause is reviewed in the literature.

Historical Context of Perimenopause

The temporal nature of perimenopause places it between the beginning of menstrual irregularities to cessation of menses, defined in terms of menopause as peri or around (National Women's Health Information Center, 2010). A woman’s psychological response to perimenopause varies around the world according to the context of the culture, which may view
perimenopause as a biological event whose symptoms require medical treatment or as a life transition with few if any symptoms (Xu, Bartoces, Neale, Dailey, Northrup, & Schwartz, 2005). Perimenopause may also symbolize unwelcomed fears of aging with diminished sexual attractiveness, or elevation of the soon to be menopausal woman to a position of valued status and freedom from the risk of childbirth (WHO, 1996). The historical context of perimenopause in the U.S has been related to women living longer and the need for open knowledge about women’s bodies beyond reproductive capabilities. Some attribute this shift to Betty Friedan’s *The Feminine Mystique* (1963) and the Women’s Movement in the 1960’s, which resulted in more women, especially the college aged baby boomers, seeking knowledge about and control over their bodies and to be part of the decision making main-stream.

A medical researcher stated in 1998 that “a difficulty in the study of perimenopause is that it has been virtually ignored” (Prior, 1998, p. 398). Before the 1990’s, perimenopause as a term was rarely used in medical texts or journals; and if it was, only very briefly as the time preceding menopause in a chapter on premature menopause (Prior, 1998). A standardized definition of menopause and perimenopause originated from WHO in 1980, but many researchers used other guidelines, making comparison of studies difficult (WHO, 1996). According to (Santoro & Chervenak, 2004) population based studies of women in their 40s began in the 1980s. The research at that time (cross-sectional or retrospective rather than longitudinal) focused on menopause (Burger et al., 1995; Dennerstein, Dudley, & Guthrie, 2002; McKinley, 1996), primarily in white women in industrialized countries, so there was very little data on women of varying races or ethnicities. Since then, research and knowledge about woman’s health,
including perimenopause, have multiplied, as have the number of female providers and health providers other than physicians.

The WHO review of research done in the 1990s on menopause was comprehensive with recommendations for future research and a solid basis for our current knowledge. However, this review included only one brief statement about obesity being a risk factor for endometrial and breast cancer (among other risk factors) and only one brief sentence that stated regular exercise, a balanced diet, and control of weight would help prevent CVD. Since then, one branch of the Study of Women’s Health across the Nation (SWAN) looked at multiethnic midlife women and BMI and concluded that the amount of physical activity a woman engaged in was more determinate of her BMI than ethnicity or menopausal status (Matthews et al., 2001). The next discussion of historical contexts will focus on the phenomenon of BMI and the various biological, social, cultural, psychological, economic and political influences on a woman’s weight.

**Historical Context of BMI**

Actuarial tables compiled by life insurance companies in the 1930s used the term “ideal body weight” to calculate risk of premature death and determine premiums (Caballero, 2007). A 1952 public health journal report identified the correlation between an increased prevalence of obesity and the also increased rates of cardiovascular disease in the U.S. (Caballero, 2007). Since then the U.S. government has periodically reported on the continued rise in obesity in the country.
Life-expectancy data demonstrates that women in the United States have a life span that is lower than in 24 other developed countries (USDHHS, 2011a). However, on average, women in the U.S. live 5.1 years longer than men (Arias, 2010), a fact that increases older women’s health care needs, since they may suffer from chronic conditions related to obesity. To be overweight and perimenopausal puts a woman’s current and future health and functional ability at greater risk. Researchers suggest that life expectancy as well as weight related disability and quality of life would improve for overweight and obese women who reduce their weight by as little as ten percent (Raynor & Champagne, 2016).

NHANES is a series of cross-sectional, nationally representative examination surveys conducted by the National Center for Health Statistics (NCHS) continuously since the 1970s. Part of the data, on weight and height, is collected through direct physical examination in a mobile examination center to determine BMI, which is widely used to assess excess body adiposity (CDC, 2006b). NHANES researchers found more validity with standardized clinician measurements compared to self-report, since females and heavier respondents frequently significantly under reported their weight; however there was sufficient correlation to use self-report for epidemiological studies (McAdams, Van Dam, & Hu, 2007). BMI is closely correlated with body fat and obesity-related health consequences (Wang & Beydoun, 2007; World Health Organization, 2011). The BMI risk for morbidity and mortality is continuous, and the BMI cutoff points may vary slightly according to ethnic background (Caballero, 2007). The percent of obesity for 30-44 year olds (15%) and 45-64 (18%) year olds remained consistent from 1971-1974 to 1976-1980 according to NHANES BMI data; however the rate gradually rose to 25% and 33% respectively in 2005-2006 (CDC, 2009). This increase in obesity from 18% to 33% is
nearly double for the 45-64 year olds from 1980 to 2006. As stated in the previous chapter, the prevalence of obesity among middle-aged (40-59) adults in the U. S. was up to 40.2% during 2011-2014, and the prevalence of obesity among midlife women (aged 40-59) was 42.1% (CDC, 2015).

Although BMI is the most frequently used indicator of overweight status, several studies demonstrated a correlation between waist circumference and waist-hip ratio as indicators of CVD, metabolic syndrome, diabetes and all-cause mortality (Balkau et al., 2007; de Koning, Merchant, Pogue, & Anand, 2007; Koster et al., 2008; Parker, Pereira, Stevens, & Folsom, 2009; Rexrode et al., 1998). Overweight and obesity had become so prevalent worldwide that in 1997 the WHO sponsored an international consultation to review epidemiological data and develop public health policies and programs for prevention and management of obesity (WHO, 2000).

**Women’s Perceptions of What a Healthy Weight Is**

Not all women recognize when they are overweight by BMI standards and are therefore not motivated to engage in weight loss and weight loss maintenance. In fact, in U.S. adults there were weak associations between obesity and self-perceived poor health in a study spanning 1976-2006 (Macmillan, Duke, Oakes, & Liao 2011). The increased average weight of the U.S. population over the past decade or so may have had a normalizing effect, and thus changed overall perception of what overweight is (Burke, Heiland, & Nadler (2010). This is particularly true for obese females when it comes to rating differences among female body types (Keightley, Chur-Hansen, Princi, & Wittert, 2011). Perception of another overweight or obese female as healthy and only slightly smaller than one’s own size and shape lessens the deviation from healthy and the need for weight loss (Keightley, Chur-Hansen, Princi, & Wittert, 2011).
additional contributing factor to not perceiving oneself as overweight is the observation that historical context has valued certain ideal body types for women and perceptions vary about what a healthy weight is.

Regardless of one’s BMI determination, there is evidence to suggest that the notion of ideal body size is culturally determined as well as related to educational level, one’s socioeconomic status where currently living, one’s socioeconomic status in the country of origin for recent immigrants, whether an immigrant’s country of origin is developed or underdeveloped, and the degree of acculturation and assimilation (McLaren, 2007; USDHHS, 2004). A body size valued as legitimate within a culture is a form of capital that can have symbolic meaning (Bourdieu, 1986/2011). This context is important to consider when looking at a woman’s weight in the United States among more recent immigrants. Some researchers have looked at the “nutrition transition” in global societies as they have transitioned from to rapid technological, socioeconomic and demographic advances, which may contribute to different dietary and physical activity patterns that affect our bodies (Popkin, 2006).

In general, the more developed a country is, the more negative the association with overweight (McLaren, 2007). Women in low and medium developed countries commonly are overweight, since the ability to afford food is an economic aspect of class distinction (McLaren, 2007). A common exception is the more educated woman who is likely to adopt the media’s Western ideal of beauty, which is being a thin woman (Drury & Louis, 2002). Bourdieu’s theory of class suggests that in more affluent areas of any country, a thinner body and healthier lifestyle may be a valued goal, the achievement of which may help maintain class differences, particularly for women, since the capacity to purchase healthy foods, which are more expensive, reflects a
person’s income (Bourdieu, 1986/2011). These findings represent the complexity of the socioeconomic and cultural patterning of weight that may affect individual attitudes, beliefs and values about their own body, as well as the bodies of others.

Perceptions of Americans about what a healthy weight is depend upon the beholder’s frame of reference. What is too heavy? What is too thin? The BMI range for normal weight is the suggested ideal to lessen one’s susceptibility to CVD, some cancers and other chronic conditions (USDHHS, 2011). Women particularly are confronted with mixed messages about their body size. The standard Western media image of a beautiful woman’s body typically is one that is not overweight, but thin, and some researchers suggest women are more susceptible to the effects of mass media than men are (Wadden & Stunkard, 1985). Some researchers have studied obese, primarily White female chronic dieters and realized that most tend to regain weight losses or even gain more weight, and engage in unhealthy yoyo dieting. These researchers and others advocate rejecting the stress of dieting toward intuitive, healthy eating in moderation, accompanied by ongoing physical activity. This approach to health is referred to as “size acceptance” or “health at any size” (Rothblum & Solovay, 2009). It suggests that one not assume by BMI alone what another’s health practices must be and that a high BMI is not necessarily a predictor of ill health or premature death (Rothblum & Solovay, 2009).

Additionally, online sites referred to as the “fatosphere” often refute claims about the health dangers of obesity and rebuke any benefit to dieting (Bellafante, 2010).

A 2008 market research survey found that the most frequently worn size in America is a 14, but sizes 14 and above represent a mere 18% of total revenue in the women’s clothing industry (Bellafante, 2010, Martinez-White, 2009). Fashion media have only very recently responded to
criticism that their standards encourage anorexia in models and in girls and women who strive to emulate a thin ideal, by including a few larger models with belly fat (Bellafante, 2010; Kang, 2004; Martinez-White, 2009). However, very few companies cater to overweight women partly because it is difficult to make a prototype pattern, since different women gain weight unpredictably in different places, and more variation exists in overweight women (Bellafante, 2010). To add to the confusion, the clothing industry has accommodated women’s vanity by changing the sizing, so a 1947 size 10 (32½-inch bust, a 25-inch waist and a 35-inch hip) is the current equivalent of a size 2 (Bellafante, 2010). Until the internet, overweight people did not congregate together around fatness unless it was at a weight-loss venue; however, now women share through sites like Fatshionista, a web-site devoted to looking good in clothes and feeling good about yourself no matter what your size (Martinez-White, 2009).

Answers to how an individual perimenopausal woman in the U.S. views her body, her weight and herself remain complex, and most likely play a role in weight loss maintenance. There is a need to know more about weight loss maintenance in perimenopausal women, since in the 45-64 age group women are more overweight and obese than the men. These women need knowledge about a realistic BMI in relation to health and how to maintain a healthier weight.

**Factors That Influence a Woman’s BMI**

This section discusses biological, familial, cultural, environmental, political, socioeconomic, racial/ethnic contextual issues that influence a woman’s weight. Other than taking in more calories than expended, experts have found that additional causes of the trend of overweight and obesity can be attributed to biological, environmental, sociological, political and psychological factors which overlap and some of which remain unknown (WHO, 2016). Thus, the human body
has emerged as a central focus for research and theory, an interest that reflects broader societal changes, whereby the body is a common target of consumerism, political surveillance and academic interest as stated by Turner (as cited in Coakley, 1997).

Public health data indicate that the heavier segment of the U.S. population is becoming much heavier, whereas the leaner segment has shown little change, which suggests a biologically based gene-environment interaction as a determinant (Flegal, Graubard, Williamson, & Gail, 2009). Among overweight or obese people who do lose at least 10% of their body weight, some researchers believe less than 25% will maintain the loss, possibly due to leptin, a metabolic hormone that controls energy intake and expenditure (Rosenbaum, Sy, Pavlovich, Leibel, & Hirsch, 2008). Leptin levels decrease during dieting to slow down metabolism and increase appetite to restore lost fat (Rosenbaum, Sy, Pavlovich, Leibel, & Hirsch, 2008). Thus a biological mechanism to restore a previous state may operate to interfere with weight loss maintenance. Other evidence of biological factors that influence weight is seen in data from studies of White and Black girls, which showed that weight gain markedly increased during adolescence, and a study of adults in their 20s revealed that many were already overweight, so clearly prevention must begin in childhood to decrease overweight among adolescents (USDHHS, 2004). Evidence also suggests that there may be neurochemical origins to binge eating and night-eating syndrome, which can contribute to weight gain (Arehart-Treichel, 2005).

Quantitative studies on lifestyle and environment suggest that they provide a major influence on weight. Some public health studies using the ecological model refer to many U.S. environments as obesogenic (Apovian, 2010), meaning they promote weight gain and have barriers to weight loss (Cook & Mueser, 2013). Parental lifestyle is blamed by some researchers
as influencing a person’s chances of becoming overweight from inactivity and high-calorie foods (USDHHS, 2004). Others suggest that advertisement for high calorie (high fat and high carbohydrate) supersized food and drinks bombard us. There is evidence that food portions and snacking have increased while eating three modest well-balanced meals per day with fiber or whole grains and no snacks has decreased (CDC, 2006, USDHHS, 2004). Healthy foods like fruits, vegetables, beans and nuts are more expensive than government subsidized corn and wheat, used primarily to make corn sweeteners and refined carbohydrates. At the same time, most Americans have adopted a much less physically active lifestyle over the past few generations (Caballero, 2007). For many, work involves less manual labor, distances to get to the work site have increased so people commute rather than walk or bike, and long work hours and time spent commuting leaves less time to be physically active (WHO, 2002). Leisure has also become more sedentary with more time spent viewing TV and searching the internet. More than 2 hours a day of regular TV viewing time has been linked to overweight and obesity (USDHHS, n. d. b). Leisure time is often spent in passive activity that involves eating, such as driving, movie going, mall walking, playing cards and going to bars and restaurants.

Overweight women tend to gain more during pregnancy than those who are in the normal weight range and some women retain excess weight following a pregnancy (USDHHS, 2004). Research had shown that women should return to pre-pregnancy weight gradually within one year to avoid a higher BMI at 15 year follow-up (Amorim, Rossner, Neovius, Lourengo, & Linne, 2007). According to the Association of Reproductive Health Professionals, physical activity and diet are important aspects of postpartum weight loss (2013); however a minority (17%) of women report receiving any information about this from a provider (Ferrari, Siega-Riz,
Evenson, Moos, Melvin & Herring, 2010). The 2007 Guidelines for Perinatal Care did not provide advice to providers about postpartum weight loss or physical activity when it addressed nutrition and the physical exam (American Academy of Pediatrics, American College of Obstetricians and Gynecologists, March of Dimes Foundation). New guidelines about weight gain and pregnancy were issued by the Institute of Medicine (IOM) in 2009 in response to the fact that 66% of women are believed to be overweight or obese. Women were advised to begin pregnancy within the normal weight BMI range; however the new guideline for weight gain during pregnancy is based upon pre-pregnancy BMI (IOM, 2009). There is a need for nurses and other providers to assist women more with postpartum weight loss that includes diet and physical activity education. Among White women especially, becoming a parent is associated with a decline in physical activity (USDHHS, 2004). Black adolescent girls, rather than White girls tend to engage in less physical activity (USDHHS, 2004). This trend continues as young Black women compared to White women and other ethnic minority women showed a decline in exercise frequency from1984-2006 (Clarke, O’Malley, Johnston, Schulenberg, & Lantz, 2009).

Some environmental contributors to overweight include lack of sidewalks, bike lanes, and safe places for recreation, such as parks, trails, and affordable gyms for people to be physically active. Higher socioeconomic neighborhoods tend to have more varied resources for physical activity (USDHHS, 2004). Other environmental factors that may influence diet behaviors, physical activity and weight outcomes include community design and demographics, transportation, availability of grocery stores and restaurants, and neighborhood crime (USDHHS, 2004). The types of physical and social environmental changes that will increase physical activity in communities may only be realized through political action (Saris et al., 2003).
In 2008, 59.5% of women were in the labor force and the labor force participation rate of mothers with children under age 18 was 71% (U.S. Department of Labor). This indicates that women may often be too tired or lacking time needed to prepare healthy meals (Candib, 2007). Low quality empty calorie diets are often less expensive and often available to eat without time spent in preparation; whereas, high protein and fresh foods are more costly (Candib, 2007). Additionally, larger numbers of never married women having children and high rates of separation or divorce, which have resulted in increasing amounts of one parent families (Rector, 2010a, b). Nearly half of children in the U.S. spend time in one parent families, which often are characterized by socioeconomic deprivation (U.S. Census Bureau, 1992). Socioeconomic status is a factor that may predict overweight and obesity (Candib, 2007). Food insecurity in the U.S. is associated with overweight, especially for women (Townsend, 2001). Women with less income, sometimes due to stigma or discrimination, may live in neighborhoods that don’t have supermarkets that sell healthy foods, or access may be limited by their income or lack of knowledge about nutrients (Candib, 2007; USDHHS, 2004). Studies have found healthier dietary practices among those who have a higher education (USDHHS, 2004).

Significant differences in obesity exist for race/ethnicity in the U.S. The highest prevalence of overweight was in non-Hispanic Black women aged 40 years or older (> 50%) and more than 80% were obese (Flegal, Carroll, Ogden, & Johnson, 2002; Wang & Beydoun, 2007). Among Black women, obesity increased at a faster pace in the high and medium socioeconomic (SES) groups compared with the low SES group between 1976–1980 and 1999–2002 (Wang & Beydoun, 2007). Mexican American women had a prevalence that was between that for Black and non-Hispanic White women (Flegal, et al., 2002). Asian-American women had a 1-4%
prevalence rate of obesity in 2003-2004. Minorities born in the United States are more likely to be obese than their foreign-born counterparts and among the foreign born; living more years in the United States was associated with a greater risk for becoming overweight or obese (Wang & Beydoun, 2007).

Ethnicity and marital status revealed patterns in a woman’s body mass index. The 1999–2002 NHANES data showed that Black separated women had greater odds of being overweight, and all Hispanic women, except those never married, tended to be overweight (Sobal, Hanson, & Frongillo, 2009). White women’s weights did not vary significantly by marital status. These patterns may reflect BMI norms within the respective ethnic groups based upon marital status, or the data may also suggest what the cultural expectations are for each group. However, when interpreting the data, the pivotal role of socioeconomic factors on diet and exercise needs to be considered as well individual differences in body image lifestyle, and the social and physical environment (Wang & Beydoun, 2007).

Many different but interrelated factors that may influence women in the U. S. to be overweight and maintain health have just been discussed. The findings have come primarily from quantitative research data. A woman’s health behaviors related to weight are also impacted by psychological factors, which will be discussed next.

Psychological issues that influence a woman’s weight.

Other factors to consider when addressing the historical context of a woman’s BMI are the psychological issues. The literature from the discipline of psychology has studied BMI in relation to depression, self-esteem/self-concept, self-motivation, body shape concerns, body size
dissatisfaction and body cathexis (Teixeira et al., 2002). The majority of these measures are self-report and therefore related to one’s perception at a given point in time.

According to mainstream public health and biomedical models, many of the previously discussed factors influence a woman’s BMI and may influence her experience of her body. For example, familial and cultural expectations and traditions, socioeconomic circumstances and societal media messages about what a normal weight is are inner twined. These factors are believed by some to play a role in the psyche early on in life. The North American emphasis on having of an ideal body can leave girls, adolescents and women feeling dissatisfied with their own bodies and through social reinforcement, even strive for impossible goals as far as weight is concerned (Stice, 2002). Also, the role of chronic stress in daily life is seen by several researchers as contributing to girls or women eating habits, such as eating more than usual through the increased reward value of calorically dense food intake (Adam and Epel, 2007; Björntorp, 2001). Generally, people with chronic or moderate to high perceived stress gain more weight (USDHHS, 2004; van Jaarsveld, 2009). The prevalence of obesity among women with severe mental illness was found to be double (50%) that of women with no known psychiatric diagnosis (27%) (Dickerson et al., 2006). The research did not address the role of stress compared to the effect of psychotropic medication. Weight gain can be traced to family pressure to be thin, and equally stressful, teasing by peers during childhood or adolescence may also result in disordered eating behavior (Stice, 2002). However, it is not clear to what degree these experiences contribute to ongoing adult bulimic behaviors (Stice, 2002).

Studies have investigated whether childhood trauma is correlated with later obesity. The greatest predictors of obesity for females during adolescence or early adulthood were poor
parental maintenance of the home (26%), physical neglect during childhood (21%), poverty (17%), harsh maternal punishment (16%), loud arguments between parents (15%), and low parental education (12%) (Johnson, Cohen, Kasen & Brook, 2002). Females who did not become obese had significantly lower percentages of these experiences. In other studies, emotional abuse has also been associated with lower self-esteem, and greater depression and body dissatisfaction (Grilo & Masheb, 2001). Most women diagnosed with binge eating disorder reported childhood maltreatment such as emotional neglect (69%), emotional abuse (59%), physical neglect (49%), physical abuse (36%), and sexual abuse (30%) (Guillaume et al., 2016). Many women with a binge eating disorder are overweight, although these researchers found no significant correlations with obesity. A similar study of childhood trauma also revealed no increased risk for adult obesity in women, suggesting that other processes mediate the relationship for many women (Gunstad et al., 2005). However, some studies did report a positive correlation between childhood sexual abuse and obesity (Noll, Zeller, Trickett, & Putnam, 2007; Smolack & Murnan, 2002).

Other studies also demonstrated early psychological issues related to the body among females. The USDHHS study (2004) suggested that Caucasian girls with adiposity reported more body dissatisfaction and less social acceptance compared to African–American girls. Similarly, a study with a large ethnically diverse sample of adolescents revealed that an overweight BMI contributed significantly to body dissatisfaction across all groups; Caucasians, Latinas, Asians and Native Americans reported similar and more body dissatisfaction when overweight than African-Americans (Wilkosz, Chen, Kennedy, & Rankin, 2011). These quantitative studies suggested that body dissatisfaction in female adolescents is correlated with
low self-esteem and greater BMI. Some researchers stated that body dissatisfaction is so prevalent among women in the U.S. that it is the norm (Murnan & Smolack, 2009). Research bears out that body image issues have been found to be more prevalent among overweight and obese women in general (Murnan & Smolack, 2009). For example, a large percentage (82% of obese women) avoided clothing that made them aware of their body shape (Arehart-Treichel, 2005a). Similarly, in this same group, obese women felt significantly less positive about themselves and engaged more in dieting compared with obese men (Arehart-Treichel, 2005b). However, ironically, according to some sources, the more frequently a person attempts to lose weight with a diet, the poorer the weight outcome (USDHHS, 2004). This data would seem to suggest that a size acceptance and health at every size model may provide better physical and mental health over time.

Obese adults consistently rated their perceived body shape as smaller than its actual shape compared to self-ratings ratings of healthy weight subjects, and as previously mentioned obese women have difficulty differentiating their body size and shape from other body types (Keightley, Chur-Hansen, Princi, & Wittert, 2011). This may reflect a general shift in social construction of obesity, as well as individual psychological issues. These obese adults also reported dissatisfaction with their body shape even when they had achieved their desired weight, possibly because their lighter weight body did not match their desired body shape (Keightley, Chur-Hansen, Princi, & Wittert, 2011). It is not known if this impedes weight loss maintenance. Obese participants attributed others’ obesity to internal factors; whereas they attributed their own obesity to external factors as much as to internal factors (Keightley, Chur-Hansen, Princi, & Wittert, 2011). Attributing one’s weight excess to external factors has been associated with poor
outcomes in terms of changing dietary and exercise behaviors, possibly due to participants thinking they have less control over their weight loss (Keightley, Chur-Hansen, Princi, & Wittert, 2011). Internal locus of control has been associated with more success with weight loss (Stotland & Zuroff, 1990). Psychological well-being has been associated with inner locus of control, which suggests that bolstering over-all psychological health may facilitate weight loss and weight loss maintenance.

Interestingly, some psychological factors pose a risk for weight regain after a loss. These include weight cycling, disinhibited eating, binge eating, eating in response to negative emotions and stress, and a more passive approach to problems (Elfhag & Rossner, 2005). It seems here too that ongoing healthy eating and regular physical activity is more likely to occur within a positive climate and an internalized attitude of acceptance.

In conclusion, psychologists using quantitative research methods and assumptions have suggested that various factors influence a woman’s BMI in the U.S. They tend to describe these factors as interrelated and dynamic. These authors suggest that health care providers cannot ascribe the etiology of overweight and obesity solely to individual factors that are within an individual’s control. Genetic, biological, environmental, socioeconomic, familial racial/ethnic and psychological factors also have profound influence on a woman’s perceptions of her body. Overweight or obese women face stigma and discrimination in employment, education, interpersonal relationships, pursuit of health care and quality of care provided (Puhl, Andreyeva, & Brownell, 2008). This study seeks to understand the perimenopausal phase of a woman’s life and her perception of her body as it relates to her experience of weight loss maintenance.

**Excess Weight During Perimenopause and Health Risk Factors**
Many studies have identified the effect overweight and obese bodies have on a woman’s health. These weight related health risks for perimenopausal and post menopausal women include the following: dyslipidemia (increased levels of total cholesterol, low-density lipoprotein, cholesterol, triglycerides), increased fasting insulin, hypertension, type 2 diabetes, cardiovascular disease (CVD) (Balkau et al., 2007; Derby et al., 2009; Keller et al., 2010; McTigue et al., 2006; Rexrode et al., 1998; Tedrow et al., 2010; Wing et al., 1991; WHO, 2011), several types of cancer (American Cancer Society, 2016; Calle et al., 2003; Feldstein, Perrin, Rosales, Schneider, Rix & Glasgow, 2011), urinary incontinence (Phelan et al., 2015b), sleep disruption (Appelhans, et al., 2013), osteoarthritis (Karvonen-Gutierrez, Harlow, Mancuso, Jacobson, Mendes de Leon, & Nan, 2013) and depression (Harlow, Wise, Otto, Soares, & Cohen, 2003). The adverse health effects women experience from overweight and obesity are summarized in Appendix C and will be briefly discussed next.

**Risk for CVD related to excess weight during perimenopause.**

Cardiovascular disease is the leading cause of death among women in the U. S (Centers for Disease Control and Prevention, 2016) so health providers need to find ways to engage women in maintaining a healthy weight. Unfortunately, there has been an increase in the prevalence of central obesity in the U.S. (Kuller et al., 2007) and increased central adiposity (waist circumference of 30 inches or more) in women aged 40- 65 is associated with a more than 2-fold higher risk of coronary heart disease (CHD) (Koster et al., 2008; Lin, Caffrey, Chang, & Lin 2010. In addition, excess weight and a larger waist girth is associated with metabolic syndrome (MetS), increased cholesterol and triglycerides, and an increased likelihood of diabetes mellitus (Balkau et al., 2007; Biggs et al., 2010). Mortality rates for adults with type 2 diabetes are 2-4
times greater than for adults without diabetes and are primarily related to CHD (American Diabetes Association (ADA), 2011). Understanding how to engage women in maintaining a healthier weight would lessen CVD disease, disability and death in perimenopausal and postmenopausal women.

**Cancers related to excess weight during perimenopause.**

The proportion of all deaths from cancer attributable to overweight and obesity in U.S. women 50 years of age or older may be as high as 20 percent, compared to 14% in men (Calle et al., 2003). Compared to normal weight women, overweight women in the $\geq 30 – 40$ BMI ranges have a greater relative risk for various cancers (American Cancer Society, 2016) (see Appendix C). Post menopausal women with an obese BMI have a 35% increased risk of developing an aggressive form of breast cancer and a 35% increased risk of other breast cancers (Neuhouser, 2015). Detecting early breast cancer in overweight or obese women may be difficult since a recent large study of 50-69 year old women revealed that those with an obese BMI had fewer mammograms, with reported pain as the mediating factor (Feldstein, Perrin, Rosales, Schneider, Rix & Glasgow, 2011). Research indicates that if women maintain a desired range BMI throughout life, various types of cancer deaths in women would decline.

**Osteoarthritis related to excess weight during perimenopause.**

Women around age 50 are more often affected than men with osteoarthritis of the hand, foot, and the knee especially (Felson, et al., 2004). Osteoarthritis of the knee results in functional limitations equal to that attributable to cardiovascular disease and more than that due to any other
medical condition in elderly persons (Felson et al., 2004). A direct relationship exists between aging, being overweight and the incidence of osteoarthritis (Murphy et al., 2008). Being overweight precedes development of osteoarthritis as well as increases the risk of progression (Felson et al., 1997). Researchers in the SWAN study measured serum leptin levels of midlife women over ten years and found a correlation with elevated leptin and knee osteoarthritis (Karvonen-Gutierrez, Harlow, Mancuso, Jacobson, Mendes de Leon, & Nan, 2013). Leptin levels are known to be elevated in people with excess fat mass, but it is not yet understood what the metabolic connection is to osteoarthritis.

Among people who are overweight, weight loss can reduce the risk for osteoarthritis (Felson et al., 2004; Murphy et al., 2008). Women who reduce their weight from obese to overweight, or from overweight to a lower BMI can appreciate a 33-50% reduction in osteoarthritis and the associated pain (Felson et al., 1997). In addition to the aging process and excess weight leading to osteoarthritis, muscle mass and strength decline as people age (Fujita & Volpi, 2006). Disability occurs when help is needed to walk or climb stairs. Obese older adults experience new or worsening functional disability in various activities of daily living (Wee et al., 2011). These findings demonstrate obvious benefits for middle aged and older women to retain a BMI in the normal range to avoid chronic pain, disability, dependence on others, poorer quality of life and any associated depression.

**Depression associated with excess weight and perimenopause.**

Many of these adverse health conditions just discussed are interrelated, such that women with metS, diabetes, CVD (myocardial infarction, stroke), cancer, and arthritis and sleep disruption are more prone to experience depression (Nouwen et al., 2010; Soares, 2008). Conversely, a
woman who experiences depression has greater CVD morbidity and mortality (Mayo Clinic Foundation, 2011; Wassertheil-Smoller et al., 2004).

Eighty percent of people with depression report some level of related functional impairment, and 27% report serious difficulties in home and work life (Pratt & Brody, 2008). Overall, women are two times more likely to suffer from depression than men, and as previously mentioned, women aged 45-64 have the greatest lifetime prevalence of depression in the U.S. (CDC, 2011a; Hasin, Goodwin, Stinson & Grant, 2005). Depression is strongly and consistently associated with obesity and less physical activity in middle-aged women (Simon et al., 2008). Among obese middle-aged women, depression is associated with increased caloric intake (Simon et al., 2008). These findings support a need to continue research in women’s health related to achieving and maintaining a healthy body weight. Understanding the meaning of the experience of weight loss maintenance during perimenopause for women who were overweight or obese may heighten provider sensitivity and appropriate engagement with women approaching perimenopause or post menopause.

**Effect of stigma on women with excess weight**

Stigma about overweight women can be associated with negative healthcare outcomes. Negative attitudes toward overweight and obese women can delay or prevent a woman from seeking care as well as affect the quality of healthcare provided (Amy, Aalborg, Lyons, & Keranen, 2006; Drury & Louis, 2002; Hebl, Xu, & Mason, 2003; Olson, Schumaker, & Yawn, 1994; Phelan, Burgess, Yeazel, Hellerstedt, Griffin, & van Ryn, 2015; Puhl, 2011; Wee, McCarthy, Davis, & Phillips, 2000; Wee, Phillips, & McCarthy, 2005). For example, overweight women may neglect preventative screens for breast and cervical cancer due to perceptions of
stigma related to their weight (Wee, McCarthy, Davis, & Phillips, 2000; Wee, Phillips, & McCarthy, 2005). A woman stigmatized due to obesity may be considered deviant or undesirable and be devalued (Drury & Louis, 2002; Goffman, 1963). Negative attitudes toward obese individuals in the form of cognitive bias and entrenched stereotypes are frequently reported by health care providers (Hebl, Xu, & Mason, 2003; Jay et al., 2009; Teachman & Brownell, 2001). For example, Yale researchers reported on studies of nurses, medical students and primary care physicians in several countries including the U.S. where respondents commonly characterized their overweight or obese patients as noncompliant, unintelligent, overindulgent, unsuccessful and lazy (Puhl, 2016). Similarly, a study of primary care physicians in the U.S. revealed that 50% of respondents characterized their overweight or obese patients as unmotivated, and undisciplined (Foster et al., 2003). Physicians in this study tended to view patients as responsible for both the cause and the solution to their obesity by rating physical inactivity, over-eating and high fat diet as behavioral factors within patient control. Maddox & Liederman, 1969 as cited in Foster et al., 2003) reported on physicians who stereotyped obese patients as weak-willed, ugly and awkward. Some researchers suggested that negative attitudes among physicians may stem from recognition that obese patients require special accommodations such as more space and effort, non-standardized size equipment and longer recovery time (Hebl, Xu, & Mason, 2003). Medical residents viewed overweight patients as less likable and too emotional, and indicated that effort to treat them was futile (Blumberg & Mellis, 1985; Jay et al, 2009). Medical students have reported beliefs that overweight and obese patients were “lazy and lacking in self-control” and primarily needed mental health care rather than medical care (Blumberg & Mellis, 1985; Hebl, Xu, & Mason, 2003; Wiese, Wilson, Jones & Neises, 1992).
The effect of these attitudes on women remains poorly understood, but it is conceivable that they create negative emotions for overweight and obese women and change their experiences of their own bodies (Blechner, 2011). The fact that stigma or health provider discrimination plays a role in an overweight or obese woman choosing to delay or even avoid seeking health care speaks to the presence of a negative body image and self-concept. Additionally, exposure to disparaging attitudes about body weight may translate into unhealthy eating behaviors and further weight gain, since negative emotional states have been shown to lead to overeating in overweight individuals (Geliebter & Aversa, 2002).

Many nursing students and nearly 69% of nurses, especially nurses with a lower BMI, in some studies, shared the same negative attitudes as physicians about obese patients (Brown, 2006; Brown, Stride, Psarou, Brewins, & Thompson, 2007; Culbertson & Smolen, 1999; Puhl & Brownell, 2002; Puhl & Heurer, 2009). One study revealed that 24% of the nurses described obese patients as “repulsive” and 12% of nurses were reluctant to touch obese patients (Puhl & Brownell, 2002). Similarly, female, Caucasian exercise science students had a stronger anti-fat bias and negative associations with obesity compared to other students, especially if there was no family history or a close friend with obesity (Chambliss, Finley & Blair, 2004).

Several studies showed that a majority of health professionals felt ill prepared and preferred not to treat obesity, and more than half the time did not provide education or counseling about weight loss (Jay et al., 2009; Puhl & Brownell, 2002; Puhl & Heurer, 2009). Among primary care physicians, 50% said they would devote more time to counseling overweight patients if they were reimbursed for the time (Hebl, Xu & Mason, 2003). These findings of discrimination among health providers are not an anomaly. The prevalence of discrimination in the U.S. against
overweight people sometimes exceeds discrimination for racial or gender reasons with reported weight discrimination experiences for women (10%) double that for men (5%), and three times more likely for women with a BMI of 30-35 (Carr & Friedman, 2006; Puhl, Andreyeva, & Brownell, 2008).

Stereotyping overweight or obese women and engaging in stigmatizing attitudes and behaviors affects more than health care utilization and quality of care. The woman may feel increased psychological stress, devalued and vulnerable to rejection (Phelan, Burgess, Yeazel,, Hellerstedt, Griffin, & van Ryn, 2015). Distress experienced is related to low self-esteem and poor body image, fosters increased eating, binge eating and decreased physical activity and is associated with current use of mental health services for anxiety, depression and substance use (Puhl, 2011, 2016). Thus, weight stigma can compromise a woman’s psychological well-being and interfere with effective treatment of obesity.

**Historical Context of Maintained Weight Loss**

The interest in one’s ability to sustain a weight loss over a long period of time is relatively recent since historically, researchers and health providers looked primarily at how to lose weight with no particular consideration for how to maintain the loss. Focus on the ability to sustain a weight loss originated from awareness of the fact that people tend to regain lost weight, which piqued researchers’ interest. This was in concert with a growing awareness that overweight and obesity rates and costs to society were increasing alarmingly (Wing, 2004; Wing & Hill, 2001).

**Approaches to weight loss.**

This section is presented to provide historical context and understanding of possible situated context for any participant rather than an exhaustive review of the literature. Treatment programs
for obesity have a history of different dietary, exercise and behavioral modification approaches with varying success for weight loss, but with less success for weight loss maintenance. According to Wing (1998, 2004), learning theory was applied to behavioral weight loss programs in the late 1960s and early 1970s to help minimally overweight adults learn to engage in different eating and physical activity practices in an appropriate environment based upon attention to emotional and environmental cues (antecedents) that reinforce behavior. Average weight loss for these overweight adults over ten weeks was 4.5kg (Wing, 2004).

During the 1970s, 1980s to the mid-1990s weight loss programs changed from ten weeks to longer than six months with a new emphasis on energy balance, with improvement in the amount of weight lost. Caloric intake was prescribed according to body weight, but generally ranged from 1000-1500 kilocalories (kcal)/day, and recommendations for physical activity advised to gradually increase the amount of physical activity to completion of 1000 kcal/week (equivalent to walking ten miles/week) (Wing, 2004). Additional behavioral components added to these weight loss programs included pre-planning, self-monitoring, and problem solving, such as strategies for stimulus control, and relapse prevention. Weight normalization was abandoned in the late 1980’s as a treatment focus, with the recognition that increased glycemic control, and decreased blood pressure and cholesterol were achieved with even a 5-10% weight loss (Goldstein, 1992). Average weight lost in the 1990s increased to 9.6 lbs, or 5-10% of an average body weight (Wing, 1998). A 5-10% loss was noted as a more realistic achievement that was possible for some to maintain rather than striving toward a normal weight range. Another factor in the research at this time was the recognition that weight loss reached a plateau at six months (Wing, 2004), which gave credence to the idea that the clinical focus should shift from loss to
maintenance at this point. Motivational interviews, recruitment into a weight loss program with friends, and intergroup competition all provided some increased success at adherence beyond the six month plateau among people with type 2 diabetes (Wing, 2004). When trying to achieve weight loss, diet is more important than physical activity, as only two of six studies revealed a significant difference in weight loss between diet alone interventions compared to diet plus exercise (Wing, 2004).

**Current considerations for weight loss diets.**

It is beyond the scope of this study to identify details of all weight loss diets. However consideration is directed toward mainstream self-guided dietary recommendations for healthy weight loss, as noted for example, in the Mediterranean and DASH diets.

The U.S. Department of Agriculture has updated comprehensive interactive information regarding healthy weight on its web-site. It includes the following recommendations for weight loss: calories consumed must be less than energy burned, diet must be balanced with recommended amounts from each of the five food groups according to personal caloric needs (whole grains and a few enriched refined grains; a variety of vegetables and fruits; fat-free or low-fat dairy and fortified soy; protein such as lean, low sodium meat, poultry, seafood, eggs, legumes, seeds and nuts); chose energy dense foods with fewer calories such as the least amount of solid fat and added sugar; engage in 60 minutes of moderate to vigorous physical activity most days; track food intake and physical activity daily, and check weight weekly (USDA, 2011). The USDA recommends that one-half of the plate should be fruits and vegetables. Added sugars to avoid are typically labeled as glucose, dextrose, fructose, maltose, sucrose, corn syrup, high fructose corn syrup, honey, or molasses. A normal weight range perimenopausal woman would
require the following recommended amounts from each food group daily: five to six ounces (oz.) of grain, two to two and one half cups of vegetables, one and one half cups fruit, 3 cups dairy, 5 oz. protein, 5 teaspoons healthy oils (may already be in some foods) (USDA, 2011). The Mediterranean and DASH diets follow these general guidelines for maintaining a healthy weight and are recommended by many health professionals as heart healthy (Mayo Clinic, 2010).

Published research usually follows diet fads to determine whether there are health benefits or negative consequences. Currently, for example, lay people waiver between a low fat, or a low carbohydrate diet. In a small study with overweight or obese adults, comparison of a low fat weight reduction diet (20% fat, 60% carbohydrate) to a low carbohydrate (CHO) weight reduction diet (60% fat, 20% CHO), each to produce a 500kcal/day energy deficit, demonstrated comparable reduction in insulin resistance and possible development of type 2 diabetes (Bradley et al., 2009). However, researchers concluded that the low fat weight loss diet may be preferable since the low CHO, 60% fat diet may have a deleterious effect on systemic arterial stiffness (Bradley et al., 2009).

Recent research that seems to support lifestyle changes in diet and exercise for health has demonstrated that low calorie dieting may be counter-productive to weight loss because it increased reported stress and cortisol levels (Tomiyama et al., 2010).

**Dietary approaches to weight loss maintenance.**

The National Weight Control Registry (NWCR) was founded in 1994 to investigate a self-selected population of more than 4,000 individuals age 18 or older who reported a weight loss of at least 30 pounds and maintained the loss for one year or longer; their average was 5.7 years (Hill, Wyatt, Phelan and Wing, 2005). Wing and James noted a lack of consistency about the
definition of the term weight loss maintenance in various studies and suggested stakeholders adopt criteria that would be in line with the IOM definition, and proposed the following definition, “an intentional weight loss of at least 10% of initial body weight and maintaining this weight loss for at least one year” (2001, p. 343). Most weight maintainers studied at the NWCR consumed a diet that was 24% fat, 19% protein and 56% carbohydrate (Wing & James, 2001). Commonalities noted among weight loss maintainers compared to weight regainers were the ability to sustain changes in their diet (usually low fat and reduced calorie), self-monitoring of intake and weight, and increased physical activity, usually ≥ one hour/day (Wing & James, 2001). Ninety three percent of registry women reported previous weight loss attempts; however, most reported that their current success was motivated by a greater commitment due to social or health concerns (Klem, Wing, McGuire, Seagle, & Hill, 1997). Wing & Hill (2001) also noted that maintaining a weight loss becomes easier as time goes by; arriving at a two to five year period of weight maintenance reduces the risk of regain by 50%.

The ideal dietary recommendation for weight loss and weight loss maintenance is still unclear (Wing, 2004). A brief review of results of recent research will follow to gain perspective on the possible context of successful weight maintainers. Studies of prepackaged meals and liquid formula substitutes (Ditschuneit & Flechtner-Mors, 2001; Metz et al., 2000) obtained better initial weight loss and weight loss maintenance results for obese adults, compared to participants who regularly obtained their own food for a moderately calorie restricted diet (800-1800kcal/day) (Wing, 2004). The (VLCD) group regained weight such that at six months all three groups (VLCD, prepackaged diet, or self-guided diet) were equivalent in terms of percentage of weight lost; by month 12 the prepackaged meal group had significant weight gain
compared to the other two groups (Pinto et al, 2008). Similarly, a more recent study of adults who lost an average 18% of their body weight found that the self-guided approach to weight loss group was the only group to maintain their weight loss at 18 months (compared to VLCD or a commercial weight loss program) (Pinto et al., 2008). This suggests there may be benefit to education from health providers so people know how to choose and shop for a balanced moderately caloric restricted diet. Pinto et al. hypothesized that people who choose a self-guided weight loss strategy over VLCD or commercial meals may have more confidence in their ability to achieve success (2008).

Other studies of commercial weight loss programs (that primarily included women) with very low calorie intake also resulted in a 15-25% initial weight loss, but a regain of 50% or more of the weight within 1-2 years (Tsai & Wadden, 2005). Participants in a commercial Weight Watcher’s type group who were able to maintain the greater weight loss had attended at least 78% of the weekly meetings (Heshka et al., 2003). This may suggest that education and group support reinforce motivation. An incentivized structured weight loss program for overweight and obese women (average age 44) resulted in a mean 10% loss at one year that was maintained at year two as an average 7% loss (Rock, Flatt, Sherwood, Karanja, Pakiz, & Thompson, 2010). The subjects in this program received free low fat 1200-2000kcal/day packaged meals based upon Jenny Craig, engaged in 30 minutes of physical activity at least five days/week, and engaged in weekly study groups that were either in person or via telephone contact, both with the option for telephone or electronic follow-up. Weekly counseling sessions were available, but only 25-33% of the women utilized them. Wing suggested that unbiased studies need to be done to compare the efficacy and cost effectiveness of various commercial weight loss programs with
one another rather than with usual care control groups (2010). Studies that compared different commercial diets found them to be similar in terms of weight loss and fat loss over six months (Truby, 2006) and one year (Dansinger, Gleason, Griffith, Selker, & Schaefer, 2005).

Overall, quantitative research on diet suggests that dietary intake for weight maintenance must remain a consistent lifestyle choice of a balanced low calorie diet, usually low fat and high fiber (Wing, 2004). This type of literature also reports a need for some flexibility in the caloric range of dietary intake (maybe one meal per week or a small portion of something that’s not part of the customary dietary plan) with weight maintenance compared to weight loss, but with at least weekly vigilance for weight, and waist or waist hip ratio circumference measurement. Calories consumed must be equivalent to energy expended to maintain a weight loss. The National Institutes of Health (NIH) (2011) provides a guideline for adult weight maintenance which suggests that daily caloric intake needs to be based upon the amount of energy expended along with other factors: sedentary or very obese individuals can consume 10 calories per pound of the desired weight they are now trying to maintain, individuals with a low activity level (occasional weekly golf or recreational tennis) and those over age 55 can consume 13 calories per pound of the desired weight they are now trying to maintain, adults who regularly engage in moderate activity (30-60 minutes of swimming, jogging or fast walking) can consume 15 calories per pound of the desired weight they are now trying to maintain, and those who engage in regular strenuous activity (≥60 minutes 4-5times/week) can consume 18 calories per pound of the desired weight they are now trying to maintain.

Recent research found that compared to a low fat diet, a Mediterranean diet with fats from olive oil or nuts resulted in lower atherosclerosis related inflammatory markers (Casas et al.,
Major medical publications also warn that dietary sugars contribute toward risk for CVD and increased mortality (Yang Q; Zhang Z; Gregg EW; Flanders WD; Merritt R; Hu FB, 2014; Johnson et al., 2009).

Self-reported characteristic strategies of adults (primarily women) who have lost at least 10% of excess body weight and maintained it for one year or longer include eating a low calorie, low-fat diet consistently across weekdays and weekends, eating breakfast daily, regular monitoring of weight, and high levels of physical activity for at least one hour/day (Wing & Phelan, 2005).

Physical activity and weight loss maintenance.

According to public health and biomedical research, frequent regular physical activity has been the greatest predictor of weight loss maintenance success (Kushner, 2007; Votrubo, Horvitz, & Schoeller, 2000; Wing, 2004). Greater amounts of physical activity are associated with a lower BMI and more favorable fat distribution (Saris et al., 2003), such that fat free mass is preserved or even increases and fat loss is increased (Votrubo, Horvitz, & Schoeller, 2000). Inactive adults have a higher mortality rate, particularly women, who have a 94% greater risk compared to inactive men with a 48% higher risk (Brooks & Patel, 2010). Staying active from age 18-30 lessens weight related weight gain, especially in women. The least active women in this age range gained 33 pounds over 20 years compared to the most active, who gained 28 pounds; and the least active women gained 1.5 more inches (3.8 cm.) in waist circumference compared to the most active women (Hankinson et al., 2010). The most active women engaged in at least 150 minutes of moderate to vigorous exercise/week. A study of over 35,000 normal weight range perimenopausal (48%) and postmenopausal (52%) women (mean age 54) who ate a diet with a mean of 1755 kilocalories (kcal)/day found that they needed to engage in moderate...
intensity exercise for 60 minutes per day to maintain this weight (Lee et al., 2010). Overweight or obese women in these age ranges needed to reduce caloric intake, and/or exercise more intensively or more often to lose some of their excess weight (Lee et al., 2010).

Recommended guidelines for physical activity were first published in 2008 by the USDHHS. Current physical activity guidelines for healthy adults suggest regular participation in moderate and vigorous activity, as well as in muscle strengthening with no specific recommendation for frequency or duration (n. d. a). These guidelines are summarized in Appendix C. The Surgeon’s General Report, the CDC and the American College of Sports Medicine (ACSM) recommend 30 minutes of daily moderate-intensity exercise to improve health (ACSM, 2009; CDC, 2010a; USDHHS, Public Health Service, Office of the Surgeon General, 2010). The CDC defines moderate-intensity physical activity as anything that causes small increases in breathing and heart rate such as brisk walking or bicycling or vacuuming (CDC, 2010a). Healthy People 2010 and 2020 objectives recommend at least 30 minutes of moderate-intensity activity five days per week, or an equivalent vigorous activity such as running or aerobics 20 minutes per day for three or more days/week (CDC, 2010a; USDHHS, n. d. a). The Institute of Medicine (IOM) recommended 60 min/day of moderate intensity activity for prevention of weight gain in normal weight women (2002). One important point is that various recommended guidelines for the amount of physical activity needed to promote a healthy weight are below what is needed for weight maintenance after a weight loss, as suggested by the NIH above and as demonstrated by NWCR studies (to follow).

Data from the 2000 National Health Interview Survey indicated that more women than men were physically inactive (Lee, 2003). The number of randomized controlled studies that tested
whether physical activity can prevent weight gain and how much activity is needed are limited, as are studies that included both men and women for comparison (Saris et al., 2003). However, researchers agree that generally among normal weight range adults, to prevent weight gain and weight regain a person needs 60-90 minutes/day of moderate physical activity. However in people who were previously obese, 60-90 minutes/day of more vigorous physical activity is required (Saris et al., 2003). Weight loss maintenance studies suggest there may be a dose response relationship between physical activity and weight maintenance (Catenacci et al., 2008). Saris et al. pointed out that in NWCR studies, participants needed at least 90 minutes/day of moderate exercise during weight loss maintenance, since about 210 minutes of brisk walking per week (900 kcal/week) was associated with a 40% weight regain; and 600 minutes of brisk walking per week (2400 kcal/week) was associated with less than a 15% weight regain (Saris et al., 2003; Votrubo, Horvitz, & Schoeller, 2000). Less time was required for physical activity if the activity level was vigorous such as weight lifting or competitive team sports. However, women tended to engage more in moderate activity such as walking, or aerobics. Weight loss maintenance in an original NWCR study required an expenditure of 2500 - 2800 kcal/week (mean 2827 kcal/week) in physical activity among overweight women who had previously successfully lost 66 pounds and maintained it for 5.5 years (Klem, Wing, McQuire, Seagle, & Hill, 1997). This was identified as the approximate equivalent of walking 28 miles/week and indicates that physical activity remains very important for weight loss maintenance among those who are still overweight or obese after a 10% or more weight loss. Other studies also support the necessity of physical activity for long term weight loss (Catenacci & Wyatt, 2007; Fogelholm & Kukkonen-Hurjula, 2000; Hill & Wyatt, 2005; Jakicic, 2002; Jakicic, 2009). Compared to the
1997 NWCR study, more recent registrants entered with a greater BMI, mirroring the weight gain in U.S. society in general over the past decade, although women did not report less physical activity to account for the weight gain (Catenacci et al., 2008). The amount of physical activity remained high (average 2621 kcal/week) for recent NWCR registrants (primarily women) to maintain their weight loss (Catenacci et al., 2008).

Although some physical activity is necessary for maintenance of a healthy weight, a combination of both a limited caloric balanced diet and increased physical activity results in a 1.5 - 3 kg greater long-term weight loss than either diet or physical activity alone (Wing, 2004). A review of factors associated with physical activity in adults found the following positive correlations: postsecondary education, higher income, belief in one’s ability to exercise, enjoyment of exercise, history of being physically active as an adult, expectation of benefits, perceived social support from family or peers, access to and satisfaction with facilities, enjoyable scenery and safe neighborhoods (Troust, Owen, Bauman, Salis, & Brown, 2002). These quantitative researchers noted that studies looking at determinants of physical activity in adults are largely cross-sectional, thus creating a need for more longitudinal intervention research over various life stages to help determine causation.

National recommendations and clinical practice guidelines have identified regular physical activity and a healthy diet as necessary to prevent and control chronic disease (American College of Sports Medicine (ACSM), 2009; American Diabetes Association, 2004; Blue & Black, 2005; USDHHS, n. d. a), and ongoing studies continue to suggest that regular physical activity helps prevent or lessen disability from chronic conditions often associated with excess weight. For example, The American Heart Association (2011) stated that women who walk at least three
miles/ hour two or more hours per week had a significantly lower risk of CVD and stroke than women who don’t walk. A recent study of older adults with CV and cardiometabolic disorders and limited mobility found that over an 18 month period, weight loss and increased physical activity resulted in greater increased mobility compared to physical activity alone (Rejeski et al., 2011). A study of adults with type 2 diabetes found that sustained participation in intensive lifestyle intervention over four years resulted in sustained weight loss and improvements in glycemic control, fitness and CVD risk factors (Wing, 2010). Two studies of perimenopausal to early postmenopausal women (the Women’s Healthy Lifestyle Project and Women on the Move through Activity and Nutrition) found that a healthy lifestyle intervention (dietary restriction and increased physical activity) resulted in weight loss or weight loss maintenance, and CVD risk reduction (Pettee, Storti, Conroy, & Ainsworth, 2008).

Nurse researchers conducted the first published synthesis of interventions in adults aimed at both increasing physical activity as well as following a healthy dietary modification to guide practice and future intervention research about primary prevention of obesity and chronic disease (Blue & Black, 2005). These authors revealed 12 areas that needed to be addressed in future interventional studies, among which were sustainability of following a healthy lifestyle, relapse prevention, and determining the most and least effective aspects of an intervention and application to real world situations. The need for participant involvement in decision-making about personal change strategies was noted.

A recent large meta-analysis of intervention studies designed to increase physical activity among over 99,000 adults revealed several results that likely pertain to many perimenopausal women since 74% of participants were women and the mean age was 44 years (Conn, Hafdahl,
Several characteristics described the most effective interventions. First, behavioral interventions increased physical activity more than interventions which targeted knowledge, beliefs and attitudes (social cognitive therapy). Successful behavioral interventions included combinations of activities such as goal setting, an exercise prescription, contracting, self-monitoring, feedback about physical activity behavior, consequences, and cues. Second, interventions that got adults moving more were those delivered personally versus via mass media or community based approaches, and those modeled by the research staff versus a train-the-trainer model. However, adults moved more when the face to face physical activity interventions were standardized versus personalized to an individual within the group. A factor that had no effect on increasing physical activity was education about the health benefits. Further research may clarify which behavioral interventions are crucial and which are better than others.

In conclusion, approaches to a healthy weight seem to have some polarized views about the dietary component, but all seem to agree that being physically active is crucial to health, including striving toward a healthy weight. This qualitative study will explore the lived experience of weight maintenance. The participants in this study will be women who have been overweight or obese during perimenopause, and intentionally lost 10% or more of their perimenopausal weight and sustained the weight loss for one year or longer. The aim is to understand the meaning of the experience for individual women who have been successful in this process.

**Chapter Summary**

This chapter described the evolution of quantitative empirical research about being overweight during perimenopause. First there was a discussion of biomedical research on
perimenopause. Next, research on BMI and factors that influence it, including perceptions of what a normal weight is, was presented. This was followed by the biological, social, environmental and historical contexts of a maintained weight loss currently in the U.S. Six data bases were used to research the phenomenon, which yielded few results. The following chapter will describe the research paradigm and methodology adopted for this study.

Chapter III

Methodology

The preponderance of research about weight loss maintenance, as well as perimenopause, is quantitative, based on positivistic understandings of reality that have identified parts of the
picture, but has not identified the experiences of weight maintenance or perimenopause. The realist believes objective truth is reality and does not attend to the meaning of experience within its contexts for the individual. This study seeks to understand the meaning of women’s stories of successful weight maintenance during perimenopause through utilization of a qualitative study guided by the philosophy and processes of interpretive phenomenology. Unlike the quantitative literature described above, it seeks to understand human experience of body and self with a particular focus on weight loss maintenance.

“If there were only one truth, you couldn't paint a hundred canvases on the same theme.”

(Pablo Picasso, n. d.)

**Phenomenology**

Phenomenology has been described as both a philosophical movement as well as an approach to human sciences research (Dowling, 2007; Munhall, 2007; van Manen, 1997). Van Manen’s web-site stated that the aim of phenomenology is to make explicit and seek meaning in universal lived experiences (2002e). Phenomenology searches for knowledge that leads to description, not explanation, and subjectivity is valued in the search to understand human experience.

Phenomenology is part of the human science paradigm, distinguished by a German philosopher, Wilhelm Dilthey (1833-1911). Dilthey wrote that one aim of human science is to understand human life by trying to capture a person’s experience or direct knowing of a phenomenon at a point in time when it originally manifest itself in consciousness, which involved understanding mental acts like thoughts and emotions (1985, 1989), and what is meaningful in life to that person (Welch, 1999). Another aim of human science according to
Dilthey is to expand the scope of our understanding of the phenomenon beyond any one person’s particular circumstance, to include social and historical realities (Dilthey, 1883/1989; van Manen, 2002a). According to van Manen’s web-site (2002f), Dilthey suggested that learning and understanding could be only partial without the perspective of the historical context. The study of human science involves interaction among three entities: personal experience, retrospective reflective understanding of personal experience, and an expression of its spirit in gesture, words or art (van Manen, 2002f). Dilthey (1989) wrote that natural science provides explanations; whereas the human sciences produce understandings.

Phenomenology as philosophy rejects realism, wherein truth is objective, and rejects idealism as too subjective; truth for a phenomenologist lies in human consciousness of experience and involves the mind (Polifroni, 1999). Truth in phenomenology is about understanding characteristics of a particular lived experience shared by a group of people (Polifroni, 1999). According to van Manen, phenomenology is intersubjective because the researcher needs the participants and the reader “in order to develop a dialogic relation with the phenomenon, and thus validate the phenomenon as described” (1990, p. 11). Husserl, the founder of the modern phenomenological movement, believed that even positivistic paradigm science should begin with awareness of the researcher’s own experience of the phenomenon under study (1970). Phenomenological understanding searches for truth, not as some known theory, deduction, or assumption, nor upon researcher preconceptions. Husserl saw the aim of phenomenology as a way to see truth by presenting essences, not to explain causes (Flynn, 2006, p. 20; Husserl, 1931). A phenomenological approach seeks to understand the lifeworld or human experience as it is lived; van Manen said it is “General orientation to life, the view of knowledge and a sense of
what it means to be human” (1990, p. 27). A phenomenological view of knowledge is concerned with the concrete (ontic) nature, as well as with the ontological nature (what it means) of a person’s lived experience in order to know what the essential nature of a phenomenon is, as experienced in a meaningful way (van Manen, 1990, p. 40). The phenomenological researcher needs to relate different ways of knowing to understand the participant’s life-world in relation to the phenomenon of interest.

The research design for this study was guided by the assumptions of interpretive phenomenology. Phenomenology is not empirically validated material, but rather whatever is talked about by the participant. This provided the researcher access to the meaning of women’s lived experience of weight loss maintenance during perimenopause. Weight loss maintenance for this study is defined as a loss of 10% or more of body weight during perimenopause which is maintained for one year or longer. The phenomenologist seeks understanding of various aspects of being in the world as described by the participant about a particular phenomenon, which may include information about such things as her perceptions, feelings, knowledge, insights, interpretations, joys, fears, and aspirations (Merleau-Ponty, 1964). The methodology used in this study is based on the work of Merleau-Ponty (1908-1961), a French phenomenologist who was influenced by earlier European phenomenological philosophers, primarily a German Jewish philosopher, Edmond Husserl (1859-1938), and a German existentialist, Martin Heidegger (1889-1976), as well as by the French existentialist, Jean-Paul Sartre (1905-1980). Some of the key points of Husserl, Heidegger, and Merleau-Ponty will be described next with the realization that overlap occurs where agreement exists.

Edmund Husserl.
A scholar primarily of mathematics, physics and astronomy, Husserl also studied law, philosophy, literature and theology (van Manen, 2002f). This broadness allowed Husserl to see the limitations of strict empirical science. Husserl has been described as both a descriptive phenomenologist and a transcendental philosopher with an epistemological focus (van Manen, 2002f). Transcendental phenomenology looks at consciousness or mental life and the objects (noema) of mental acts such as beliefs, meanings, values and judgments (Welch, 1999). Husserl inspired the thinking of other philosophers such as Heidegger, Gadamer, Levinas, Merleau-Ponty, Ricoeur, and Derrida (van Manen, 2002f).

Husserl, like Dilthey, did not believe a person could be reduced to a measurable object and therefore found that natural scientific approaches to understanding of the human being were lacking. Husserl looked at the way knowledge came into being and stated knowledge of one’s life-world experiences (past, present and future) should be based only upon insights that are certain, through analysis of consciousness (van Manen, 2002d). The main focus for Husserl became the study of the phenomenon as it appeared through consciousness, which he referred to as a return to the things themselves zu den Sachen selbst (Welch, 1999). Husserl’s phenomenological process involved the transcendental ego and a disembodied consciousness to “know” the essence of things as “constituted in consciousness” (van Manen, 2002b). This initial focus of Husserl’s phenomenology was to describe the essence or perceived meaning of an experience to elucidate knowledge and universal understanding rather than denote facts.

The concept of intentionality, which was described by his mentor, Brentano, was prominent in Husserl’s thinking as a connection between the subjective knower and the objective known (Welch, 1999). Intentionality means that all thoughts, feelings and actions accessible through
consciousness are about things (objects) in the world (van Manen, 2002d). All consciousness is consciousness of something and conscious awareness is intentional awareness (van Manen, 2002d). Later in his writing Husserl focused on the pre-reflective life-world as the actual essential nature or “essence” of everyday experience, meaning the world “as lived” before any reflective representation or analysis (Flynn, 2006). This referred to a description of the immediate experience before it is labeled by preconceptions or theoretical assumptions. Husserl believed essential structures of consciousness in one’s pre-reflective life-world could be intuited through reflection (Stanford Encyclopedia of Philosophy, 2004) and intentional analysis (Merleau-Ponty, 1964, p. 58) through a process called phenomenological reduction (Welsh, 1999). “Intentionality is only retrospectively available to consciousness” (van Manen, 1990, p. 182). Merleau-Ponty (1964) suggested that intentional reflection and analysis required an active effort in order to understand the meaning of one’s experience, rather than a passive stance of watching oneself live.

Husserl’s concepts of life-world, inter-subjectivity and intentionality are interrelated and part of a larger gestalt (Drew, 1999). Inter-subjectivity occurs during reduction when a person grasps the experience of another person through a process of intentionality, and “eidetic insight” (Merleau-Ponty, 1964). To engage in this process, a phenomenological reduction needs to occur whereby the researcher first needs to become aware of personal presuppositions about what is real or true regarding his or her experience of the phenomenon, and set these beliefs aside in a process called bracketing by assuming the “natural attitude” (Creswell, 2007; Flynn, 2006). Various phenomenological thinkers differ in their stance about how possible it is to accomplish this (Flynn, 2006). In order for a researcher to remain objective from Husserl’s point of view, all
personal biases and beliefs must be held in *epoche* or suspended in favor of what the participant says about her experience (Creswell, 2007; Flynn, 2006). Next, the researcher must withdraw from the natural attitude of the everyday world to the inter-subjective level of the transcendental ego for intentional understanding of another’s conscious world to occur (Creswell, 2007; Flynn, 2006; van Manen, 2002d). Intentional analysis explains how the meanings of things are constituted by consciousness (van Manen, 2002d); intentionality includes any meaning that we have for and intend toward something we perceive (Welch, 1999). Transcendental phenomenological reduction allows for eidetic insight, which is capturing the essence of the subject’s experience of a phenomenon. Eidetic insight according to Husserl, resembles the ‘aha’ experience of discovery (Flynn, 2006).

Husserl’s terms *epoche* and *bracketing* both relate to separating researcher experience from participant experience to allow the authentic voice of the research participant to emerge and allow the researcher to uncover the essential meaning of the participant’s experience (Bednall, 2006). These terms have been used interchangeably by some researchers due to their similarity; however others make a clear practical distinction (Bednall, 2006; Gearing, 2004). *Epoche* refers to the researcher setting aside all preconceptions from the very beginning of the study before data collection and through “the ongoing analytic process” (Bednall, 2006, p. 123). Bracketing should occur during interpretation of the data when personal beliefs and feelings held in *epoche* are utilized “to synthesize with those observations as interpretive conclusions” (Bednall, 2006, p. 123). This process promotes empathy and connection (Bednall, 2006). Reflexivity, will be necessary in this phenomenological study, since it requires the researcher to reflect upon the
ways her own values, beliefs, experiences, interests, social identities and life goals may have shaped the research (van Manen, 1990).

In conclusion, transcendental phenomenological inquiry about any phenomenon would be a description of thoughts, feelings and actions in the world involving the phenomenon according to how they are constituted in the pre-reflective consciousness of the person experiencing the phenomenon (van Manen, 2002d).

Martin Heidegger.

Heidegger became interested in the ideas of Dilthey and others, such as the idea of hermeneutics, the interpretation of another’s text (van Manen, 1990). Heidegger developed hermeneutic or interpretive phenomenology to understand the possibilities “for being in the world in certain ways” that are revealed by a narrative text (van Manen, 1990 p. 180). He drew from a tenant of ancient Greek philosophy, which was to have a sense of wonder, for understanding of truth. Heidegger adopted Husserl’s interest in everyday life, but Heidegger’s inquiry became ontological rather than epistemological like Husserl’s (Flynn, 2006; van Manen, 2002f). Ontology is concerned with the nature and relations of being (Cohen & Omery, 1994). Heidegger’s focus on being reveals his turn to existentialism. Heidegger, once an assistant to Husserl, deviated from some of his mentor’s beliefs about description of essence as true knowledge. For Heidegger the essence of a thing is whatever leads us to recognize a property as essential, and what is essential can change over time or among cultures (Wrathall, 2005). Heidegger’s ontological focus is evident in his work Being and Time (1927) where the meaning of “being in the world” is exemplified by the question “What does it mean?” He wanted things to show themselves to us the very way they are, as we are Being in the world. Heidegger remained
concerned with understanding a person’s natural life-world from the perspective of the person. He used the term *Dasein*, which literally translates to “there being” (Wrathall, 2005), but which actually refers to mode of being or “the human way of being” (Flynn, 2006, p. 52). Heidegger considered our ability to be open to being to be the most important human asset. He stated that understanding being –in-the –world is not something we possess like bits of knowledge, but rather find in something we do, the way we do things, or in knowing how to live in a particular world (Wrathall, 2005).

In hermeneutical phenomenology the description is used to explain something about the phenomenon of being. However, Heidegger argued that phenomenology should also be a methodology of interpretation of one’s historical contexts, which differed from Husserl’s aim to only describe pure pre-reflective subjective knowledge as essence in relation to objects in the world. Heidegger also disagreed with Husserl’s belief that presuppositions could be set aside and not enter into the process of understanding meaning. Heidegger spoke of hermeneutic circle, as a reflexive phenomenological process that included experience of both the participant and the inquirer, which necessitates inquirer self-disclosure. He used hermeneutics to replace Husserl’s bracketing. Hermeneutics is a dialogical engagement of the researcher and the phenomenon as described by the participant.

Heidegger stated there are many sources of knowledge for understanding everyday existence, and suggested that artwork is not a reproduction of something that actually exists, but a reproduction of the thing’s general essence. He described the nature of art as “the truth of being setting itself to work” (Heidegger, 1993, p. 180). Similarly, Merleau-Ponty later wrote that philosophy is… “like art, the act of bringing, truth into being” (2004, p. xxiii).
In conclusion, existential phenomenology allows for a deeper understanding of meaning in everyday lives through descriptions of experiences, which Heidegger believed were already interpretive (Van Manen, 2002c). It is a process cogenerated by the researcher and participant, each influenced by their own past, that offers existential insights and more direct contact with the world (van Manen, 1997).

**Maurice Merleau-Ponty**

Merleau-Ponty suggested phenomenology was a transcendental philosophy that studied the essences of perceptions or consciousness, after preconceptions in “the natural attitude” are first set aside, a philosophy that tries to arrive at the time of the experience before reflection (1945/1962, p. vii). However, Merleau-Ponty moved away from Husserl’s original idea of the pre-reflexive life-world, transcendental ego and consciousness to the lifeworld of everyday experience. Merleau-Ponty’s phenomenology then wondered existentially about the meaning of an experience in the lifeworld. Merleau-Ponty relied upon phenomenological description as did Husserl, however he also believed in the hermeneutic process of interpretation as did Heidegger. Merleau-Ponty therefore agreed with other philosophers that phenomenology was a description of experience without concern for psychological origins or “causal explanations” (1945/1962, p. vii). This philosophy indicated his disenchantment with deductive positivist views about objective truth (Merleau-Ponty, 1964).

Merleau-Ponty also sought to avoid the error created by Descartes, who viewed the mind and body as separate and the mind as superior and the body as inferior. Merleau-Ponty presented a new view of human embodiment from a phenomenological perspective that did not believe in a Cartesian division between mind and body (Merleau-Ponty, 1968). Merleau-Ponty overcame
traditional metaphysics’ dualisms such as subject-object, mind-body and conceived of the body as we experience it, as simultaneously presence and absence, incarnation and transcendence, being and consciousness (Carey, 2000). Merleau-Ponty was the first phenomenologist to suggest one’s lifeworld is mediated through bodily perception and that perception via the body senses was consciousness. For Merleau-Ponty the self is the “body-subject” and the site through which perception occurs (Carey, 2000). With embodiment “Consciousness is existence in and toward the world through the body” (Van Manen, 2002b). Merleau-Ponty’s “body-subject” is the primordial pre-rational basis for meaning in the world (Carey, 2000).

Merleau-Ponty’s original writings revolve around this corporeal schema; he used the term “operative intentionality” of our lived bodies to indicate how the body interacts with the world before we have any reflective conceptualization (Flynn, 2006 p. 23). His original concern was to analyze the human body within the context of everyday life. According to Merleau-Ponty, "The body is our general medium for having a world” (Merleau-Ponty, 1945/1962, p. 81). Merleau-Ponty said our relationship to our body is always direct and internal; the body contributes to our knowledge of the world through perception of objects in space (1964). The body is not an object in the world apart from one’s mind and spirit, it “is our point of view on the world…” and contributes to pure knowledge (Merleau-Ponty, 1964, p. 5). The body is neither an external object of experience nor an internal subject; the body is the agent of all our perceptual acts. According to one Merleau-Ponty scholar, “We understand ourselves as being bodies, not as having bodies” (Carman, 1999, p. 208). This corporeal schema provides “the visible form of our intentions” making the body a means “of expression in the world” (Merleau-Ponty, 1964, p.5). Merleau-Ponty further believed that one never completely escapes from perceptual reality and
one’s thoughts or rationality “are ultimately founded in perception” (1964, p. xvii). Thus, the body is our basis for cognition and reflection, and the foundation for any claims to validity and truth.

Merleau-Ponty’s conception of a person as a ‘body-subject’ saw the physical and mental as fused or intertwined into perceptual consciousness, such that one’s perceptions determine one’s experiences. “To perceive is to render oneself present to something through the body” (Merleau-Ponty, 1964, p. 42). Merleau-Ponty defined perception “in terms of a sensory-motor behavior through which the world is constituted for man as the world of human consciousness prior to any explicit or reflexive thought about it” (1964, p. xvi). Perception according to Merleau-Ponty is one’s “presence at the moment when things, truths, values are constituted for us” (1964, p. xv, 25). Thus a person’s experience of a phenomenon is not in the world as a separate entity, as something else. Merleau Ponty said that what perception and thought have in common is temporality, a past and a future, such that “at each moment our ideas express not only the truth but also our capacity to attain it at that given moment” (1964, p. 21). Therefore, although scientific knowledge helps to clarify truth, it is always approximate, and an unfinished endeavor.

Merleau-Ponty shared Husserl’s later view about the pre-reflective life-world, where reflection illuminates the essence of an experience, and is used to understand what one “lived through” from the point of view of consciousness. Merleau-Ponty stated, “the world is what we perceive” (1945/1962, p. xviii) and referred to this reflective person as “the subject that I am” (Merleau-Ponty, 1964, p. 64). Although unlike Husserl, Merleau-Ponty thought it was not possible to return to the original state of subjectivity about an experience, since reflection is founded on a pre-reflective experience of being. Merleau-Ponty believed that this transformation
was no longer an object of the same type. The following passage is illustrative of this point, “things present themselves …not by their roots, but by some point or another situated toward the middle of them” (Stanford Encyclopedia of Philosophy, 2004). Merleau-Ponty implied that perception is unique to the individual at that point in time. He was also interested in psychoanalysis, but considered Freud’s concept of the unconscious as undeveloped and more appropriately named “ambiguous or non-reflective perception” (Flynn, 2006, p. 49).

According to van Manen, Merleau-Ponty used phenomenology to search for the ontological core of a person’s being so that the research narrative helps to discover ‘memories’ that were ‘never thought or felt before’ (1990, p. 13). He sought to rediscover the experience as if for the first time, before it became objectified. Phenomenology is not as concerned with factual (nomological) aspects of a phenomenon, although understanding is not achieved apart from the facts (van Manen, 1990; Merleau-Ponty, 1964).

Merleau-Ponty agreed with Heidegger’s writing in Sein und Zeit that human reality was related to the world in which one lived, and that this was discovered through active intentionality according to Edie in Merleau-Ponty (1964). Merleau-Ponty’s philosophy is about ontology of situations, or modes of being -in -the world, which refer to the way people must relate to their present milieu and understand it (Malin, 1979). Merleau-Ponty borrowed from Heidegger’s concept of Dasein as representative of situatedness (Malin, 1979). Malin clarified that the circumstances include involvement with and interchange between ourselves and others. Merleau-Ponty (1945/1962) stated that the core of existential meaning involves seeking understanding “from all angles simultaneously, everything has meaning…., such as one’s history of relationships, religion, economic status and politics (p. xxi). Both Heidegger and Merleau-Ponty
stated that study of peoples’ experience was the way to know their world as lived and to get at unexamined meanings that exist in one’s everyday world of experience (Welsh, 1999, p. 243).

Some of Merleau-Ponty’s beliefs are unlike Heidegger’s. Heidegger viewed Being as the primary reality, but his concept of Being was not related to perceptual consciousness (Merleau-Ponty, 1964). Merleau-Ponty thought the foundational mode of one’s experience, the lifeworld, is mediated through perceptual consciousness, which indicated that the perceived world is one’s primary or true reality (1964). Merleau-Ponty wrote, “I am a consciousness, that is, in so far as something has meaning for me…” (2004, p. xii). He also said, “It is through experience that we have the idea of being, and …‘rational’ and ‘real’ receive a meaning simultaneously” (1964, p. 17). Thus, to Merleau-Ponty, being a reflective person “the subject that I am” (previously mentioned) also refers to consciousness (Merleau-Ponty, 1964, p. 64). Merleau-Ponty conceived of phenomenology as a disclosure of a person’s world “revealed where the paths of my various experiences intersect, and also where my own and other people’s intersect and engage each other like gears…It is …subjectivity and inter-subjectivity” (Merleau-Ponty, 1945/1962, p. xxii). Part of life is “the knot”, a network of intertwined relations that help sustain us as a source of support, recognition and affirmation (Thomas, 2005, p. 71).

Merleau-Ponty asserted that although humans are influenced by physical, psychological and social forces, it is consciousness that gives us freedom to assess and respond to these forces, a concept called situated freedom. In this sense he subscribed to existentialist ideas about responsibility and free will (Dowling, 2007, Flynn, 2006). A related existentialist idea Merleau-Ponty subscribed to includes the thesis that as beings-in-situation our consciousness can
transcend or respond to the sense of temporality in order to image the future by reaching beyond what we actually perceive to what could be (Flynn, 2006).

**Chapter Summary**

Chapter III discussed the evolution of phenomenology as a method for doing research. This evolution of the philosophy of phenomenology was briefly identified along with some of its proponents, with emphasis upon Merleau-Ponty’s ideas as the basis for this study. The next chapter will elaborate upon van Manen’s phenomenological method for data collection and analysis.

**Chapter IV**

**Methodology Applied**

“The sagacious reader who is capable of reading between these lines what does not stand within them, but is nevertheless implied, will be able to form some conception.” (Goethe, 1919)

**Description of Method**

The phenomenological method to analyze the qualitative data generated from the interviews with the participants was that of Max van Manen’s approach. Van Manen views phenomenology as a philosophy of being, as well as a human science practice approach (Munhall, 2007). His method has been used by numerous nurse researchers to explore human experiences. The aim of phenomenological research according to van Manen is to construct a description. For example, description of a woman’s lifeworld includes her actions, behaviors intentions and experiences (1990), which helps to more fully understand the meanings of her everyday existence (Angen, 2000). Merleau-Ponty alluded to how difficult a task such description is, and identified the need
for researcher attentiveness in order to capture the meaning in writing as it comes into being, much as an artist would capture a particular moment (van Manen, 1990). The researcher was open to any areas of human experience described by the participants, but also reflected upon four existential themes often considered by Merleau Ponty, which will be described next.

One of the issues in phenomenological research is the inadequacy of language; the writer or the language may not really represent the unique subjective experience of the participant’s inner life (van Manen, 1990). Many aspects of one’s lifeworld are preverbal and difficult to describe, such as experiences of “lived body, lived time, lived space, and lived human relation” (van Manen, 1990, p. 18), but are important considerations for phenomenological reflection (Munhall, 2007). These four experiences were considered as guides for reflection in this study during the research activities followed below that van Manen (1990) suggested. A more detailed discussion about these existentials is included in Appendix K.

After reflection upon the four existentials in relation to weight loss maintenance during perimenopause van Manen’s research activities (below) were used as a guide for further understanding of weight loss maintenance during perimenopause (1997). Chapter V incudes examples of these four existential ways of being –in-the –world in each essential theme.

**Research Activities**

This section shows how each of van Manen’s (1990) methodology processes were used in this study:

1. Turn to a phenomenon that seriously interests us.

2. Investigate the experience of a phenomenon as it is lived.

3. Reflect on essential themes that characterize the phenomenon.
4. Describe the phenomenon through writing and rewriting.

5. Maintain a strong and oriented pedagogical relation to the phenomenon.

6. Balance the research context by consideration of the parts and the whole.

These activities are presented as steps in van Manen’s phenomenological process; however these steps may be conducted simultaneously or intermittently rather than consecutively.

The first step involved turning to the phenomenon or the nature of the lived experience that the researcher had a serious interest in. The phenomenon of interest in this study was the experience of weight loss maintenance during perimenopause.

The second step, investigating the experience of the phenomenon as it is lived, first entailed the researcher writing an account of her own lived experience of weight loss maintenance during perimenopause because investigation of the experience as it is lived by the participant entails the researcher being part of the participant’s world (see Appendix K). According to van Manen, “The best way to enter a person’s life-world is to participate in it” (1990, p. 69). Thinking about my own experience, as the researcher, I tried to capture particulars in each participant’s story, such as a specific incident or example, her state of mind, how her body felt, “the feelings, the mood the emotions., etc.” as suggested by van Manen (1990, p. 64). These personal descriptions helped develop a better sense of what the researcher hoped to obtain with the participants (van Manen, 1990).

Next the research turned to the lived experiences of weight loss maintenance during perimenopause by conducting individual in-depth interviews based upon the main research question. Concrete anecdotes and examples of description of experience were sought to develop a “richer and deeper understanding” of each woman’s weight maintenance experience during
perimenopause. This type of interview allowed the researcher and participant to “explore the whole experience to the fullest” as well as to converse about the meaning of the experience for the participant (van Manen, 1990, p. 66). This necessitated following a path with the stated research question clearly in mind. According to van Manen (1990), “a good phenomenological description” of a lived experience “resonates with our sense of lived life” (p. 27).

The researcher began by attempting to temporarily bracket to the extent possible, personal preconceptions and biases about her own perimenopausal weight maintenance experiences, and the research literature about the experience in an effort toward authentic reporting of the participant’s story, realizing that this is not objective reporting. This was appropriate since phenomenology is a subjective process based upon perception.

Other than conducting an in-depth interview, there were other ways the lived experience of weight loss maintenance in perimenopausal women was investigated. Anecdotes were recorded in a journal during close observation of each participant’s lifeworld as a participant observer. These ongoing reflective journal entries provided a record of new insights about the research phenomenon as a means of knowledge about the lived experience of weight loss maintenance in perimenopausal women. Additional sources for learning about a phenomenon may be descriptions of the experience in literature, and any representational artistic expression of the experience such as a story, poem, music, film, a photo, drawing, painting or sculpture (van Manen, 1990). Artistic expressions may represent and reflect a participant’s experiential world, albeit the themes are implicit rather than explicit, since phenomenology tries to understand experience (van Manen, 1990, p. 97). Some artistic expressions that represented an aspect of weight loss maintenance during perimenopause were included in Chapter VI.
The third research activity van Manen identified involved reading the written transcripts to analyze for understandings of what weight loss maintenance was like in the life of these women during perimenopause. An in-depth audio recorded interview was conducted of each woman’s story and professionally transcribed by a university based research department. Analysis of data was ongoing and unfolding, reflection was utilized to identify deeper meanings or themes of weight maintenance experiences (van Manen, 1990) and ultimately an understanding of what the experience of weight maintenance during perimenopause meant to a group of women. This process involved review of each participant’s transcript for accuracy while listening to the audio recording and repeated review of each participant’s transcript and other sources of related phenomenological experience just mentioned above in the second research activity. The research journal and any anecdotal notes taken immediately during or after each interview were read, followed by reflection and consultation with dissertation advisors who have done phenomenological research, to identify the emergent themes of a woman’s weight maintenance life-world. Each participant’s experience of her lifeworld was analyzed according to her perception, since Merleau-Ponty believed that perception is the foundation for all experiences and meaningful interactions with the world (1962). Merleau-Ponty wrote, “Perception is not…..a deliberate taking up of a position; it is the background from which all acts stand out and is presupposed by them. The world is…the natural setting of, and field for all my thoughts and all my explicit perceptions” (1962, xi-xii). Seidman corroborated this position when he stated that for phenomenological interviews,” reconstruction is based partially on memory and partially on what the participant now senses is important” about the lived experience (2006, p. 88).
Next the research involved reflection on essential themes that characterized the phenomenon, which entailed being thoughtful about what distinguished this experience from other ones by bringing close that which seemed obscure, and making a distinction between what appeared to be the experience, and what was the essence of the experience in order to grasp its true nature. Van Manen wrote that, the purpose of phenomenological reflection is to try to grasp the essential meaning of something” (1990, p. 77), which is in keeping with Merleau-Ponty’s belief that “phenomenology is the study of essences” (1945/1962, p. vii). Essence as described by van Manen “may be understood as a linguistic construction, a description of a phenomenon” (1990, p. 39). Such a description allows another to “grasp the nature and significance of this experience in a hitherto unseen way” (van Manen 1990, p. 39). “In order to understand truly what has been discovered…we must…combine induction with the reflective knowledge…from ourselves as conscious subjects” (Merleau-Ponty, 1964, p. 58). During this step of reflective thinking the researcher considered her own experience of weight loss maintenance during perimenopause as well as the experiences of each participant. When the researcher understands her connection to a theme, then the researcher has personal awareness of her consciousness of the phenomenon under investigation; this begins the interpretive process (Drew, 1999). The meaning of the experiences is expected to be multi-dimensional and multi-layered (van Manen, 1990, p. 78).

The fourth research activity, the art of writing and rewriting, was a way of combining thought and language to present the lived experience as though the researcher was speaking about it, which means in a clear, thoughtful way “precisely as it shows itself” (van Manen, 1990, p. 33). The final two chapters of this dissertation began the process of “linguistic transformation” as the researcher tried to write “phenomenologically sensitive” paragraphs that captured the various
isolated thematic statements from the three approaches to thematic analysis, as well as from other sources from the reading and research activities (van Manen, 1990, p. 96). van Manen suggested that an anecdotal story, use of imagery and creation of tone may create a vivid presence of what constitutes a thoroughness of the lived experience (1990). Ultimately, phenomenology strives to ascertain and mediate the contradiction between the particular, the concrete, and “what is unique,” and the universal, the essential, and “in difference that makes a difference” (van Manen, 1990, p. 23). This study attempted to make the interpreted interviews about weight loss maintenance in perimenopausal women “reflectively understandable” (van Manen, 1990, p. 125). Readers of this dissertation may gain knowledge and understanding about the phenomenon studied and change their pedagogical or clinical approaches, or build upon this research.

Activity five involved remaining oriented to the phenomenon and the research question, and maintaining a strong interest in the participants in order to educate others about the lived experience of weight loss maintenance during perimenopause. Strong personal engagement in the phenomenon helps to remain “oriented” and develop a “rich text” with poignant interpretations (van Manen, 1990, p. 151-155).

The last and sixth activity required stepping back from writing the analysis, periodically, to envision the whole, to avoid getting lost in particular parts of the process. The overall design must constantly be envisioned by the researcher, which gives clarity about the significance of the parts and enhances the revealing power of the study (van Manen, 1990, p. 33). Lived experience is the starting point as well as the end point of phenomenological research (van Manen, 1990). The description of the lived experience, at the end of the study, becomes one possible
interpretation of this phenomenon. The description as well as the interpretation could be different if done at a future time.

The researcher attempted to bracket her own perimenopausal experiences with weight loss maintenance to achieve Husserl’s phenomenological epoché (1999/1950) by suspending her prior assumptions and biases (previously described) to better find the essence of the phenomenon described by the participants. According to van Manen (1997) it is difficult for the researcher to ignore what she has already experienced, thus bias and assumptions were made explicit. Bracketing was consistently maintained during reflection upon each woman’s story to arrive at a truthful interpretation.

Sample Selection

Purposeful sampling was utilized to obtain participants who were perimenopausal or post menopausal and met the identified criteria of experiencing an intentional weight loss during perimenopause. Participants were recruited for the study through flyers and through word of mouth. Flyers were posted in public places throughout several northeastern communities. (see Appendix D) Flyers were also distributed to health providers who agreed to refer potential participants. Participants were screened by the researcher over the telephone (see Appendices E and F) to be certain that criteria for perimenopause and weight maintenance were met. To be in this study a woman needed to have been overweight or obese during perimenopause and have intentionally lost at least ten percent of this weight during perimenopause through diet and exercise, and not related to a disease, illness, medication or bariatric surgery. At the point of the in-depth interview, a participant needed to have maintained at least a 10% weight loss ≥ 1 year.
Participant number in qualitative research is determined by general principles and researcher judgment that data saturation has occurred (Zuzelo, 2007). Data saturation occurred when the researcher was no longer seeing or hearing new information when analyzing each narrative during the study.

**Data Collection**

Phenomenological research refers to the lived experiences of several individuals around a specific phenomenon that each participant has experienced, which becomes the data (Creswell, 2007, van Manen, 1990). In this study narrative stories were collected from women located in a northeastern metropolitan area who had the lived experience during perimenopause of maintaining a $\geq 10\%$ weight loss for one year or longer. The purposive sampling method described was appropriate to the method. Each participant chose her own private place, time and day for one unstructured in-depth approximately 90 minute interview during which the participant was asked, “Can you tell me about your experience of maintaining weight loss during perimenopause? Thinking back over the whole time you maintained your weight loss, what was the experience like?” The interview was designed to promote open-ended responses, whereby the participant became a collaborative co-investigator of the phenomenon with the researcher, who is the instrument (van Manen, 1990). Individual in-depth interviews allowed the researcher to co-create meaning with the interviewee through reconstruction of her perception of events and experiences (DiCicco-Bloom & Crabtree, 2006). To facilitate this process the researcher used verbal prompts such as, “You mentioned …Can you tell me more about that” to encourage reconstruction. The interview was audio-taped with consent of the participant and transcribed verbatim using a professional dissertation transcription service.
During narrative collection I attempted to bracket biases about weight loss maintenance among perimenopausal women from my previous experience and from quantitative empirical literature reviewed. Interviews occurred in a private setting the participant chose, and narratives were collected accurately by two tape recorders, in case one failed. I wrote anecdotal notes as immediately as possible after each interview to reconstruct non-verbal behaviors and record my thoughts. I continued interviews until redundancy was heard. Data saturation occurred after seven interviews. A second interview was requested to validate accuracy of the transcript and provide the participant with an opportunity to clarify or add further data.

All tapes and verbatim transcriptions of participant narratives remain available for review, since only segments of narratives, deemed representative of the essence of the experience was selected for the analysis.

Participation in this study was completely voluntary and participants were not remunerated for their time involved for participation in the study. Women contacted the researcher from posted flyers in various community settings, and by word of mouth. A brief telephone interview with the researcher was used to screen those who met the study criteria (see Appendices E and F). Women who did not meet requirements of this study were offered an explanation about this study’s needs and offered an opportunity to participate in a possible future weight maintenance study. Women who met the study criteria from the telephone survey were told about the aim and duration of the study, its potential benefits to the participant and society, the risks to the participant and their rights as a participant. The benefits were expected to outweigh any potential risk. Those who agreed to participate in the study were asked to sign a consent form (see
Appendix H) prior to the interview, after being informed about their right to withdraw without penalty at any time during the interviews if they so choose.

The researcher did not expect participants to be harmed during the course of the telephone screening survey, in-depth interview nor the subsequent theme validation interview. The interviews were conducted at a place chosen by each participant where privacy was protected and the participant and researcher felt comfortable. The researcher recorded personal thoughts and feelings in a journal for ongoing reflection during the study and consulted with committee members when needed.

**Analysis of Data**

The transcribed participant interviews were read and re-read, with the audio recording and then without to ensure accuracy and begin reflection. Statements from the participant interviews were isolated into fundamental meaning units about weight loss maintenance in these midlife women. The fundamental meanings were clustered into preliminary themes and then initial themes. The four existentials discussed by van Manen (1990) and others were considered in light of weight loss maintenance in perimenopausal women. After further reflection, and interpretation these themes were clustered into essential themes. Essential themes were combined to create an interpretive statement describing the experience of weight loss maintenance during perimenopause.

**Biases and Assumptions Related to the Study**

The researcher’s epistemological position was that findings or knowledge about the phenomenon of weight loss maintenance in perimenopausal women may be influenced by the researcher as well as the participants, in that it is not possible for the researcher to entirely place
herself outside of the subject matter. However, the method chosen included several strategies to identify the researcher’s standpoint as distinct from the participants’ and thus enabled the researcher to remain open to understanding any meanings the participants connected with their experience. Additionally, some qualitative researchers suggest that the researcher’s presuppositions and expert knowledge have value as a guide in the inquiry (Lopez & Willis, 2004).

Another bias was the researcher’s experience and belief that it is more difficult for a woman to lose weight as she approaches middle age. The researcher assumed that past, present and future interpersonal and cultural contexts influence a woman’s perceptions of her body and herself and her health, and that overweight perimenopausal women differ from other overweight people by virtue of experiences related to being female and the hormonal changes unique only to this group, being a middle-aged woman in U.S. society, and the meaning she ascribes to approaching menopause and being overweight. One last assumption was that the small percentage of perimenopausal women who have succeeded at weight loss maintenance had essential resources beyond knowledge of an appropriate dietary intake and exercise regimen.

The researcher did not expect one objective true reality exists to address weight loss maintenance. The road to weight loss maintenance during perimenopause was assumed to be different for each woman, affected by the women’s feelings, various motivations, differing circumstances, and some unique strategies.

One last philosophical assumption for this study was that invariably, individuals’ realities are influenced by the world in which they live, so their subjective experiences are linked with the social, cultural and political contexts (Lopez & Willis, 2004). Nevertheless, the researcher
believed each individual was free to make choices within her situated context and act based upon her choices.

One potential area for bias in this study was the researcher’s professional experience with people who gained weight induced by either a clinical syndrome of depression or by psychotropic medication used to treat various symptoms of mental illness. Weight loss was rarely achieved, so weight loss maintenance was even less common. There was often sadness, frustration, anger, helplessness and sometimes hopelessness associated with their excess weight. The bias was that both weight loss and weight loss maintenance seemed subject to the person’s perceived level of stress, cognitive lens, as well as perception of support from significant others.

**Establishing Rigor**

The rigor of quantitative research is judged by its reliability and validity. Therefore, it must convey trustworthiness, accuracy and usefulness to people other than the participants. Several researchers have identified criteria to appraise the rigor of qualitative research findings, which will be identified. One noted researcher believes rigor can be demonstrated by sufficient data collection, validation that participant stories are accurate, multiple levels of data analysis, and reduction of themes from narrower to broader, more abstract meaning (Cresswell, 2007). A similar view is that criteria related to validity include a clear, justified research question, an appropriate sampling method, and an appropriate data collection and analysis method (Russell & Gregory 2003). Morse also agreed that reliability in quantitative research is concerned with the consistency, stability and repeatability of the participant’s story, as well as the researcher’s ability to collect and record information accurately (1991).
Munhall (2007) identified 12 criteria that may be used to evaluate the rigor and merit of phenomenological research which will be described. First, the description of the participant’s human experience must be reasonable and rich, and represent many dimensions of the experience, meaning “full-bodied, multifaceted, multilayered, thoughtful, sensitive and impassioned” (Munhall, 2007, p. 563). Some aspect of the experience may be recognizable to the reader, but new understanding or insight occurs. The interpretation of the meaning must resonate or seem correct or familiar. The reader may notice what has been concealed - not revealed. The reader needs to agree that the study’s findings have captured the meaning of the participant’s experience (sometimes referred to as the phenomenological nod). Phenomenological findings, although philosophical and abstract, should aid in understanding of the phenomenon and offer possible meaning to guide our personal and professional lives. This increases our consciousness and brings us closer to our humanness. The reader should be responsive to the study in some way, such as rethinking preconceptions about the phenomenon, or to act based upon the findings.

Many researchers believe the knowledge generated in description of findings must enhance understanding within the clinical practice context. Lastly, Merleau Ponty believed that precision and exactness in human science strives for full complete descriptions of detail of some aspect of a life-world that illuminates the essences of that experience (van Manen, 1990). This study followed van Manen’s (1997) method for phenomenological research to become oriented to the life world of weight loss maintenance during perimenopause.

Participants were interviewed until it was determined that new knowledge would not be obtained. Use of standardized methods for journaling and transcription of interviews helped to reduce bias. A total of seven women were interviewed when saturation or redundancy of themes
had occurred. Written transcripts were read for accuracy against the audio recordings and validated by the researcher. The researcher analyzed interview data by rereading the transcripts multiple times. Each time was accompanied by reflection. Transcripts were subsequently color coded to develop initial themes from fundamental meanings and to glean essential themes from initial themes with further reflection and consultation with three other phenomenological nurse researchers, which contributed to the reliability of the process (Angen, 2000).

Protection of Human Subjects

Each participant’s privacy, confidentiality and rights were protected in this study as required by approval from The City University of New York (CUNY) Hunter College Human Research Protection Program (HRPP). There were no conflicts of interest in this study. There was little foreseeable risk to any of the participants. Participants were informed that a list of licensed mental health professionals who accept private insurance or provide uninsured public care will be provided, if at any time during the course of the study they feel they may need this resource (see Appendix J). Participants were informed of their right to discontinue participation at any point without penalty to them. The benefit risk ratio offered justification for the study. Explanation was given to participants regarding confidentiality of their names in field notes, audiotapes and interview transcripts. A confidentiality statement was signed by the transcribers. Each participant was assigned a pseudonym to protect anonymity. An informed consent was obtained voluntarily from each participant. Signing the consent indicated that the participant agreed that the researcher may submit her de-identified comments for publication in a scholarly publication or presentation at professional conferences or meetings used for educational purposes, even though ownership of the narrative is jointly shared by participant and researcher (Seidman, 2006). All
participant audiotapes are stored in a locked cabinet in the faculty advisor’s office for a minimum of three years before being destroyed. Possible benefits for participation in the study were identified in the consent form.

Chapter Summary

Chapter IV discussed the method used in this study. The qualitative processes were six research activities suggested by van Manen (1990, 1997). Each was identified and discussed individually. The sample selection method was identified as was the method for data collection. The storytelling and interview process for data collection was explicated, followed by a description of data analysis and data storage. The researcher’s biases and assumptions were identified related to weight loss maintenance during perimenopause, and rigor of the study was addressed. Finally, the ethical concern of protection of human subjects was included, along with informed consent.
Chapter V

Findings of the Study

A detailed analysis of the data is presented in this chapter. It followed the van Manen (1990) methodological guidelines to explicate a deeper understanding of the lived experience of weight loss maintenance during perimenopause. The chapter includes: 1) briefly stated characteristics of the research design, 2) a description of the pertinent characteristics of the participants, 3) a description of the natural setting where the study occurred, 4) the participants’ experiential stories, 5) a presentation of the essential themes, and 6) an interpretive statement of the essential themes.

The study explored the phenomenon of the lived experience of weight loss maintenance among perimenopausal women. Each participant had lost at least ten percent of her body weight during midlife while experiencing perimenopause, and maintained the weight loss for one year or longer. Seven women participated in an individual interview and each was asked, “Can you tell me about your experience of maintaining weight loss during perimenopause? Thinking back over the whole time you maintained your weight loss during midlife, what was the experience like?” Each participant’s story revealed her lifeworld related to the phenomenon. The interview process allowed me to develop a relationship with each participant that aided in gathering an
understanding of her weight loss maintenance experience during perimenopause. It seemed like a relationship grounded in openness and honesty.

The researcher listened to each interview soon after it was recorded and entered personal reflections in a field journal. Major excerpts and description of each participant’s narrative is included in Appendix M. Interviews were listened to once again for accuracy of the transcription, and then the transcripts were read to capture the totality of each participant’s story, which van Manen coined a holistic reading. The transcribed stories were reflected upon several times to interpret the meaning of the midlife weight loss maintenance experience for each woman. Each participant’s words were highlighted on the transcripts during the next two readings without the audio. Accurate notes were made in the margins to begin thematic analysis. To aide in this process, observational notes about the participant taken during and immediately following each interview were reviewed. This allowed the researcher to gather her thoughts into themes. Each thematic statement was reread within the context of the whole interview, and reflected upon to uncover essential themes and consider the four existentials (Appendix L) as valid categories for analyzing a human experience (van Manen, 1990). Some examples of how the four life world existentials were evident in this study will be included later in this chapter during the discussion of each essential theme.

Seven essential themes eventually emerged from the data, which were evident in each participant’s interview. The essential themes were cast anew into an interpretive thematic statement that represented the experience of weight loss maintenance during perimenopause. During the thematic analysis, whenever new information was gleaned from the transcript, a new interpretation of the whole emerged, which was in keeping with van Manen’s process.
Research setting

The research was conducted in a setting of each participant’s choice. Two interviews were conducted in a private office rented by the researcher, and another took place in the private electrolysis office of the participant. One was conducted in the living room of a mutual friend after the three women shared a Shabbat meal one Friday evening. Another took place privately in the participant’s living room. A fairly secluded hallway of a college health science department was the setting for another. And lastly, one interview was conducted over the phone and audio taped, as the participant was not near enough for a face to face interview.

Study sample

The participants included seven women who were recruited for the study through flyers and through word of mouth through colleagues. Once recruited the participants were screened for the research study as identified in the Telephone Screening Questionnaire for Sample Selection (Appendix F). Body weight data was not retained because it was only necessary to determine eligibility for the study and then discarded as stated in the IRB application. Additionally, the focus of this study was to gain understanding of the participants’ perceptions of their lifeworld related to weight loss maintenance during perimenopause.

Most of the participants were recruited either by the flyer or by personal referral. One woman volunteered to be considered for the study after a social encounter when the researcher briefly discussed being involved in doctoral research. Two were referred by a long- time acquaintance and another by an owner of a women’s beauty business. A participant was referred by a mutual friend who was familiar with the researcher’s study. Another approached the researcher after hearing about the study during a professional nursing workshop. One woman
responded to a flyer the researcher posted. All participants lived within the greater New York City metropolitan area including the five boroughs, Westchester County and New Jersey.

The demographic information in Table 1 was collected and validated at the end of the initial in-depth interview.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Race/ Ethnicity identifies with</th>
<th>Age when began perimenopausal weight maintenance</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lucinda</td>
<td>Caucasian/ Jewish</td>
<td>50</td>
<td>Attorney</td>
</tr>
<tr>
<td>Lenore</td>
<td>Caucasian/ Jewish</td>
<td>51</td>
<td>Attorney</td>
</tr>
<tr>
<td>Sally</td>
<td>Caucasian/ Jewish</td>
<td>50</td>
<td>Attorney</td>
</tr>
<tr>
<td>Tamara</td>
<td>Caucasian/Italian American</td>
<td>50</td>
<td>Nurse educator</td>
</tr>
<tr>
<td>Peggy</td>
<td>Caucasian/Italian American</td>
<td>47</td>
<td>Electrologist, business owner</td>
</tr>
<tr>
<td>Ava</td>
<td>African American</td>
<td>53</td>
<td>Nurse practitioner</td>
</tr>
<tr>
<td>Ella</td>
<td>Caucasian/Italian American</td>
<td>48</td>
<td>Medical practice office manager</td>
</tr>
</tbody>
</table>

**Thematic Analysis**

The next research activity I engaged in, van Manen’s third research activity, (previously described in Chapter IV) involved thematic analysis of the transcripts, which occurred with multiple readings, reflection and analysis. At first, the written transcript of each interview was reviewed, and then reviewed a second time for accuracy while listening to the audiotape version.
Then, three specific approaches were used to isolate themes of the phenomenon being studied, as suggested by van Manen (1990). The first approach involved looking at the narrative text as a whole and formulating a “sententious phrase” that captured “the fundamental meaning.” (1990, p. 93).

After analyzing with the holistic approach for finding meaning within the transcript, I then used van Manen’s second thematic approach, selective reading or selective highlighting. This involved reading each sentence or clusters of sentences several times to identify those that “seem particularly essential or revealing” (van Manen, 1990, p. 93) about the experience of weight loss maintenance in perimenopausal women.

Analysis of all the women’s lived experiences entailed pooling all the early key words, phrases and sentences, by rereading and highlighting each participant’s transcript according to emerging themes (van Manen, 1990). The highlighted words were grouped into similar categories, which helped identify different meanings of the experience. At this point eleven fundamental meaning units were identified: 1) former body weight, 2) weight loss, 3) health concerns, 4) current body weight goal, 5) maintenance eating (indulgences and restrictions), 6) physical activity, 7) monitoring myself and my weight, 8) future outlook, 9) feelings about myself, 10) thoughts about myself, and 11) relationships with self and others.

I reflected on each clustered group for redundancy and overlap, and decided some could be subsumed under a more fundamental meaning. Table 2 shows how fundamental meanings were combined.

<table>
<thead>
<tr>
<th>Table 2: Evolution of Fundamental Meanings</th>
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</thead>
<tbody>
<tr>
<td>Fundamental Meanings</td>
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<td>----------------------</td>
</tr>
<tr>
<td>former body weight</td>
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<tr>
<td>weight loss</td>
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<tr>
<td>health concerns</td>
</tr>
<tr>
<td>current body weight</td>
</tr>
<tr>
<td>goal</td>
</tr>
<tr>
<td>maintenance eating</td>
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<tr>
<td>indulgences and restrictions</td>
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<tr>
<td>physical activity</td>
</tr>
<tr>
<td>monitoring myself</td>
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<tr>
<td>my weight</td>
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<tr>
<td>future outlook</td>
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<tr>
<td>feelings about</td>
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<tr>
<td>myself</td>
</tr>
<tr>
<td>thoughts about</td>
</tr>
<tr>
<td>myself</td>
</tr>
<tr>
<td>relationships with</td>
</tr>
<tr>
<td>self</td>
</tr>
<tr>
<td>others</td>
</tr>
</tbody>
</table>
After consolidating fundamental meanings, the next and third, approach to isolation of thematic statements was a detailed, line-by-line reading of each transcript to discern what seemed to be revealed about the nature of the weight loss maintenance experience in perimenopausal women. Sentences or phrases that represented the weight loss maintenance experience were clustered according to the relevant fundamental meaning and these preliminary initial themes were listed. Table 2 below depicts this process.

Table 3: Grouped Fundamental Meaning and Preliminary Initial Themes

| Weight Story                  | 1. Revealing former me  
|                              | 2. Telling story of my body weight and weight loss |
| Future Outlook               | 3. Awareness of overweight body as health concern  
|                              | 4. Contemplating aging  
|                              | 5. Fear of future disability |
| Thoughts and Feelings About Myself | 7. Changing moods affects weight  
|                              | 8. Changing weight affects mood |
Some themes were then combined after consideration for redundancy, overlap and saturation.

Table 3 below depicts this process to show how the fundamental meaning units and initial themes were arrived at during the final analysis to be representative of all participants’ stories.

Initial themes were reviewed with two phenomenological nurse researchers on my committee for consensus.

**Table 4: Grouped Fundamental Meaning and Preliminary Themes**

<table>
<thead>
<tr>
<th>Fundamental Meaning</th>
<th>Initial Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Story</td>
<td>Revealing self and commitment toward a more ideal self</td>
</tr>
<tr>
<td>Future Outlook</td>
<td>Realistic concern about future health and loss of function around being overweight and aging</td>
</tr>
<tr>
<td>Aging</td>
<td>Perimenopause is accompanied by undesired weight gain</td>
</tr>
<tr>
<td>Thoughts and Feelings About Myself</td>
<td>Midlife hormonal changes lead to fluctuations in thoughts and feelings</td>
</tr>
<tr>
<td>Habits</td>
<td>Maintaining desired weight required ongoing monitoring with daily attention and discipline</td>
</tr>
<tr>
<td>Sticking With It</td>
<td>Sustaining weight loss is self- awareness and self-management despite relapses</td>
</tr>
<tr>
<td>Relationships</td>
<td>Caring for my midlife self includes having a supportive relationship with self and others to</td>
</tr>
</tbody>
</table>
These fundamental meaning units and initial themes were shared with the three participants who opted to read these themes for validation that their full experience was represented. Four participants declined an opportunity to validate their transcript for accuracy or to contribute new data. None chose to provide additional comments about the transcript or initial themes. Ava, Peggy and Ella each remarked about how at length they had spoken initially, and believed the transcript was an accurate account of their initial interview. Later, Ella unexpectedly sent me before and after weight loss photos for the study.

During the analysis, I recollected that van Manen (1990) described theme analysis as a process of “insightful invention, discovery or disclosure”, “not a rule-bound process but an act of ‘seeing’ meaning” (p. 79-88). Themes “are not categories or concepts” they are the “experiential structures that make up the experience” from van Manen’s point of view (1990, p.79). In this study, themes reflected the “structures,” of the weight loss maintenance experience during perimenopause.

The approach of each method of thematic analysis provided different information for the analysis, which enabled me to uncover meaning in the data, as well as themes. This reflective process of analysis helped me determine, clarify and explain of the phenomenon of weight loss maintenance during perimenopause and make the meaning of this lived experience more explicit.

I tried to retain an open view about what each participant’s description of weight loss maintenance said about the meaning of her experience. Weight loss maintenance during midlife as an object in the world will not be the same as weight loss maintenance during midlife that is
subjectively realized in consciousness as a phenomenon. The subjective realization of the phenomena is highly personal, so some understandings may not be shared with others. At this point in the analysis bracketing of the researcher’s own preconceptions and biases was employed to contribute toward authentic reporting of the participants’ experiences in the phenomenological reduction (Caelli, 2000; Dahlberg & Dahlberg, 2004).

Essential Themes

Determining Essential Themes

Even though three individual participants sanctioned the fundamental meanings and initial themes for their own stories, one of the research tasks was to distinguish between essential themes unique to the weight loss maintenance experience during perimenopause and incidental themes that may be historically or culturally determined or shaped. The free imaginative process suggested by van Manen (1997) was used to change or remove each initial theme to determine if it was truly an essential representation of the weight loss maintenance experience during perimenopause. van Manen advised researchers to “discover aspects or qualities that make a phenomenon what it is and without which the phenomenon could not be what it is” (1997, p. 107). All fundamental meanings and initial themes (Table 3) were kept.

Seven interpreted themes were reviewed with two phenomenological nursing researchers on my committee to seek feedback about any need for further interpretation. The seven interpreted themes were rewritten with broader meanings to arrive at seven essential themes that depicted the women’s experience of weight loss maintenance during perimenopause. These essential themes evolved after reflection, and eventual consultation and discussion with three other phenomenological nurse researchers on my committee. When there was agreement, a discussion
about the reasons for agreement occurred; and when there was disagreement, negotiation with cogent argument occurred to reach consensus, as suggested by Sandelowski & Barroso (2003).

The following seven fully interpreted themes were constructed:

1. Telling stories of self, and weight gain and loss over time.
2. Apprehension about being overweight prompted changes in lifestyle.
3. Body mind awareness and vigilance while struggling with life’s challenges during perimenopause to maintain weight loss.
4. Coping to overcome negative thoughts and emotions.
5. Maintaining weight loss is a journey of attentiveness, struggle, balance and self-discipline.
6. Sustaining weight loss is negotiating with self to maintain consistency and restraint all at once.
7. Caring for self requires seeking supportive connections from people and places.

The interpreted themes and essential themes are depicted below in Table 5.

**Table 5: Interpreted and Essential Themes**

<table>
<thead>
<tr>
<th>Interpreted Themes</th>
<th>Essential Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telling stories of self, and weight gain and loss over time.</td>
<td>Revealing self and making a commitment toward a more ideal self.</td>
</tr>
<tr>
<td>Apprehension about being overweight prompted changes in lifestyle.</td>
<td>Caring for myself released apprehension leading to a hopeful future with good quality of life.</td>
</tr>
<tr>
<td>Body mind awareness and vigilance while struggling with life’s challenges during perimenopause to maintain weight loss.</td>
<td>Struggling with life’s challenges during perimenopause and maintaining weight loss.</td>
</tr>
<tr>
<td>Coping to overcome negative thoughts and emotions.</td>
<td>Hopefulness promotes positive thinking and feelings and effective coping.</td>
</tr>
<tr>
<td>Maintaining weight loss is a journey of attentiveness, struggle, balance and self-discipline.</td>
<td>A journey guided by enduring faith in self amidst success and failure.</td>
</tr>
</tbody>
</table>
Step five of van Manen’s methodology advises the researcher to remain oriented to the phenomenon and the research question. Therefore, the following discussion provides examples from participants’ stories of weight loss maintenance during perimenopause for all seven essential themes to help provide trustworthiness as well as understanding.

**Essential Theme 1: Revealing self and making a commitment toward a more ideal self.**

This essential theme was derived from the fundamental meaning, “weight story,” which was interpreted to become the initial theme, “revealing self and commitment toward a more ideal self.” The initial theme was reinterpreted to be, “telling stories of self, and weight gain and loss over time,” and became the essential theme of “revealing self and making a commitment toward a more ideal self.” All participants spontaneously spoke about themselves in terms of their body weight variations over time and about a pledge to lose weight and maintain the loss based upon dissatisfaction with their body weight.

Three participants’ weight stories began in midlife. Lucinda’s said, “I began to lose weight…around when I was about fifty years old I just decided it was time for me to try to lose some of that weight I had gained with the kids, pregnancies.” However Lucinda indicated that she had never been thin. For example, she noticed some “super thin” “nonstop exercisers” who seemed to be at her gym all day long and said, “Well maybe that’s how they stay that way, I don’t know.” Her more ideal self was reflected in, “When I look at myself in the mirror I am happier and I

| Sustaining weight loss is negotiating with self to maintain consistency and restraint all at once. | Perseverance despite life’s oscillating peaks and valleys. |
| Caring for self requires seeking supportive connections from people and places. | Caring for self and being receptive to support from others. |
think when people see me I get compliments…I definitely feel better.” Lenore said, “I’ve been heavy much of my married life. I’ve been married for 25 years… “I lost a little more than 10% of my weight about two years ago. I’ve lost nineteen pounds… The weight loss has really helped me in my most recent job search because I look younger with the weight loss.” Ava began by saying, “I have been in weight loss maintenance off and on since I entered my forties after I had stopped smoking and put on a lot of weight.” “I didn’t go above one seventy-seven. Then after that, I wouldn’t go past one seventy. Now I won’t go past one sixty-six.” She was resolute in her statement, “It’s important to have longevity and feeling good. Have some quality of life.” Three of the participants began their weight story with childhood. Sally said, “I was chubby as a teenager. I’m 5’3 and a half, but I was about 170 pounds when I was, you know, 13, 14, 15 years-old until 18 or 19.” “About two years ago I lost 25 pounds on Weight Watchers.” Ella’s perception of her teen self was, “I considered myself fat.” She used “recreational drugs” and alcohol to cope, began a series of weight loss weight gain cycles, but “I’m 98 pounds down from my original weight.” Peggy said, “I was a heavy child growing up.” But, “into my 20’s, I really quickly became informed and educated about nutrition, I just didn’t want to be that anymore.” Tamara’s “I’ve always had a weight problem most of my life.” “I couldn’t stop eating” I lost 60 pounds in a very short period of time” “I probably put on 40 of the 60 pounds that I lost starting to eat out of control again” “I would like to be thinner, of course. I’ve been this weight for a long time. And I guess the gift is not getting heavier and heavier, and being able to wear the same clothes from season to season, which, when I was younger, that did not happen.”

The participants’ experiences were connected by the fact that they had all deliberately achieved a ten percent or more weight loss during perimenopause via life style changes, and
maintained at least a ten percent weight loss for a year or longer. Additionally, the women believed they were more the self they wanted to be as a result, even though some still wished to maintain at a lower weight.

This data revealed how each participant viewed herself – a subjective sense of embodiment or corporeality. Another example was Sally, who compared her body unfavorably to all of her sisters’ bodies. She remarked during her interview,

I have three sisters and of the four of us, I’m the biggest, I’m the tallest, I probably am the biggest boned. I have two sisters that are 5’ and they’re both 93 pounds soaking wet. But can eat anything. And then my sister, [name], is only 5’2 and she’s probably about 108 pounds. She watches a little bit more, but, you know, standing next to them, I always felt like I was the heavy one, I was the fat one, I was the large one, even though if you looked at us nobody has ever said, “Oh my God,” you know, “you’re big.

Another participant, Tamara, who remained noticeably overweight, also shared a remark about her body size twice during her interview. “I think back, I was a size 2 Calvin Klein jeans at that point, I could buy size 2 jeans. I was very little, yeah.” And Ella said of her body, “I was never any of the sizes that my friends were. I was always at least 25 pounds or more overweight.”

Peggy began her interview by stating, “…this goes back to when I was a child, I struggled with weight. I was a heavy child growing up. I have two brothers, they were skinny, skinny, skinny, and I was the one that always – I was chubby. You know, you see pictures of me as a child.” She also lamented, “I would like to be maintaining at 125 pounds, rather than at 160 pounds.”

Lucinda commented on her body in relation to her son, “…he’s got my kind of body type where he needs to keep active or he’ll start putting on weight.”
Essential Theme 2: Caring for myself released apprehension leading to a hopeful future with good quality of life.

This essential theme was the re-interpreted theme, “apprehension about being overweight prompted changes in lifestyle.” Each of these two themes derived from the fundamental meaning, “future outlook,” with the initial theme, “realistic concern about future health and loss of function around being overweight.” Participants expressed concern about their future health and ability to function related to being overweight, which was the primary expressed impetus for weight loss during perimenopause. They engaged in caring for their physical and emotional health by maintaining a weight loss during midlife.

Lucinda shared, “I think in general working your body is a positive because it helps all your systems stay in sync.” Lenore said, “I want to enjoy life, but I don’t want to be overweight. Now my weight is nearly in the BMI range it should be.” Although pleased about maintaining weight loss for two years, Sally still expressed concern when she lamented, “Unfortunately, my doctor’s always yelling at me, I am not physically active the way I should be” Tamara’s comments reflecting her weight related weight concerns were, “I don’t have, thank God, metabolic syndrome.” Peggy revealed about her future health and her weight, “I have the initial beginning of osteopenia and I have arthritis. So I know that I have to take care of my bones.” It feels good that I go to the doctor, I have my checkup, and everything was great.” Ava realized, “As an African American woman, hey, you know, I am very prone to, obesity, hypertension, and diabetes. That’s not what I want to have.” Ella described her parents and siblings as “obese” with obesity related diseases. She said about her future outlook, “I don’t ever want to look like that again.” “I didn’t feel healthy; I know that I’m healthy now. And I’m not going to die – well
hopefully I’m not going to die from, you know. Because I have a good clean bill of health from my doctor.”

The women’s concern and worry about their future health, well-being and ability to function independently was assuaged by their weight loss and ability to maintain it for at least one year, which afforded a more hopeful future outlook. Wondering about future health, changing body weight over time and maintaining weight loss involved a sense of temporality as did aging itself.

**Essential Theme 3: Struggling with life’s challenges during perimenopause and maintaining weight loss.**

The fundamental meaning was “aging” with the initial theme of “perimenopause is accompanied by undesired weight gain.” This theme was reinterpreted to mean “body mind awareness and vigilance while struggling with life’s challenges during perimenopause to maintain weight loss,” and reinterpreted as an essential theme of “Struggling with life’s challenges during perimenopause and maintaining weight loss.”

Lucinda said, “I feel more energized definitely when I get my body moving.” Lenore remarked about her midlife body, “I got so heavy during my 40’s trying to get pregnant.” Sally said of midlife, “The maintenance I don’t think is any different. I think it was harder to lose the weight. I don’t think it came off as readily. Because I don’t think my metabolism is what it used to be.” Lenore said, “I gained more weight with in vitro fertilization cycles over several years in my early to mid- forties.” Referring to midlife, Peggy shared,

This is definitely challenging. I said to myself, well now here you are going into menopause when women generally gain at least 10 to 20 pounds. When I was in my 20’s and 30’s, losing five pounds was a piece of cake. And now it’s a struggle to maintain your weight, to make
sure that you don’t gain weight.”

Tamara revealed, “I probably put on 40 of the 60 pounds that I lost. And again was starting to like eat out of control again.” Ava harbored resentment about her body gaining weight midlife and struggled between wanting freedom to indulge in occasional midlife binging behavior and wanting a healthy body weight. She said, “Knowing full well that when I was younger, I could eat that way and there wasn’t a problem…the resentment is the deprivation and that I cannot do what I did before.” Ava lamented, “It’s always hard, it’s always difficult. When I was younger, I could eat that way and there wasn’t a problem.” “As I’m getting older, with all the aches and pains, I want to try and drag my life out a little bit longer without having to worry about developing a lot of medical issues.”

One example of Ella’s midlife weight struggle “Once again, I put on a little bit more weight. So I probably put on about another 30 pounds. But I was still down 50 pounds.” Later in her early 50s, “I lost about 10 pounds, but I just couldn’t get under 160.”

Participants all spoke about midlife weight gain and the challenge of losing it, which incorporated lifeworld existentials of corporeality and temporality. The women made explicit that as perimenopausal women, they had a more difficult time losing body weight compared to when they were younger. Some felt satisfied with the weight achieved, whereas others would have liked to lose more. Similarly, some found maintaining at midlife more challenging than others. Women in this study recollected that to be perimenopausal means that a woman is aging and no longer young, time is passing. Peggy said, “I thought I was young to be going through this. I’m too young for this. So that was hard for me. I hear women say, ‘I can’t wait not to get my period.’ For me, it was upsetting that I wasn’t getting my period anymore.”
Essential Theme 4: Hopefulness promotes positive thinking and feelings and effective coping.

The fundamental meaning was “thoughts and feelings about myself” with the initial theme of “midlife hormonal changes lead to fluctuations in thoughts and feelings.” This theme was reinterpreted to mean “coping to overcome negative thoughts and feelings,” and reinterpreted as an essential theme of “hopefulness promotes positive thinking and feelings and effective coping.”

This study revealed that perimenopausal women expressed varying degrees of satisfaction about their lived bodies after loss for a year or longer. For example, prior to weight loss, Sally perceived her body as too big compared to her sisters’ bodies. This changed over time. After her weight loss she said, “Relative to them…I think it makes me feel better that I’m now closer in size to them.” This is an example of Merleau-Ponty’s belief that we are always bodily in the world as a habitual mode of being, and that our perception of ourselves is likely to be altered (1945/1962, p.143). Merleau-Ponty wrote, “The phenomenon of habituality is just what prompts us to revise our notion of ‘understand’ and our notion of the body. To understand is to experience harmony between what we aim at and what is given, between the intention and the performance - and the body is our anchorage in the world” (Merleau-Ponty, 1945/1962, p. 144).

Lucinda remarked, “When I do stick to my exercise routine and stay closer to the weight I like to be, I feel more independent I guess, when I am staying home and eating and not exercising I feel like I am sort of stuck in a rut and I feel sort of depressed some of the times.” Sally said of her ability to maintain a weight loss, “I love it.” I feel much better, I feel healthier, I think I look better, and I think it gives me a more positive attitude.” Lenore recalled about
midlife weight gain, “I became depressed for a while… too depressed to exercise.” But, “I realized I could be disciplined with my weight. I am disciplined and accomplished in my professional life.”

Peggy said, “If my emotions are OK, it’s so easy to say no to food I should not eat.” Tamara realized that earlier in her life maintaining a weight loss was “stressful” “I would, disappoint myself, regain and think Oh my God, now I’m going to have to go on a diet again.” “This time around I’ve been maintaining the weight for a really long time” and it is “peaceful and serene.” Ava expressed vacillating thoughts and feelings about herself midlife and her weight control, “I won’t go really past one sixty-six. It’s just I guess a degree of regimentation I’ve always had.” In contrast, “It’s just my personality not to be regimented too much. I can do it for a while and then after that, I just have to, I have to stop.” Ella’s weight loss maintenance allowed for positive and hopeful comments such as, “When I first started going on Facebook and I was heavier, I hated posting family pictures” “Because of the weight loss, I feel more positive.”

The women’s experiences revealed the reciprocal nature of the effect of thoughts and feelings upon weight loss maintenance behavior and vice versa. The participants shared how their thoughts and feelings about themselves influenced their weight loss maintenance behaviors, and similarly, how adhering to or deviating from behaviors that support their weight goal influenced their thoughts and feelings.

Essential Theme 5: A journey guided by enduring faith in self amidst success and failure.

This essential theme was derived from the fundamental meaning, “habits,” which was interpreted to become the initial theme, “maintaining desired weight required ongoing
monitoring with daily attention and discipline.” The initial theme was reinterpreted to be, “maintaining weight loss is a journey of attentiveness, struggle, balance and self-discipline,” and became the essential theme of “a journey guided by enduring faith in self amidst success and failure.” The participant’s comments show how all four life world existentials corporeality, temporality, spaciality and relationality were applicable.

The women spoke about how they needed to strategize to have healthy food choices in their daily spaces at home or at work and when grocery shopping or dining out. The implicit assumption was that this made the spaces safe for maintaining a desired weight. Peggy summarized, “I watch what I eat, I do a lot of mental affirmation, and I exercise like crazy…Saying to myself it’s going to pass, the craving will pass.” “It’s challenging, but at the same time it can be rewarding.”

All women spoke about their relationship with themselves allowed them to monitor themselves along the weight loss maintenance journey. Lucinda’s belief in herself was revealed when she said the experience provided her with, “a sense of accomplishment” “it does make you feel like you set a goal and you can reach it.” Sally did not have time to plan daily exercise, but related, “My mother just always taught us portion control.” And Sally monitored herself by weighing, “I will weigh myself every, probably, other day, rather than every day, until the weight comes off. And then I probably get on the scale once or twice a week.” Lenore recounted a past unmonitored holiday season where she “gained ten pounds,” and since then “I weigh in every day.” Lenore was introspective and attentive, “Now, I control myself. But I don’t deprive myself.” Ella said of her journey, “I don’t buy as much crap as I used to… Now I can resist. I always bulk up on produce, because it is healthier.” Ella’s daily habit now consists of beginning
her day with a “green drink”, “a little accelerator pill with no ephedra, a protein shake and a little bit of coffee, but not too much.” “Sometimes I’ll eat supper. But most of the time, I’ll just have lunch.”

Tamara thought “It’s not just the food, it’s having a spiritual connection, and working through your emotions, and accepting your feelings.” She also said, “I really never get on the scale. But I eat three meals a day with a snack at night, and that’s what I do every single day. So that’s my way, I guess, of maintaining my weight.” Ava exclaimed, “I want to be able to eat, even if it’s not good for me, what I want, but within control.” “When my clothes start to feel too uncomfortable, then I know without even getting on the scale that ...” Ava described her weight loss maintenance habit as, “I’ll let myself get to a certain weight, about fifteen pounds more than what I want to be, and then I’ll go back to Weight Watchers and I’ll get started over again.” Peggy revealed, “I need to really be what I call strict, to be focused on what’s going in. I’ll just maybe taste something instead of eating the whole thing – but that’s huge discipline.” “Now it’s a struggle to maintain your weight, to make sure that you don’t gain weight.” It’s more challenging – my life of food journey, because it is a relationship that I have with food.”

A temporal aspect of weight loss maintenance became evident as the women commented upon how much time was devoted to physical activity. Tamara did not exercise. She said, “I’m not an exercise person… I just don’t do it. Have never really been an exercise person.” Lenore said, “I don’t schedule in daily amounts of a particular type of exercise. I couldn’t spend an hour and a half every day on exercise machines. I would like to hire a personal trainer to tell me what to do for only ten or fifteen minutes a day.” But she did shovel snow in her driveway and garden without reference to the time involved. Staci declared, “I don’t exercise” There just isn’t time at
this point in my life.” “I don’t like to exercise. So, it’s a chore for me.” In contrast, Lucinda and Peggy looked forward to regular physical activity almost daily for one and one half hours at varying spaces. Ella also worked out “on a regular basis” at two different gyms and became devoted to selling nutritional supplements over the past couple of years. Ava regularly walked long distances and participated in two annual walks for charity.

Each woman’s own unique experiences demonstrated varying timelines that delineated periods of continuous versus discontinuous weight gain, weight loss and weight loss maintenance. Merleau-Ponty wrote, "what enables us to centre our existence is also what prevents us from centering it completely, and the anonymity of our body is inseparably both freedom and servitude" (1964, p.85). Merleau-Ponty's point seems to be that though the body searches for equilibrium, as a mortal and temporal body it is also precluded from perpetual equilibrium (Reynolds, (n.d. Habit); (1945/1962, p. 346).

Participants acknowledged that ironically, daily success or failure was part of the overall balance for the weight loss maintenance experience. They remained thoughtful or even vigilant in their habits in varying unique ways to remain faithful to their choice to maintain a particular weight.

**Essential Theme 6: Perseverance despite life’s oscillating peaks and valleys.**

The fundamental meaning was “sticking with it” with the initial theme, “sustaining weight loss is self- awareness and self-management despite relapses.” This theme was reinterpreted to be, “sustaining weight loss is negotiating with self to maintain consistency and restraint all at once,” and reinterpreted to the essential theme “perseverance despite life’s oscillating peaks and valleys.”
Lucinda’s words really resonated with this theme, “The key is not to feel bad if you have one or two bad days. People will backslide, it’s normal, and I have done it myself, you just have to wake up the next day and get back on track.” Sally indicated she is able to persevere because, “I’m a creature of habit.” Lenore reflected back about midlife weight gain and loss, “It was peaks and valleys” “I really do go back to many of the strategies I learned in Weight Watcher’s for losing weight. I just have to continue with them, but make eating enjoyable.” Tamara stuck with weight maintenance for eight years during perimenopause and after, “It’s really the 12-step program that has taught me so much about myself. I’m living it one day at a time. That’s my religion, I guess you would say. Peggy shared thoughts about her “struggle” with maintenance of perimenopausal weight loss

Now, going through the perimenopause… you’re battling with your body changing and your metabolism going down… you do get stuck where you’re being so good, you’re going to the gym, and nothing happens. “So with the body changing more than ever you can’t eat sugar and carbohydrates – because they just settle in your middle, which is where women gain weight…

Peggy also revealed that her body during perimenopause felt like “constant PMS” with “compulsive eating, emotional eating, and feeling horrible about yourself, where you don’t want to go to the gym because you feel horrible. So it’s this vicious cycle.”

Ava had boundaries for her body size, and health considerations that kept her in relative control. “The highest that I have gone in the last five or six years is maybe one seventy or for my clothes, it’s 10 and 12s. I will not go to a 14, I will not.” “I am not willing to become a fat old
lady. I just am not willing to do that, I’m just not willing to do it.” “I don’t want to get old and then not be able to walk.”

Ella’s persistence was evident with comments such as, “I was doing food logs, trying to keep honest with it” and “I’ve been working out like a fiend.” Ella’s inner determination was reflected by the following insight, “Even if I didn’t have self-esteem and the support of other people in my life I don’t think it would deter me on my path.”

Upon reflection, I understood that the participants had a common experience of continuing on to maintain a weight goal despite setbacks. Successful days were imbued with self-awareness, self-discipline and self-acceptance.

The participant’s habit of self-monitoring, one way or another and struggle to maintain perimenopausal weight loss addressed themes of corporeality, temporality and spaciality. One scholar suggested that the meaning of perception in general for Merleau-Ponty was taking some responsibility to be actively perceptive to the world through our body mind, so to Merleau Ponty, perception was not a passive stance before sensory stimulation (Reynolds, n.d. Early Philosophy). To substantiate his interpretation of Merleau Ponty, Reynolds (n. d. Habit) referred to excerpts from Merleau Ponty (1945/1962, p. 137) “consciousness is primarily not a matter of "I think that," but of "I can."

**Essential Theme 7: Caring for self and being receptive to support from others**

Some participants followed doctrine of Weight Watchers or Overeaters Anonymous, and attended the support meetings; whereas other women managed to maintain their weight loss
without organized meetings. The four women who engaged in regular physical activities, Lucinda, Peggy, Ava and Ella, did so with support from others, or at least contact with others.

This essential theme derived from the fundamental meaning “relationships,” with the initial meaning “caring for my midlife self includes having a supportive relationship with self and others to assist with weight loss maintenance.” This was reinterpreted to mean “caring for self requires seeking supportive connections from people and places.” And the essential theme became “caring for self and being receptive to support from others.” This theme was in keeping with van Manen’s view that relationality is an important aspect of phenomenological observation and many participants made references to the spaces where they felt comfortable exercising, which connects with the existential, spaciality. For example, Lucinda expressed concern about how “safe” the jogging path was in the nearby park because of the “often present unsavory characters.” Peggy referred to her spinning space as an experience she “became addicted” to “that’s been fun.” She also enumerated other spaces she goes to for “essential” physical activity. Different outdoor neighborhoods were a regular part of Ava’s lived space to engage in miles of walking.

Women in this study identified support from others as a component of their weight loss maintenance experience. Some women expressed unequivocal dependence upon support from another person; whereas others depended only somewhat upon others. Ultimately, all depended upon themselves to maintain their weight loss. Some followed doctrine of Weight Watchers or Overeaters Anonymous, and attended the support meetings; whereas other women managed to maintain their weight loss without organized meetings. Ella relied upon a nutritionist initially
and then became more involved in a nutritional supplement program not sanctioned by the nutritionist. Ava recounted, “I need to have the structure of a Weight Watcher’s meeting… be weighed, hearing people with success, and I need that feeling of obligation to really do this.” “When you can hear people, you can hear yourself, too. There’s a comaraderie that goes on.”

Lucinda and her running partner of six years depended on one another, “You need to be motivating each other so that you feel you are letting the other person down if you don’t go.” Sally and her husband found some support in one another. “My husband and I went on Weight Watcher’s together.” Lenore recalled enthusiastically how she once cared for herself. “I was feeling so good after the weight loss that I went to the Flemmington Fur outlet store near here and picked up a little fur jacket.” And her husband supportively said, “Now you can’t say I never bought you a mink.” Ella cited several examples of being open to support from others. The initial one was, “I had gone to my doctor, and I said, “I’m ready, I’m ready to like take care of this.” So he gave me a name of a nutritionist.” Another source of support came from her AA group, “I have a wonderful group of women that I’m connected with.” Also, “I have a lot of friends that have lost weight.” And Ella recalled before weight loss, “I decided to focus on me” and after a period of weight loss, “I was doing something good for me.” Ella, became tearful during her interview when she identified altruistic factors her weight loss maintenance journey was beginning to have on others pursuing the same path. Ella commented on the positive feelings she felt at the two health clubs she attended.

I joined a gym called Kinetic. It’s a fabulous gym. I just fell in love with the facility, and they have trainers and they have classes. Planet Fitness doesn’t have classes. And it’s just,
the energy there, it’s just like, you feel like you’re part of a family. I don’t how to explain it.

Tamara believed that accepting her feelings was helpful. And, “Today I focus more on my relationships with people than on the food.” Peggy said, “I reached out to a couple of friends, they reminded me…” being kind to myself is to feel good, and to eat the good food that makes you feel good. You know. And exercising. That’s a huge part of it.

This essential theme of caring for self and being receptive to support from others was a universal participant experience. Four were more inclined to reach out for organized group support, or go to facilities where people engaged in physical activity. Each participant mentioned at least one supportive relationship, but the degree of importance for each woman’s weight loss maintenance varied from being crucial to being nice to have.

To conclude this discussion of the thematic analysis, bear in mind that the essential themes individually offer only a small glimpse into the experience of weight loss maintenance during perimenopause. To comprehend the nuances of any lived experience, the themes must be interpreted together. Also, the phenomenological researcher acknowledges that the “whole might be quite different than the sum of its parts” (Omery, 1983). While there is a chronological flow in the way the essential themes were presented in this dissertation, they are actually intertwined and in motion. Therefore, a caveat for understanding phenomenological research exists: each theme can be understood at a moment in the experience and then be brought back into the whole whenever new data is presented.

**Table 6: Thematic Progression**

<table>
<thead>
<tr>
<th>FUNDAMENTAL MEANING</th>
<th>INITIAL THEME</th>
<th>INTERPRETED THEME</th>
<th>ESSENTIAL THEME</th>
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| Weight Story | Revealing self and commitment toward a more ideal self | Telling stories of self, and weight gain and loss over time | Revealing self and making a commitment toward a more ideal self |
| Future Outlook | Realistic concern about future health and loss of function around being overweight and aging | Apprehension about being overweight prompted changes in lifestyle | Caring for myself released apprehension leading to a hopeful future with good quality of life |
| Aging | Perimenopause is accompanied by undesired weight gain | Body mind awareness and vigilance while struggling with life’s challenges during perimenopause to maintain weight loss | Struggling with life’s challenges during perimenopause and maintaining weight loss |
| Thoughts and Feelings About Myself | Midlife hormonal changes lead to fluctuations in thoughts and feelings | Coping to overcome negative thoughts and feelings | Hopefulness promotes positive thinking and feelings and effective coping |
| Habits | Maintaining desired weight required ongoing monitoring with daily attention and discipline | Maintaining weight loss is a journey of attentiveness, struggle, balance and self-discipline | A journey guided by enduring faith in self amidst success and failure |
| Sticking with It | Sustaining weight loss is self-awareness and self-management despite relapses | Sustaining weight loss is negotiating with self to maintain consistency and restraint all at once | Perseverance despite life’s oscillating peaks and valleys |
| Relationships | Caring for my midlife self includes having a supportive relationship with self and others to assist with weight loss maintenance | Caring for self requires seeking supportive connections from people and places | Caring for self and being receptive to support from others |

**Interpretive Statement**

The interpretive statement of the lived experience of weight loss maintenance during perimenopause is, “Weight loss maintenance during perimenopause is a journey guided by an
enduring faith and commitment toward a more ideal self and future quality of life by coping with the struggles of midlife through, perseverance, positive thinking and support.” This statement reflects an interconnectedness of the seven essential themes that emerged from this study. The participants described an experience that included each theme as an element of the weight loss maintenance during perimenopause. The women’s weight loss maintenance stories were like an infrastructure of highways that got rerouted for the better.

**Discussion**

One finding common to all participants in this study was the fact that each woman believed she was overweight and chose to maintain at least a ten percent weight loss during her midlife. None of the women mentioned being directed to do so by a provider, friend or family member. None were recruited as part of an interventional study. The participants did not mention any particular health event that precipitated their decision to lose weight. However, each participant identified that her primary motivation to maintain at least a ten percent weight loss during perimenopause was to remain healthy, retain good physical mobility and have a good quality of life as she aged. Women in this study were knowledgeable about negative effects of overweight on health and sought out appropriate resources for calorie reduction. Only some women exercised regularly and sufficiently, indicating need for providers to know how to initiate supportive interventions and what they may be for any given mid-life woman. Less educated overweight women may have less access to health knowledge than the women in this study, which has implications for providers as to what approaches would best help to engage women in long term weight loss maintenance.
A secondary finding in this weight loss maintenance study was that each woman felt a renewed sense of identity, facilitated by the psychological perception of maintaining health, and having a better overall sense of well-being. Some women mentioned that they were also pleased about looking and feeling more attractive after their weight loss and during the maintenance, but this was not their initial objective.

Third, all women in this study, as in other weight loss maintenance studies, experienced more successful weight loss maintenance when they adhered to the same behaviors that helped them to lose weight. All had specific strategies and habits they used for eating based upon knowledge from Weight Watchers, OA or a nutritionist. Most women engaged in regular exercise to maintain weight loss. A lack of regular exercise caused some weight regain and maintaining at a higher weight. All women mentioned that losing weight and maintaining the loss during perimenopause was more challenging than when they were younger. The woman who regained some of her weight loss and did not exercise believed that she would always remain overweight. This has implications for beginning earlier in women’s lives to help them consistently maintain a BMI within the healthy range. The weight loss maintenance experience during midlife remained a constant, but not insurmountable struggle for most that required monitoring. The women discussed feelings that occurred during perimenopause as sometimes self-defeating to the weight loss maintenance process, and purposefully developed strategies to help themselves be hopeful.

All women in this study discussed the importance of having a caring attitude toward themselves, which entailed being realistic, forgiving, and optimistic about their weight loss maintenance process. Participants had varying strategies for maintaining a positive outlook and believed it helped reduce stress and impulsive unhealthy eating.
Lastly, an integral part of the weight loss maintenance process for all the women was finding positive connections with other people who provided either necessary knowledge, or emotional and psychological support. A summary of the findings suggests that the participants studied were successful at weight loss maintenance during perimenopause because they perceived that the issue had relevance to their future health and well-being, and they had a sense of agency to do things in their daily lives that demonstrated progress toward their weight goal.

**Chapter Summary**

This chapter discussed the rigor of the study and findings of the experience of weight loss maintenance during perimenopause using van Manen’s phenomenological methodology for human research analysis. Description of the research sample and the research setting set the context for the life world of each participant. Each participant told her story to the researcher which further portrayed her life world in relation to weight loss maintenance during perimenopause. Each woman’s transcribed story was reflected upon for sententious phrases and fundamental meanings. Eleven fundamental meaning units were listed initially; however upon reflection, some were subsumed into one fundamental meaning. Two fundamental meaning units (former body weight and weight loss) were combined to the fundamental meaning of weight story. Two (thoughts about myself and feelings about myself) were combined into one fundamental meaning of thoughts and feelings about myself. Lastly, three fundamental meaning units (maintenance eating, physical activity, and monitoring myself and my weight) were placed in one fundamental meaning of habits. The eleven original fundamental meaning units thus became seven in number.
Further reflection upon separate sententious phrases and fundamental meanings revealed initial themes and meaning emerging from the women’s experiences. Initially fifteen initial themes emerged from this level of reflection. Upon further reflection there were no incidental themes. Some initial themes were combined to become one more general theme and seven initial themes remained, which were later reconstructed into seven essential themes. Examples were provided from participants’ stories of weight loss maintenance during perimenopause for all seven essential themes as part of an audit trail. Lastly, an interpretive statement was created from the essential themes to capture the phenomenon of weight loss maintenance during perimenopause.

Finally, the main findings of this study were summarized. This helped identify what was unique to the weight loss maintenance experience among a group of perimenopausal women. The next chapter provides some reflection about how the findings and how the findings relate to nursing care.
CHAPTER VI

Reflection on Findings

The limited amount of research on the phenomenon of weight loss maintenance during perimenopause presented a challenge to study. The participants’ narratives provided a means to a deeper understanding of the meaning of the weight loss maintenance experience during perimenopause. Repeated reviews of each narrative with thoughtful engagement helped illuminate the meanings within the descriptions. Essential meanings of the experience were arrived at by abstracting out the themes. These themes were essential aspects of the phenomenon without which the experience of weight loss maintenance during perimenopause would not have been the same.
The writing attempted to portray the essential elements of weight loss maintenance during perimenopause in a way that is recognizable to other women who have had the experience. An attempt was also made to understand how weight loss maintenance differs from other similar experiences such as weight loss, or weight loss maintenance at another time in a woman’s life.

**Relationship of the Findings to the Extant Literature**

The following section of the chapter illustrates how the interpretive statement that emerged from women’s experience of weight loss maintenance during perimenopause relates to the extant literature. The reader will recognize the interconnected nature of the essential themes that evolved into the interpretive statement, which describes the experience of weight loss maintenance during perimenopause as the literature is reviewed. The interpretive statement of women’s experience of weight maintenance during perimenopause is: *Weight loss maintenance during perimenopause is a journey guided by an enduring faith and commitment toward a more ideal self and future quality of life by coping with the struggles of midlife through, perseverance, positive thinking and support.* The statement evolved from the seven essential themes that emerged from this study. All participants described an experience that included each essential theme as an element of the weight loss maintenance experience during perimenopause.

**Synthesis of Data and Literature**

The women’s narratives revealed stories about their body weight and themselves, each uniquely different from the other. Each story included making a commitment to one’s self toward becoming a more ideal self. Each woman arrived at this decision by herself. The definition of *revealing* means allowing a look at or an understanding of something inner or
hidden (Revealing, n.d.). As a verb it means to describe, disclose or tell. As a noun revealing can mean an acknowledgment or confession.

We all have a self and regularly talk about our *self*, however, what constitutes a self is unclear, even though many noted scholars have written about the self (James, 1890/1950; Cooley, 1902; Freud, 1923; Lewin, 1935; Maslow, 1943; Erikson, 1950; Sullivan, 1953; Carl Rogers, 1967 & Bandura, 1986, 1997). A current social psychologist concluded,

“Despite centuries of thought devoted to the problem, it has proven notoriously difficult to provide a set of propositions capable of transforming our acquired knowledge into a satisfying description of what a self is…We all have the experience of a unitary self, an I that remembers, chooses, thinks, plans, and feels. Yet it has been notoriously difficult to provide an account of just what this thinking, feeling remembering, and planning entity is” (Klein, 2012).

Researchers and theorists have described a few different concepts related to self that lend more understanding of the women in this study. Rogers pointed out that incongruence may exist between a person’s self- image and ideal self, a condition that would interfere with self-actualization (1967). The term *self-esteem* is distinct from but related to *self*. One of the first to write about self-esteem was James (1890), who said self-esteem describes how we feel about ourselves and depends on the success with which we accomplish those things we wish to accomplish. Self-esteem is generally considered to exist at a conscious level of awareness. The most frankly stated comment about self-esteem in my study was expressed by Ella. When talking about family support regarding her weight loss maintenance Ella thoughtfully said, “If I didn’t
have self-esteem I think it would affect me if they weren’t supportive. I mean, yeah, it would be hurtful. But I don’t think it would deter me on my path, because I’m doing it for me.”

Bandura suggested that self-efficacy and self-concept beliefs represent different views of oneself (1986). Self-efficacy is a judgment of capability to perform a task or to engage in an activity. Self-concept refers to a self-evaluation of one’s competence in addition to any feelings of self-worth associated with the judgment in question. Succinctly, self-efficacy is a judgment of one's own confidence; self-concept is a description of one's own perceived self along with a judgment of self-worth.

Feminist perspectives on self-knowledge include at least four tenets (Welch-Ross, 2000, p. 124): 1) learning about one’s self is a social process involving language in a close interpersonal relationship, 2) people construct personal meanings through evaluation of concrete experiences in their daily lives, 3) self-knowledge occurs through reconstruction of experiences when telling stories about one’s experiences, 4) learning about one’s self is a fluid process that changes with context.

There seems to be agreement that the concept of self is a continually evolving neuropsychological construct that impacts our relationship with ourselves and our ability to achieve our goals. Each woman in this study reported dissatisfaction with aspects of her self that related to body weight. Each woman gradually over time during midlife intentionally reduced her weight to move toward a more ideal self.

The ideal self also has a variety of definitions. Baumeister (1998) suggested that the ideal self is viewed a psychological component of the self, which is privately conceptualized and socially influenced. Positive psychology sees the ideal self as, “the core mechanism for self-regulation
and intrinsic motivation. An ideal self is manifest as a personal vision, or an image of what kind of person one wishes to be, what the person hopes to accomplish…” (Boyatzis & Akrivou, 2006). Organizational management researchers proposed a model of the ideal self that suggested it helps provide the drive for intentional change in one’s behavior, emotions, perceptions, and attitudes (Boyatzis & Akrivou, 2006). They also believe that the ideal self provides motivation for maintenance of an already achieved desired state. These authors hypothesized that the ideal self tends to activate a person’s “will,” and possibly increase self-monitoring in ways consistent with achievement of goals. They suggested that attending to the notion of an ideal self may mitigate against immediate gratification to achieve longer term goals as long as the goals are authentic rather than an from an external source or from an “ought self.”

In this model, the ideal self is comprised of three major elements: optimism, efficacy and hope. Hope may be seen as a belief that one’s goals will be met, but hope must be accompanied by optimism and agency in order to be feasible to attain (Boyatzis & Akrivou, 2006). This notion seems to apply to the women in the current study who successfully lost at least ten percent of their weight and maintained for a year or more, solely with lifestyle changes in diet or diet plus physical activity. Perhaps these women entertained a notion about their ideal selves that served as a motivation. Their optimistic hope for the future about maintaining the weight loss was based upon the reality of having self–efficacy for the weight loss according to Bandura’s theory. Thus, weight loss maintenance for a prolonged period of time seemed feasible to the women in my study. Another theorist hypothesized
about the ideal self and midlife, and characterized midlife as “the time when we must face whether what we have become matches our ideal self (Sheehy, 1976, p. 357).

To conclude, each participant in this study revealed herself to me when she shared her weight loss story. During the narrative, each woman reflected back in a mindful, conscious way to points in time when her weight was more than she wanted it to be. All participants committed to and lost weight during midlife to become more the selves they wanted to be. Commitment in this study meant a promise or a pledge to oneself to maintain the weight loss (Commitment, n.d.). The concept of the ideal self was described in the literature as a driver of intentional change, and is entwined within all essential themes of this study.

All the women expressed realistic concern about their future health outlook and decided to take care of themselves in order to lose some body weight. This helped them feel less apprehensive about their future health and well-being. As women age, we rely on future-oriented representations of what one hopes to become or is afraid of becoming. A key to ongoing well-being may be to revise future images to achieve a better match between desired and achieved goals. Women in my study said that looking back, before their weight loss, their future health and physical abilities were concerns that provided an impetus to commit to weight loss and weight loss maintenance. The timing for beginning the journey of weight loss maintenance during perimenopause was precipitated by these concerns. They wanted to stay healthy and avoid illness and disability to secure a hopeful future. The women expressed varying degrees of awareness of health and physical function related to weight. Future quality of life was important to them as they continued to age beyond midlife. Health, according to one nursing theorist (Parse, 1981, 1992) is viewed as “a process of becoming that is lived moment by moment in
rhythmical patterns unfolding all at once” (Pilkington, 2000 p. 502). Parse (1990) also wrote that people freely choose life’s priorities to commit to, and that health and quality of life have personal meaning known best by the person living the life. Participants in my study all mentioned degrees of concern, anxiety, apprehension or fear regarding their future health and ability to function independently with a good quality of life.

Participant’s apprehension about future disability and decreased quality of life after perimenopause were not unfounded in my study. Recent qualitative studies of midlife women also found that they expressed “fears and concerns” about their future physical and mental health and ability to be independent (Ritchie, 2014; Rubinstein, & Foster, 2012). The prevalence of chronic health conditions increases with age (Parekh, Goodman, Gordon, & Koch, 2011), and perimenopausal symptoms signify aging. One group of researchers described menopause as, “a tangible marker of, and synonymous with, aging” (Rubinstein & Foster, 2012). In addition to aging, excess body weight often causes long term weight related illness such as cardiovascular disease, diabetes, and cancer are the main reason adults in general, seek health care and the leading cause of death and disability in the United States (CDC, 2011). The trajectory of a chronic illness as well as the complications and comorbidities that develop can significantly alter quality of life (Schulman-Green et al., 2012). One study of midlife women showed that some had uncertainty about the future because of the thought that they were more vulnerable to illnesses or conditions that their family members had (Lindenmeyer, Griffiths, Green, Thompson, & Tsouroufli, 2008). This concern was also common among the women in my study and seemed to be an impetus for losing weight and maintaining the weight loss.
A multiethnic study of midlife U. S. women’s health in the (SWAN) study demonstrated that perimenopausal and postmenopausal women were more likely to have more physical limitations compared to premenopausal women (Avis et al., 2009). As previously cited in Chapter II, studies reported a greater frequency of disability among postmenopausal women who are overweight. The following example shows how great an impact. In one study, muscle strength had less impact on physical function than a woman’s fat mass. Greater body weight was significantly correlated with lower physical activity and a lower physical performance score, along with greater frequency of disability (Lebrun, van der Schouw, de Jong, Grobbee, & Lamberts, 2006). Most women in the current study mentioned physical limitations they experienced during perimenopausal weight loss maintenance. Lenore avoided aerobics for fear of injury. Lucinda needed to alter her physical activity to accommodate joint aches and pains. Ava and Tamara referred to waning energy. Other researchers demonstrated that among elderly women, obesity added much greater odds (44–79% higher) of having physical difficulties than loss of muscle mass (sarcopenia) did; and sarcopenic obese elderly women had only slightly greater odds of physical difficulties compared to obese women (Rolland, et al., 2009). This demonstrates the importance of maintaining a normal BMI range for midlife and older women. As one participant in my study said about excess body weight, “Do you really want to get old huffing and puffing to breathe?”

The World Health Organization (WHO) first developed a cross cultural Quality of Life (QOL) Questionnaire in 1995 “to assesses individuals' perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns” (Saxena & Orley, 1997). A health related quality of life
(HRQOL) instrument also exists, which is a subjective measure of perceived physical and mental health over time in the U. S. (CDC, June 23, 2015). Items surveyed in this instrument coincide with future concerns the women in the current study expressed, such as problems with stress, depression, or anxiety, limitations with energy level, self-care, walking, recreation, or shopping, frequency of pain, and ability to sleep. Women in the current study hoped to enjoy a future beyond perimenopause with a good quality of life and were optimistic they could do so if they maintained their body weight within a normal range.

Having sufficient optimism to persevere with weight loss maintenance during perimenopause corresponds with feminist points of view, which encourage women to freely choose how they perceived themselves in the context of their own experiences, intuition and emotions (Herlihy & Corey, 2005). In addition to feminist points of view, studies about optimism also pertain to the women in my study. Research reported that optimism connotes having a view of the future as turning out to be favorable and as anticipated, and was found to be an important component of health, functioning level and quality of life (Rasmussen, Scheier, & Greenhouse, 2009). Another study found that optimists were more able to confront life’s problems, cope adaptively and be more proactive about enhancing and protecting their health (Carver, Scheier, & Segerstrom, 2010). The paradox lies in the fact that it may be difficult for a woman to be optimistic and execute behavioral changes to protect her health in the context of midlife hormonal changes. Also, most women in my study had a history of being overweight and not maintaining prior weight losses, which could stifle optimism. Nevertheless, the women in my study did lose at least ten percent of their body weight during perimenopause and maintain the loss for a year or longer. One participant, Tamara, remained dissatisfied with the weight she maintained and
wished for it to be a lower weight, but was optimistic about her ability to maintain and not gain more weight. Ava seemed cautiously optimistic about maintaining what she referred to as a reasonable weight because she struggled with 15 pound ups and downs. Nevertheless, each woman expressed a hopeful outlook for her future health while remaining independent with good quality of life.

The women in the current study released apprehension when they participated in caring for themselves by caring for their health and future quality of life. There are many points of view about what constitutes self-care. In general, self-care as a concept in nursing literature suggests that self-care behavior involves having the motivation to undertake the required activities to achieve a particular health goal. A person engages in self-care when the following perspectives or health beliefs are present: personal issues that require self-care impact everyday life, a person has perceived personal control over effecting change, likelihood exists that adverse events may occur without self-care, and a person has perceptions that the self-care strategies used are effective. One nursing theorist (Swanson, 2009) believed that well-being is linked to the perception of being cared for and being cared about.

The women in the current study actively exhibited self-care behaviors that were adaptive coping responses to fears about their future if they remained overweight during perimenopause. The narratives of the current study described many different self-care strategies the women used to maintain their weight loss in terms of food and physical activity. Additionally, several participants described their philosophy of what was really self-compassion as a form of self-care, which involved being understanding, and not harshly critical of themselves when they deviated from their weight maintenance goals. For example, Ava said, “When you fall off the horse, just
jump back on.” Lucinda commented, “You just have to wake up the next day and get back on track.” Peggy offered, “What works for me is words of affirmation.” The women advised themselves to minimize disappointment, be mindful in the present, and focus on a hopeful, optimistic future.

Other studies have looked specifically at self-care during perimenopause with similar results to this study. A grounded theory nursing study (McCloskey, 2012) of women’s experience moving through the menopausal transition found that the most significant finding was the women’s change in focus from others to monitoring themselves. Comments about maintaining a healthy weight were nearly identical to those of the current study, “It’s realizing that the metabolism is much slower than it was and it is going to take a lot longer” (p. 544) and “taking time for me” to exercise is also taking care of my family (p.550). Some women in McCloskey’s study mentioned seeking help for mood swings or temper, and that it helped to be aware of what influenced their feelings when thinking about self-care. These women also sought knowledge from older sisters, mothers or other women about ways of coping with the menopausal transition. For some of these women, self-care during perimenopause was adopting an attitude of being part of a sisterhood from the beginning of humanity, and knowing that perimenopausal symptoms are temporary. One woman said, “I find that part of it is a mind thing.” Midlife as a time to begin fulfilling long standing personal ambitions was also echoed in the current study as a feature of self-care.

A nursing study guided by Orem’s theory of Self-Care Deficit and Theory of Self-Care found that intrinsic motivation to practice self-care during perimenopause was understandably predictive of self-care, and that perimenopausal self-care is influenced by a woman’s perception
of her mother’s attitudes toward the menopausal transition (Zehnder, 1996). Perimenopausal women with more positive attitudes toward the menopausal transition practiced self-care more than those who had more negative attitude in Zehnder’s study. Intrinsc motivation to practice self-care, and positive attitudes toward the menopausal transition were considered components of self-care agency necessary for self-care practice. Interestingly, possessing knowledge about perimenopause was not predictive of self-care. Lastly, Zehnder’s study, like mine, found that time constraints contributed most to lack of perimenopausal self-care for women who worked full-time and still had children at home.

The women in the current study had concerns about the weight gain that accompanied their perimenopausal phase of aging and began to have concerns about aging itself, since perimenopausal symptoms signify aging. Aging signified the possibility of diminishing health and physical function. Participants experienced more difficulty losing weight during this phase of life and realized a greater need to control their weight. Weight control was not the only struggle. There were physiological changes accompanied by psychological, emotional and knowledge based struggles the women experienced during perimenopause, which are validated in the literature to follow.

Most of the women in the current study were gaining knowledge about aging, body weight and future health as they progressed through perimenopause, rather than entering this stage of life as well informed. One study (Trudeau, Ainscough, Trant, Starker, & Cousineau, 2011) investigated educational needs of perimenopausal women and identified many of the same needs that women in my study talked about. Four of the most important things women wanted to know included: 1) how to cope with the perimenopausal symptoms of weight gain and
maintain a healthy weight, 2) what is the “best way to beat the blues when menopausal changes get you down,” 3) “when to be concerned about being depressed” and 4) how to obtain “information about life after menopause.” Women in the current study also conveyed a need to know more about all of these topics. As referred to above, knowledge about the menopausal transition may not translate to performing self-care, but the degree of knowledge a woman has likely affects her experience of perimenopause. Similarly, women’s attitudes and beliefs about the menopausal transition influence whether symptoms they experience are problematic or not (Ayers et al., 2010).

Another challenging life struggle that perimenopausal women in the current study experienced was ambivalence about their own self-perception during this life transition. Negative thoughts and feelings existed. Perimenopausal women’s ambivalent feelings about themselves have been researched in terms of their attitudes about approaching menopause. Findings in one study revealed greater body dissatisfaction among women with negative attitudes about menopause (Rubinstein and Foster, 2012). This study found that for many, menopause signifies aging, loss of fertility, decreased youthful beauty, weight gain, illness and disorders (Rubinstein & Foster, 2012). Women’s narratives in the current study reflected ambivalence about their perimenopausal bodies, with some expressed negativity about how excess weight affected bodily appearance.

A participant in a feminist study thought that a common public perception of a woman sixty or older was of someone “incontinent,” with “osteoporosis” and “not sexually active” (Coleman, 2012). How a midlife woman may perceive herself was suggested in a novel explanation by a modern Jungian psychologist, who believed that women’s midlife is an archetype. Jungian
theory suggests that a collectively-inherited unconscious idea or image may be universally present in individual psyches regarding midlife women. Women’s midlife transition is referred to by Jungians as *liminality*, meaning a transition from one way of being to another (Collinson, 2014). Social anthropology uses the term *luminality* to mean a transitional phase during which a person lacks social status and connotes being barely perceptible (http://www.dictionary.com/browse/liminality). Concern about ageism and marginality was noted by some midlife women in one study who stated, “I do not want to be made invisible… to be seen as insignificant” (Ritchie, 2014, p. 87). In contrast to a portrait of a midlife woman being barely noticed, most women in the current study found gratification from new found compliments or attention received while maintaining their weight loss; however some women made comments about their less youthful appearance due to aging. Cultural ideals of female beauty in the U. S. make physical aging difficult for most women (Gilless & Higgs, 2013).

Women in the current study struggled with life’s challenges during midlife and redefined themselves partly through weight loss maintenance. Reimagining self during perimenopause fits in with what Jung (1933) said of midlife, “The afternoon of life is just as full of meaning as the morning; only, its meaning and purpose are different” (p. 108).

Despite a woman’s struggle with her perception of herself at perimenopause, some women in my study expressed positive aspects about perimenopause such as the kids no longer living at home, having more time for herself, and an inability to continue living as she had throughout all of her earlier adult life. This lends support to the Jungian idea that perimenopause is a time to psychologically transition from one way of being to another. For many women, it may boil down to “Will I stay other directed, or does my own commitment to myself and my reality, matter?”
(Collinson, 2014). Positive attitudes toward the menopausal transition in my study were similar to findings in other studies where perimenopause was accompanied by feelings of social freedom without children to care for, and freedom from regular menses and fear of pregnancy (Hvas, 2006; Lindh-Åstrand et al., 2007; Perz & Ussher, 2008). Paradoxically, one woman in my study experienced cessation of regular menses as a loss because it signified that she was aging; she was not psychologically ready to think of herself as old enough for perimenopause. She wished for a menstrual period so that she could gain relief from feeling bloated. In contrast to this participant’s wish for continued menstrual cycles, a 2014 song entitled “Crimson Wave” speaks to the negative side of being premenopausal, “Call my girls see if they wanna go / take their minds off dumb Aunt Flow” (Tacocat).

Recent research about weight maintenance revealed an association between depressed mood and insufficient physical activity as well as excessive exercise. Excessive physical activity may result in breakdown the essential amino acid tryptophan, possibly affecting the biosynthesis of serotonin; whereas moderate physical activity could improve mood and prevent carbohydrate craving and weight regain (Strasser & Fuchs, 2016).

All of the women in my study spoke of having some negative thoughts and feelings about their experience of themselves during perimenopause. However, positive emotions of pride in their accomplishment expressed that they were pleased with their weight loss and weight loss maintenance, except for Tamara who wished she weighed less. Tamara was an outlier in the group. Although she maintained a weight loss that met criteria for my study, she had regained much of her original weight loss and she remained dissatisfied with her body size. The following provides some understanding. Overweight women who internalize negative societal
attitudes about overweight have a greater association with avoidance of exercise (Vartanian & Novak, 2011). Tamara expressed bewilderment about why she never exercised despite dismay about her current body size when she said, “I don’t actively do anything about it.” Conceptualization from Johari’s Window explains Tamara’s apparent lacuna as a blind area and illustrates that there is information we do not know about ourselves, that others do know (Luft, 1969).

The first study to look at locus of control and weight loss maintenance had three findings relevant to Tamara, who seemed to have had an external locus of control. The study found: engaging in regular physical activity was associated with an internal locus of control, having the ability to maintain weight loss was associated with internal versus external locus, and being able to lose weight by yourself was associated with internal versus external locus of control. (Anastasiou, Fappa, Karfopoulou, Gkza, & Yannakoulia, 2015). Tamara stated repeatedly that she was only able to control her eating with regular OA attendance and adherence to the program.

Locus of control is also positively related to body satisfaction, one example in my study was Lenore. She expressed dissatisfaction with a roll of adipose tissue between her waist and bra line, but was confident she could lose ten more pounds during the year to help with that. Perhaps the participants in my study who maintained closer to their ideal weight operated from an internal vs external locus of control and had more self-efficacy for sustaining the weight loss maintenance balance. Other studies looking at body satisfaction found that when a woman subscribes to feminist ideas there is less dissatisfaction with her own body, particularly with measurement of body shame as an attitude about the body (Murnan & Smolack, 2009). Two correlations were
found among women with self-reported feminist thinking: they had less drive to be thin and had a lower incidence of eating disordered behavior (Murnan & Smolack, 2009). Most participants in the current study were baby boomer generation or younger and likely to subscribe to some feminist ideas, although this was not made explicit in the interviews. Although not generalizable to midlife women, a study about prediction of long-term weight loss maintenance in premenopausal women who were previously overweight concluded that three factors likely helped with weight loss maintenance at three and five years: improved body image, increased autonomous behavior for exercise, and increased intrinsic motivation for exercise (Santos, Mata, Silva, Sardinha, & Teixeira, 2015).

Another aspect of a woman’s struggle to maintain weight loss during perimenopause will be addressed by literature that portrays hope as a function of struggle. Hope may be the perception that one’s goals can be met, that a person has the necessary positive cognitive outlook, determination, commitment and willingness to begin and maintain effort to achieve a goal, and a realistic way to achieve a particular goal (Snyder, 1994). To restate, hope seems to be a cognitive and a behavioral process that is learned through the experience of adversity when we have trustworthy people in our lives, who have faith in our ability to improve our situation. Snyder observed that hopeful people rate themselves positively for goal attainment. Women in the current study certainly were proud of their weight loss and ability to maintain within at least a ten percent loss.

Snyder wrote about the path that leads to a more hopeful outlook. He suggested that positive successful interpersonal relationship development with significant others throughout infancy and childhood provides necessary experiences and tools for adult hopefulness. Developmentally
helpful parental responses help the infant and child to problem solve, be resilient and develop positive self-talk in the face of obstacles. Snyder believed that adults with early traumatic experiences will struggle more with adversity and likely require specialized mental health approaches, although Snyder suggested that small fundamental changes can have a large “ripple effect” toward kindling hope in a patient’s thinking and behavior (p. 347). Snyder believed that for people needing treatment for lack of hope about their situation, an emphasis on hopeful thinking is primarily what determines the efficacy of therapeutic interventions. However, in addition to positive verbal feedback such as “you will improve,” the therapist needs to include discussion about how to achieve goals, as inclusion of both strategies has led to better outcomes in goal attainment (p. 360).

The current weight loss maintenance study shows evidence of the relevance of Snyder’s work. Perhaps the participants remained successful at maintenance for one year or more, while most people do not, because their overall cognition about themselves remained more hopeful. The women’s narratives revealed that they realized a need to be self-compassionate, and took on the role of positively parenting themselves. Possibly installation of hope came from the women themselves with positive self-talk. Peggy was one example of this when she said, “What works for me is words of affirmation…”

Another researcher familiar with Snyder’s work on hope as a function of struggle explored the idea of personal vulnerability and suggested that feeling vulnerable derives from shame and fear of not being worthy (Brown, 2012). Brown said the challenge is to embrace what we believe to be our flaws as well as our strengths. Being our authentic selves allows us to have hope that we are worthy despite imperfection, and to feel positive emotions such as happiness, joy, or
gratitude. The dialect is to become aware of things as they really are with self-acceptance, and then engage in a creative process of change to make a new and better situation. The women in the current study seem to be a testament to Brown’s line of thinking. They confronted personal shortcomings in order to lose weight, practiced self-acceptance while they continued on with the weight management struggle long-term, and were willing to share some deeply personal information during their narratives. One participant’s comment about her weight loss maintenance seemed to capture these ideas, ”I don’t think it would deter me on my path if I did not have my family’s support because I have self-esteem.”

Hormonal changes experienced during perimenopause and associated fluctuations in thoughts and feelings were discussed by women in the current study. Part of their weight loss maintenance journey was a struggle to overcome negative thoughts and feelings about themselves while trying to maintain their weight loss, as well as having the ability to maintain their weight at a desired level.

There is a body of neuroscience research data about the experience of emotion, which essentially addresses philosophical questions regarding consciousness, although discussion remains beyond the scope of this study (Barrett, Mesquita, Ochsner, & Gross, 2007). Blechner (2011) holds that how we feel emotionally changes our experience of our body and vice versa, thus our experiences of our body change how we feel. The literature bears out that symptoms of perimenopause affect the thoughts and feelings in some women more than others. For example, a recent study found that whether hot flashes and night sweats were problematic to women in the menopausal transition was positively correlated with their report of increased stress or anxiety, and scores indicating an increased tendency to focus on bodily reactions (Hunter & Chilcot,
Cognitive behavioral therapy as a way of coping was suggested by these researchers, which may prove useful for the 25% of perimenopausal and postmenopausal women who find that hot flashes or night sweats have a negative impact on quality of life. Other researchers found that sleep problems during perimenopause contribute to depression, as do recent stressful life events (Singh, Jackson, Dobson, & Mishra, 2014). Two women in the current study, Lucinda and Tamara mentioned that they began to experience hot flashes and insomnia during perimenopause. Researchers found that women aged 41-58 had a greater likelihood of experiencing hot flashes if they had subcutaneous abdominal adiposity (Thurston, Sowers, Sutton-Tyrrell, Everson-Rose, Lewis, Edmundowicz, & Matthews, 2008).

Women in the current study referred to having depressed feelings at times especially related to difficulty losing some gained weight. Research about depression among midlife women has mixed findings. In terms of major depression during midlife, women and their providers may usually be reassured that most women are not clinically depressed, and that if a woman enters midlife without major depression, the progression to menopause will likely be similar. Studies that investigated longitudinal patterns of depressive symptoms in midlife women found that most midlife depression was another episode of previously diagnosed major depression, or was seen in women with a family history of mental illness (Colvin, 2012; Freeman et al., 2004; Mariella, 2001). For example, perimenopausal women were especially at an increased risk of new onset (Freeman, Sammel, Lin, & Nelson, 2006), and recurrence of a depressive episode, if they experienced premenstrual syndrome or postpartum depression (Parry, 2008). Thus, when perimenopausal women do experience depressive symptoms they are more likely to be severe,
and independent of negative attitudes, stressful events, poor perceived health and basic financial concerns (Bromberger et al., 2007).

Perimenopausal women with depression were more likely to experience diminished self-esteem (Schmidt, Murphy, Haq, Rubinow, & Danaceau, 2004). When midlife women do experience emotions such as depression or anxiety, it likely influences their body weight. For example, women aged 35-55 with high levels of hostility were followed for 19 years and found to have higher BMIs than non-hostile controls (Nabi et al., 2008). Women in the current study spoke about emotional eating when feeling depressed. Recent results from the Nurse’s Health Study showed that anxiety and depression are correlated with making unhealthy lifestyle choices, which lead to increased cardiometabolic disease (Trudel-Fitzgerald, Tworoger, Poole, Williams, & Kubzansky, 2016). Other researchers also found similar results: that perimenopausal depression may cause weight gain over the next three years (Singh, Jackson, Dobson, & Mishra, 2014), and that baseline perimenopausal depression contributed to weight gain at a 10-12 year follow-up (Pan et al., 2012). Negative emotion can trigger physiological changes that increase systemic health risks such as cortisol dysregulation and increased inflammation (Slavich and Irwin, 2014).

Recent studies do show an increased risk for depression during perimenopause among overweight women, and a correlation between depression and being overweight. For example, a bidirectional relationship existed at a 10-12 year follow-up between being overweight or obese, and depression in midlife women (Pan et al., 2012; Singh, Jackson, Dobson, & Mishra, 2014). Similarly, bidirectional correlations have also been found between depressive symptoms, central adiposity and diet quality (Beydoun et al., 2016). This data demonstrates a need to find
successful ways to foster weight loss among overweight midlife women, and to assess for and treat depression among perimenopausal women to avoid weight gain.

An excerpt from a nurse’s qualitative study (Marciana, Nosek, Kennedy, & Gudmundsdottir, 2012) on the menopausal transition described one woman’s concurrent experience of depressive feelings expressed as a poem:

**Stanza 11**
You don’t want to do any self-care.
So that when the self-care starts going down the tubes,
then you look even worse.
Like when one is clinically depressed,
It’s just a downward spiral,
it just keeps going down.

**Stanza 12**
And I really want to say
I need to get up,
I need to fix my hair,
I need to clean the house,
you have no energy so there you are,
you’re back in that, its,
it’s pretty insidious.
And you know you’re not attractive.

Research found that risk for experiencing anxiety increases during the menopausal transition. A study of women’s health in the U.S. (SWAN) found that women with low anxiety prior to perimenopause were more likely to report high-anxiety symptoms at early or late perimenopause, or postmenopause, independent of multiple risk factors, including upsetting life events, financial strain, fair/poor perceived health, and vasomotor symptoms (Bromberger et al., 2007). Women with high anxiety before perimenopause continued to have high rates of high anxiety throughout follow-up (Bromberger et al., 2007). Anxiety in aging women can lead to poor quality of life and complicate or worsen a comorbid mood disorder, or a medical illness (Siegel & Mathews, 2015). Anxiety, when combined with depression, negatively affects a perimenopausal woman’s health related quality of life independent of sleep disturbance or vasomotor symptoms (Joffe, et al.,
Therefore, one significant way to help perimenopausal women with weight loss maintenance and future quality of life is to monitor for and treat symptoms of anxiety and depression.

One small study found that unpleasant emotions play a role in the ability to maintain long term weight loss. Eating became a form of emotional regulation in response to situational or interpersonal stressors (Tal, 2012). Intake of high caloric foods seemed to assuage or divert attention away from uncomfortable feelings such as sadness, anger, fear, or frustration. Participants had insight into the relationship between their emotions and making poor food choices, which was also true of participants in the current study. It seems that emotional eating is at times, part of the struggle of long term weight loss maintenance.

Some published data exists about strategies to cope effectively with changing feelings during perimenopause. For example, one study found the following to be helpful to cope with depressive symptoms: exercise, massage, positive affirmations, hypnosis, music, reading, painting, and taking vitamins and minerals (Skarsater et al., 2003). Hypnosis was not mentioned as a strategy in the current study, nor was painting, but jewelry making and crochet were part of Lucinda’s midlife routines and Peggy spoke about doing yoga. Most participants referred to adopting a compassionate attitude toward oneself during weight loss maintenance as a form of caring for self.

The ability to cope with emotions during perimenopause can affect quality of life. Among midlife women who perceived perimenopause as either a neutral or a challenging but positive event versus a negative stressor, certain coping strategies were found to be significantly related to quality of life. (Greenblum, 2010). Coping that enhanced a sense of quality of life focused on
problem solving. Some coping strategies were emotion focused and used social support or positive reinterpretation. These same strategies were found by women by in the current study.

Women in this study embraced strategies that promoted hopefulness and optimism. The word *hopefulness* means the general feeling that some desire will be fulfilled. A synonym for hopefulness is optimism (hopefulness, 2011). Theorists have suggested that optimism must be incorporated into the components that affect a person’s experience of hope (Boyatzis & Akrivou, 2006). Another theory is that more optimistic people with positive emotion are more hopeful (Seligman, 1991; Fredrickson & Soiner, 2002). Hope theory conceives of hope as having the ability to think in a goal directed way to “find routes to desired goals and the motivation to use those routes” (Kelsey et al., 2011). The women in the current study conceived of a more positive image of themselves, a more ideal self, which enabled them to contemplate a desired future for themselves and mindfully engage in behavior to secure what they hope for.

A hopeful positive outlook, characterized by realistic optimism, helped the participants cope when negative thoughts or feelings arose. Similarly, a qualitative study of midlife baby boomer women found that in this life stage they tended to endorse an overall optimistic outlook about middle age despite health concerns (Hilber, 2010).

In addition to the expressed belief that optimism helped the participants in the current study to stay on track with weight loss maintenance, they all spoke at length about habits they developed and followed to loose and maintain weight, which required ongoing monitoring with daily attention and discipline. Each woman in the current study spoke of a need for optimistic but realistic change in herself that prompted her weight loss maintenance journey. The journey was described as having ups and downs, but the path was characterized by a degree of self-
acceptance and faith that she could achieve her weight loss maintenance goals. The knowledge and skills these women learned for weight loss remained a critical foundation for weight loss maintenance; however maintenance required more than weight loss strategies and habits. The participants spoke about their experience of being aware when faced with challenging situations, such as the impulse to sit down rather than exercise, or to eat high calorie food vs an apple. They spoke about keeping weight goals in mind, and tolerating some distress at times to engage in healthy habits every day, moment by moment.

The word journey suggests travel or passage from one place to another (Journey, n. d.). In this study journey suggests passage from being overweight in midlife to losing ten percent or more of the weight and maintaining the loss for one year or longer and hopefully for the duration. Unlike weight loss, weight loss maintenance is a journey that does not end. This study suggested that weight maintenance is a long arduous journey through time, a journey of attentiveness and monitoring and self-discipline in a struggle for balance. This study suggested weight loss maintenance entailed good days and bad days, good weeks and bad weeks during a gradual passage to a more ideal self.

The word journey itself connotes have a safe and pleasant journey. Weight loss should be done safely and participants in my study demonstrated knowledge and use of appropriate resources for safe weight loss while maintaining their lifestyle changes. But the journey of weight loss maintenance was not entirely pleasant. It was described as a struggle. This study illuminated a process that is not necessarily enjoyable, but with an outcome that produces a feeling of happiness or pleasure, or in Tamara’s case “feeling peaceful.”
Some participants described their weight loss maintenance journey as routine, but that they tried to spice it up at times to avoid feeling deprived or bored. Some spoke of eating one bite of something desired, or one half of a portion of French fries on occasion, to not feel deprived nor think they were dieting, to avoid relapse to unhealthy eating. They rewarded themselves on occasion while still trying to maintain balance. To maintain balance, participants said that they deliberately planned how to engage in successful habitual eating behaviors, many followed habits learned from W.W. or O.A. The monotony of the routine was expressed by Tamara’s remark, “I just do what I do every day. And I basically eat the same thing every day, which works for me.” Sally also expressed the sameness in her eating, “A lot of salads helps with the maintenance.” Nearly all participants volunteered what they usually ate at each meal.

Another common comment among participants in the current study related to deviation from successful habits, or relapses. All the women mentioned having experienced these times. Similar responses were found in Duhigg’s reports about weight loss (2014). Duhigg recently studied the nature of habits and poisted that successful habit change involves planning for occasional setbacks while finding ways to ensure that a fall back to old ways does not become frequent. Duhigg also suggested that having a plan for recovery from a relapse period helps the return to engaging in successful habits. Several of my participants stated that it was important to have self-acceptance, despite slips, and quickly get back on track with monitoring and behavior control.

One research report corroborated the experiences of women in the current study in a description of self-regulation strategies for eating and exercise behaviors used for weight control where “the aim is to foster willingness to experience potentially aversive internal experiences
while simultaneously promoting behavior that is consistent with desired goals and values” (Forman & Butryn, 2015). There was more variance with physical activity compared to diet among participants in the current study. Two participants did not engage in regular planned exercise. One remained dissatisfied with her weight. Research demonstrates a higher success rate with long-term weight control in individuals who have the internal motivation to exercise (Teixeira et al., 2010). One study suggested that self-regulation with exercise helps provide adherence to healthful food intake (Mata et al., 2011). As previously cited in Chapter 2, a large study of perimenopausal women in the normal or healthy BMI range who consumed a mean of 1755 kilocalories (kcal)/day found that they needed to engage in moderate intensity exercise for 60 minutes per day to maintain this weight; and overweight or obese women in these age ranges needed to reduce caloric intake, and /or exercise more intensively or more often to lose some of their excess weight (Lee et al., 2010). The less physically active women in the current study remained overweight during perimenopause despite weight loss maintenance. In addition to maintaining a healthy body weight, the importance of adequate physical activity is emphasized in a systematic review which found that physical activity for adults of 60-75 minutes/day eliminates risk of death from high sitting times and reduces the risk associated with high TV viewing time (Ekelund et al., 2016).

There were many different habits that the women engaged in during weight loss maintenance to ensure they achieved and then maintained their weight goals. The women were attentive to their habits surrounding eating, physical activity, body weight or body size, feelings, attitudes and beliefs, and self-talk, and supportive environments and relationships. They all
engaged in the habit of self-discipline to maintain their weight loss, but without feeling deprived. Positive self-affirmations were important for maintaining a balance.

The weight loss maintenance journey for most women in this study involved deliberate changes in diet and physical activity. Tamara, the least successful at maintaining her original weight loss, did not exercise. A dietary study of midlife women found that individual nutritional counseling did not necessarily help the women avoid weight gain, even though dietary intake was improved (Perry, Degenneffe, Davey, Kollannoor-Samuel, & Reicks, 2016). The authors recommended more frequent and comprehensive dietary review and counseling, as well as initiation of continued physical activity to achieve weight goals.

Ava described her weight loss maintenance as a struggle with underlying power and control issues and told about periods of time when she rebelled by eating only large amounts of junk food all week. Although the frequency of this behavior does not meet DSM-V criteria for binge eating disorder, it did contribute toward weight regain. Prevalence for binge eating among midlife women is about 10% and is the most commonly seen eating disorder among midlife women (Baker & Runfola, 2016). One group of notable researchers reported that among overweight or obese midlife women, 38% engaged in moderate binge eating and 19% met criteria for probable clinical depression (Teixeira et al., 2002). Eating disorders tend to decrease as a woman ages, but do not disappear with age (Baker & Runfola, 2016). These researchers cautioned that in addition to dangers of weight cycling, eating disorders in perimenopausal and postmenopausal women result in more medical comorbidities and mortality than in younger women.
The findings in this study highlighted the importance of having faith in oneself once committed to weight loss and weight loss maintenance. At its most general, faith means much the same as trust or trusting. The Meriam-Webster definition of faith means having confidence in or having a strongly held belief; faithful means to be true to or loyal to (Faith, n. d). A concept analysis of faith in relation to a nurse researcher’s notion of health (Dyess, 2011) yielded the following:

Faith is an evolving pattern of believing, that grounds and guides authentic living and gives meaning in the present moment of inter-relating. Four key attributes of faith were identified as focusing on one’s beliefs, having a foundational meaning for life, living authentically in accordance with one’s beliefs, and interrelating with self, others and/or Divine.

This essential theme speaks to enduring faith. Synonyms for the word enduring are abiding or constant (Enduring, n. d.). The narratives in my study revealed that weight loss maintenance during perimenopause was a journey guided by each woman’s enduring faith in herself amidst days of success interspersed with failure. For example, Tamara described her faith in the O A program she followed, “One of the benefits of living the program, it’s peaceful and serene, having a spiritual connection, and working through your emotions, and accepting your feelings…, I’m living it one day at a time. That’s what I do. That’s my religion, I guess you would say.” Tamara’s narrative exemplifies the expression, keep the faith, which has a Biblical origin (Timothy 4:7, The New King James Version). Another passage (Hebrews 12:1) implies that keeping faith requires commitment and perseverance.

Meriam Webster’s simple definition of perseverance is the quality that allows someone to continue trying to do something even though it is difficult (Perseverance, n. d.). The
perimenopausal participants found ways during weight loss maintenance to stick with attitudes, beliefs, values and behaviors overall that led to weight loss in the first place, and some incorporated new knowledge to engage in different ways of thinking and new behaviors. The two main behaviors participants talked about were dietary intake and physical activity. Most participants in my study reported that they engaged in physical activity regularly most days of the week, and that they noticed benefits in how they felt afterward. Some looked forward to exercise mainly to feel better afterward, in addition to the benefit of burning calories. Consciously using physical activity in addition to consuming fewer calories and eating more healthy foods was characteristic of other successful weight loss maintainers (Chambers & Swanson, 2012).

Some studies of perimenopausal women tried to understand relationships between physical activity and various psychological constructs and emotions. Studies examined the temporal relationship between a single lifestyle factor and mental health, such as relationships between physical activity and depression; whereas others looked at more factors.

One study examined the relationships among physical activity, perimenopausal symptom reporting, self-esteem, and satisfaction with life in 133 women (M age=51.12), with results suggesting that being physically active reduced perceived severity of menopausal symptoms and enhanced psychological well-being (Elavsky & McAuley, 2005). These researchers posited that the relationship between physical activity and quality of life in the women may have been mediated by physical self-perceptions and any experiences of menopausal symptoms. Perhaps participants in my study who routinely engaged in physical activity were better able to persevere with weight maintenance because they felt better as time passed.
Another study found that women reported fewer menopausal symptoms when they experienced self-efficacy for exercise (McAndrew, et al., 2009). This may not have been the case in the current study, as the two women who did not exercise did not mention any perimenopausal symptoms, although they were not asked about it. Only four of seven participants in my study spoke much about symptoms of perimenopause per se and they were all physically active. Symptoms mentioned were hot flashes, insomnia, depression about bloating or body weight, and aches and pains from aging joints. Cognitive function was not mentioned. Most women in my study seemed more concerned with potential health related symptoms due to aging and excess weight. It was not clear whether lack of self-efficacy for physical activity was a factor for the two participants in my study (Sally and Tamara), who said that planned physical activity had not been part of their weight loss maintenance. One woman in my study, Lenore, did lack self-efficacy for a particular type of exercise that she thought would help maintain her weight. Lenore expressed a desire to do high impact aerobic exercise but was fearful of hurting herself unless she hired a trainer to learn how, but she didn’t have a budget for that yet. Interestingly, mental health benefits (less depression, anxiety, and burnout) were not found for aerobic fitness activity compared to regular physical activity, which did improve these mental health factors (Lindwall, Ljung, Hadzibajramovac, & Jonsdottir, 2012).

Other researchers found that one’s perception of efficacy for physical activity was associated with improved affective states and fewer depressive symptoms from leisure time physical activity compared to non-leisure time physical activity (Pickett, Yardley, & Kendrick, 2012). These studies suggest that a woman’s perception about and experience of doing physical activity
is just as important as burning calories when it comes to alleviating perimenopausal symptoms and feelings of depression with physical activity.

One large study showed that women aged 50 or older who were satisfied with their body size exercised more than those who were dissatisfied (Runfola, Von Holle, Peat, Gagne, Brownley, Hofmeier, & Bulik, 2013). Only 12% of these women were satisfied with their body size, but those that were had a lower body mass index and reported less dissatisfaction with their weight and appearance. This result does not explain how women in my study who were dissatisfied with their midlife body size were able to lose weight. Perhaps holding on to an image of their ideal selves and wanting to reduce future health risks provided the motivation. However, satisfaction with body size after weight loss does lend understanding about why most midlife women in my study were able to persevere in maintaining weight loss. Nearly all women in my study did engage in exercise or physical activity to maintain their body weight. Only one participant, Tamara, remained dissatisfied with her body mass index and she did not exercise; however, she maintained ten percent of her weight loss for eight years rather than continue to gain. A study that looked at 112 overweight (41%) and obese (59%) primarily White non-Hispanic and Hispanic midlife women’s (age 40-55) (45% postmenopausal) satisfaction with their bodies found that on average, women said an 11% loss would achieve an ‘acceptable’ weight, and a 14.8% loss would cause them to feel ‘happy’ (Teixeira et al., 2002).

Not surprisingly, the Study of Women’s Health across the Nation (SWAN) found that midlife women with poor body image may be more likely to have clinically significant levels of depressive symptoms (Jackson, et al., 2014). Body satisfaction or dissatisfaction is related to body image. This constellation of factors may help understand one woman in the current study,
Tamara, who did not persevere to maintain her entire weight loss. Perhaps these body image and depressive factors may also help understand Ava, who allowed herself a comparatively wide weight maintenance range of 15 pounds.

Exercise in the form of yoga was endorsed by two participants in this study, Lucinda and Peggy, as a way to destress. A systematic review of eight studies on the effects of mind-body therapies on perimenopausal symptoms found that a trial of yoga reduced hot flushes and improved attention, concentration and memory more than exercise did (Woods et al., 2014). The yoga group also had less pain symptoms and less sleep symptoms (awakening during the night, difficulty getting to sleep, early morning awakening, and sleep disorders). Another study found that yoga decreased the degree to which hot flashes were bothersome (Booth-LaForce, Thurston, & Taylor, 2007). Mindfulness based stress reduction exercises, such as, but not limited to muscle relaxation, breathing and relaxation interventions were found to improve mood symptoms (depressed mood, mood changes, crying, irritability, anxiety, melancholia) as well as sleep symptoms (Booth-LaForce, Thurston, & Taylor, 2007). The researchers found that mindfulness exercises also reduced hot flashes over time. Similarly, a doctoral dissertation about mindfulness interventions for midlife women found that depressive symptoms, psychosocial stress, anxiety and sleep quality improved slightly after eight weeks (Frisvold, 2009).

Meditation practices were found to be beneficial in helping people to bounce back from adverse situations when combined with education (Saunders, 2015). One participant in the current study mentioned meditative aspects of yoga as helpful for increasing her resilience in her struggle to maintain her weight loss when she had gained weight. Peggy said of yoga, “It’s a mental thing because it’s all about being focused and centered. And that’s what yoga teaches
you, you know, meditation.” Weight loss maintenance in this study was portrayed as practicing body mind awareness and vigilance while struggling to maintain.

Lastly, a study found many benefits of physical activity for perimenopausal women: prevention of weight gain, improved sleep, improved mood and well-being, improved mental and physical aspects of quality of life, and reduction in postmenopausal breast cancer risk (Sternfeld & Dugan, 2011). However, findings from a 2012 Cochrane review of exercise and nutrition interventions that addressed perimenopausal changes in body weight did not provide strong evidence that dietary and exercise interventions would reduce abdominal adiposity characteristic of the menopausal transition. The researchers concluded that there is a need for “high quality” studies in this area. Women in this study would concur. Research looking at what sustained physical activity long-term (beyond one year) found that the major influences were “incorporation of physical activity into the self-concept” and having self-efficacy for exercise (Crain, Martinson, Sherwood, & O'Connor, 2010). Among physically active older adults, exercise behavior continued when they negotiated a follow-up plan with a provider that included telephone reinforcement at 18 months (Ory, Smith, Mier & Wernicke, 2010).

Women in the current study varied with their abilities to persevere with weight loss and weight loss maintenance prior to midlife, as well as during the midlife weight loss maintenance period of this study. Most of these women stuck meticulously to a small 1-3 pound weight range during weight maintenance; whereas a couple had difficulty maintaining this weight range at certain times and gained a bit more, then struggled to lose and then maintain again. Most women monitored their weight or the fit of their clothing and made immediate small adjustments in eating and exercise to return to a particular weight. In contrast, two participants had more
difficulty maintaining a particular weight. Ava and Ella described their eating behavior as “like an addiction.” Ella is an alcoholic in recovery and Ava has a brother who is an addict. Ava described a strong need for salty, fatty snacks from time to time that became her entire diet for the week during weight loss maintenance. She described giving in to periods of impulsive binge eating. However, she had a clear upper weight limit and said she never surpassed that. Tamara stated that during prior unsuccessful weight maintenance experiences she could not stop eating or never have just one desert. She characterized her current maintenance eating as, “I really don’t compulsively eat anymore. I eat like a normal person.” Patterns of overeating have been considered within an addiction framework because of the following characteristics: diminished control or loss of control while eating, food cravings, and continued behaviors despite negative consequences (Balodis, Grilo, & Potenza, 2015). According to these authors, functional and structural neuroimaging studies of people with binge eating disorder are only beginning to emerge; however, evidence shows that binge eaters have greater sensitivity to food cues, which helps explain the motivation to seek certain foods as well as the rewards. Other recent neuroscience research investigated urges to eat junk food and found associated triggers that affect the nucleus accumbens brain area (Oginsky, Goforth, Nobile, Lopez-Santiago, & Ferrario, 2016). Foods that seem to reward this neurocircuitry most are high in fat, sugar or salt (Balodis, Grilo, & Potenza, 2015).

A woman’s mind-set about her weight may affect her ability to maintain a particular weight. Some studies demonstrated that women dieters trying to lose weight experienced more food craving than women who watched their diet so they did not gain weight (Massey & Hill, 2012). Nearly all women in my study volunteered comments about the temptation of food desires and
cravings during weight loss and weight maintenance phases, and spoke about strategies they used to prevent eating or over eating these foods in order to sustain their weight loss. Some spoke at length about habits such as how they meticulously planned ahead to ensure having healthy food choices always easily available, or self-talk they engaged in to support making the healthiest choice most of the time. Most women in the current study mentioned specific foods they enjoy but no longer eat very often, or in large amounts, such as sugar and other carbohydrates, and unhealthy fats. They all spoke about acceptable portion sizes.

Another experience that may have been characteristic of women in the current study relates to psychological issues that may have influenced their ability to persevere. Two phenomenological nursing studies (Pilkington, 2000 & Kostas-Polston, 2007) explored the experience of persisting while wanting to change, which provides more understanding about weight loss maintenance during perimenopause as it relates to the interpreted theme, “Weight loss maintenance during perimenopause is a journey guided by an enduring faith and commitment toward a more ideal self and future quality of life by coping with the struggles of midlife through, perseverance, positive thinking and support.”

These two nursing studies followed Parse’s theory of human becoming as a way to understand a person’s experience of voluntary behavioral change. Pilkington found three themes in her study that are also apropos to the current weight loss maintenance study: “waverning in abiding with the burdensome-cherished, engaging-distancing with ameliorating intentions, and anticipating the possibilities of the new.” Pilkington’s participants, in addition to participants in the current study, envisioned future possibilities, considered their options and the likely consequences of their choices. Women in the current study persisted with unhealthy choices at
times, but chose not to make unhealthy choices become an overwhelmingly self-defeating pattern. They had a vision of having a healthy future.

The other qualitative study (Kostas-Polston, 2007) found a theme of “acquiescing with the customary amid relinquishing aspirations in persisting while wanting to change.” Participants in the Kostas-Polston study also spoke about ideas that the women in the current study referred to. They talked about their struggle to change or maintain change vs persist in familiar ways. They also acknowledged their freedom to choose and a need to take responsibility to decide.

Women in the current study provided many examples of persistent struggling with their new way of being, which was weight maintenance. Even though they committed to weight loss maintenance and invested substantial thought, energy and willpower to do so, it was nevertheless easy for them to veer from mindfulness and perseverance and subsequently gain weight. Rather than proceeding consistently and continually to maintain their weight change, some women reverted back to previous negative habits. Despite the draw of persisting with habits that contributed toward weight gain, or the struggle not to regress and revert back to consuming comfort foods or over eating, the women in the current study were able to maintain a ten percent or more weight loss for a year or longer. Actively persevering through difficult times to maintain weight loss involved the paradox of persistence vs change to pursue what the women valued for themselves. This illustrates the complexity of weight loss maintenance during perimenopause, as well as the interrelated nature of the essential themes of this study.

The experience of having supportive relationships emerged as a major aspect of weight loss maintenance among women in my study. This finding is supported by research in the area of positive psychology. Proponents of positive psychology focus on a person’s positive attributes,
such as support derived from relationships and the good feelings that the experience of support engenders (Seligman & Csikszentmihalyi, 2000; Seligman 2005). In this study, women preferred to have another person or persons who provided a positive attitude, some motivation and perhaps an opportunity for altruism. Many had established new friendships to have this. Some women deliberately sought out an exercise buddy, a nutritionist a physician, or environments that would help them to achieve their goals, such as a gym, swimming pool, Weight Watchers, Overeaters Anonymous, blog sites or healthier eateries. Most women mentioned the helpfulness of structure that a buddy or program provided and said that this helped guide them.

Future research may enlighten us about which types of positive supports are essential versus critical for different types of circumstances perimenopausal women face. For example, one weight loss maintenance study of predominantly midlife women found that when friends verbally encouraged participants about healthy foods to eat, that the participants had more weight regain compared to those who were not encouraged by friends (Brantly et al., 2014). Similarly, this study also found that Black participants who were encouraged by friends to exercise had greater weight regain.

Positive psychology research shows that people who felt thankful for their perceived connectedness to others were more optimistic and felt better about their lives in general (Duckworth, Steen, & Seligman, 2005). The participants in this study depended upon their supportive relationships, although verbalized the realization that during their weight loss and weight loss maintenance, they alone were responsible for deciding to maintain their weight loss. Qualitative studies that looked at the meaning of aging in late midlife women also found that connectedness to others stood out as an important aspect of redefining themselves and finding
meaning in life (Ritchie, 2012; Wiggs, 2009). Similarly, another qualitative study found that after midlife, women found meaning primarily from their relationships, as well as psychological, intellectual and spiritual growth (Harrison, 1994). The driving force behind Brene Brown’s previously mentioned research on vulnerability is the desire for human connection. Brown believed that we must risk shame and vulnerability to find true connectedness with another (Brown, 2012).

Positive comments about the value of relational connections made by participants in this study were prefaced with statements about the need to actively pursue these connections and the realization that some of the relationships changed over time. For example, Sally and her husband resolved one year to lose weight together, but she decided to remain committed when he could not and she found helpful work related relationships for lunching. Similarly, Lucinda abandoned exercising with her husband because he could not keep up. The nature of Ella’s relationship with her nutritionist changed over time from nearly complete dependence to Ella becoming much more independent. Some women needed to attend a support group regularly; whereas, others needed the group only on occasion. Those who attended a support group found it helpful or even necessary to effect change and maintain weight loss. The group support helped foster their belief in their ability to maintain their weight goal.

Positive psychology suggests that emphasizing the good aspects about oneself and having an optimistic attitude may buffer pathology (Seligman & Csikszentmihalyi, 2000; Duckworth, Steen, &Seligman, 2005). In the current study, pathology would refer to an underlying need to undermine one’s goal, among other types of issues. The women in this study spoke about their struggles to maintain their weight loss, but pessimism was not heard, even though some had
experienced weight regain after previous weight loss. To maintain an optimistic attitude about weight loss maintenance, a positive relationship with themselves as well as with others helped, which, as previously mentioned, meant having self-compassion when they faltered from weight loss maintenance goals.

Caring for self among women in this study was also characterized as having awareness of personal strengths. Areas of strength women in this study recognized and exploited appeared to be acquisition of confidence from having achieved midlife weight loss, and optimism about maintaining the loss, as well as the capacity to obtain the knowledge and resources needed. These strengths added to their ability to be resilient, which is a goal of positive psychology. Other areas where tenants of positive psychology were apparent in women in this study included the research on concepts such as subjective well-being, happiness, optimism and self-determination because they all related to caring for self as well as being receptive to support from others (Seligman & Csikszentmihalyi, 2000). Some examples were Ella’s self-affirmation while proudly gazing at herself in a full length mirror, and other participants’ positive comments about their improved appearance and feelings of accomplishment.

Many of the participants in the current weight loss maintenance study spoke about how particular relationships helped and about how they helped others. Altruism is viewed as one among many positive social behaviors correlated with emotional intelligence (Keidar & Yagoda, 2014). Neuroscientists and social psychologists have viewed motivation for altruistic behavior from two perspectives, as empathy or as reciprocity (Gluth & Fontanesi, 2016). One is an empathic response to another’s suffering, whereas, the other is an obligation to return a favor. It
would be interesting to include assessment of many criteria believed to constitute emotional intelligence and determine whether there is any predictability for weight loss maintenance.

A general analysis of the participants’ weight loss maintenance experiences in this study may also be viewed from the perspective of Frank, a medical sociologist, who wrote about the body as a topic. Two body typologies that Frank (1991) characterized are: the disciplined body and the communicative body. Frank suggested that “control, desire, self-relatedness and other-relatedness” constitute the disciplined body (p.55). The participants in the current study chose to exert control over their future well-being by engaging in predictable self-care that resized and reshaped their bodies. Secondly, the women had a desire to remain healthy and independent; however they realized this could only occur when they matched their desire with commitment sufficient to effect behavior change. Lastly, the way each woman related to her body was intertwined with her conception of herself in the world, her self-image. Each participant’s narrative revealed a sense of self and body characterized by plurality and ambivalence. Frank posited that one’s body is socially constructed through human interaction and action and is therefore, inextricably linked to relationships with others and to social forces (p. 49). For each participant in the current study, self-identity and identity re-construction, as well as presentation of self before others involved her body.

Frank conceived of the communicative body as one essentially engaged in a form of praxis, or reinvention when he wrote that it is a body “in process of creating itself” (p.79). This type of body is self-aware and unpredictably recreates its everyday world. Women in the current study needed to be self-aware and introspective about their body weight in the context of their
perimenopausal bodily changes and changing sense of self. Each woman arrived at unique plans and varied changeable behaviors to maintain her weight loss in the context of perimenopause.

Although he wrote about illness, Frank concluded that the presence of significant disease changes a person’s view of future life and the fundamental meanings of life (Frank 1998). Frank suggested that a way people could care for themselves would be to relinquish the tendency to be passive victims of disease with bodies that are different from others and take planned actions to be involved in their experience in ways that are meaningful to them. This point of view is in keeping with existential philosophy and the paths chosen by the participants in this study.

The literature just discussed provided understanding about women’s experience of weight loss maintenance during perimenopause. The interpretive statement contributed insight into the women’s day to day authentic existence and reflected four prominent existential themes: choice, freedom, commitment and self-identity. The women attempted to live a life with meaning, in the moment, despite challenges, while they hopefully envisioned a healthy future with good quality of life. This study was based upon the existential thought of Heidegger and Merleau Ponty and the idea of intentionality grounded in Husserl’s phenomenology. The research process for this study exemplified in a quote from Merleau-Ponty, “Philosophy is not the reflection of a pre-existing truth, but, like art, the act of bringing truth into being” (Merleau Ponty, 1945/1962). These philosophical ideas lend understanding to the meaning each participant found during the perimenopausal phase of life as each participant committed to becoming more the self she wanted to be.

**Thematic Statement Reflection Using a Nursing Model**
Caring is a central concept in nursing and several models or theories of caring have been developed based upon a human science perspective to promote health. The model used for this study is Watson’s Theory of Human Care. Theory as a word is rooted in the Greek theōros for spectator and later in theoria, which meant contemplation. Jean Watson, a psychiatric nurse believes that theory means “to see.” (Watson, 2012, p.1). Her theory has metaphysical origins, meaning it is based in a philosophy of being and knowing, which makes her theory compatible with the simultaneity paradigm in nursing (McCance, Mc Kenna, & Boore, 1999) and qualitative research. The simultaneity paradigm is oriented toward quality of life from the patient’s perspective, and views a person as being able to freely choose about health matters through a “mutual interchange with the environment” Parse (1987). An important point is that the patient (person) has the ultimate authority about accepting or rejecting nursing care, which is “cocreated” within the transpersonal relationship.

Watson’s theory has been continually evolving since 1975. She has authored subsequent books and articles using her theory directed toward practice, education and research to the present day. Currently Watson speaks about body, mind and spirit as units for caring to attend to and that “caring touches the depth of our humanity” (Watson, 2012b). Caring theory encompasses multiple ways of knowing about another. Watson said, “Compassion is central as caring resides in our hearts (Watson, 2012b). Watson has authored subsequent books and articles using her theory directed toward practice, education and research to the present day. Watson described in detail how the following are viewed within her framework: caring, a human being, nursing, environment, well-being, health.
The focus of Watson’s theory is the lifeworld of the experiencing person (Ranheim, Kärner, & Berterö, 2012). Watson’s theory places value on the nurse patient relationship. Her theory revolves around helping a person, group or family to experience more harmony within their minds, bodies and souls as a result of caring transactions from a nurse (McCance, McKenna, & Boore, 1999). Watson suggested that the caring nurse patient relationship can promote healing. Watson believes nurses provide care for the patient’s fundamental needs but also provide caring for the patient’s values and experiences (2007). One outcome when using Watson’s “caring healing” theory is that patients find meaning in their illness, suffering, pain or existence (McCance, McKenna, & Boore, 1999). Three major concepts that accompany Watson’s current theory are: a transpersonal caring relationship, carative factors, and caring moments. The nurse detects the person’s “condition of being” and “feels this” with the person” (Watson, 2007). Transpersonal caring is the nursing approach suggested by Watson to achieve connectedness with a patient so that they may engage together in a process of change. A transpersonal caring relationship is characterized by the nurse’s intentional moral commitment to protect, enhance and potentiate human dignity, and involves the nurse and patient in a mutual search for meaning and wholeness (Watson, n. d.). Caring moments between a patient and a nurse are described as uninterrupted time spent with a patient to make a human-to-human connection.

Watson’s theory describes ten carative factors, later renamed caritas, and ten well defined carative processes aimed toward healing. The original carative factors (caritas) in Watson’s theory were based upon the curative factors in Yalom’s existential theory as applied to the process of group psychotherapy (Watson, 1979). Caritas and carative processes are of a spiritual, emotional, and human care-giving nature that serve as a guide to clinical implementation of the
theory. These factors impart values important in the helping relationship. The Greek origin of caritas means to cherish, to appreciate or to give special attention to (Watson, 2010; 2012b). The following ten caritas processes illustrate Watson’s focus for nurses:

Watson’s Ten Caritas Processes 2007

1. Embrace altruistic values and Practice loving kindness with self and others within the context of caring consciousness.
2. Instill faith and hope and honor others.
3. Be sensitive to self and others by nurturing individual beliefs and practices.
4. Develop helping – trusting - caring relationships.
5. Promote and accept positive and negative feelings as you authentically listen to another’s story.
6. Use creative scientific problem-solving methods for caring decision making.
7. Share teaching and learning that addresses the individual needs and comprehension styles.
8. Create a healing environment for the physical and spiritual self which respects human dignity.
9. Assist with basic physical, emotional, and spiritual human needs.
10. Open to mystery and Allow miracles to enter.

Watson’s theory can best be explained as having humanistic, phenomenological, existential and spiritual origins, and is applicable to this study, the experience of weight loss maintenance during perimenopause. For example, Watson asserts that “the basis of human experience” is to persist with “both the good and the bad in life and life’s journey,” as we strive or struggle to actualize our real selves (2012, p.69). This particular belief is consistent with several of the essential themes in the current study of women’s weight loss experience during perimenopause.
The seven essential themes derived from the findings in my study were interpreted into the following statement: *Weight loss maintenance during perimenopause is a caring journey guided by an enduring faith and commitment toward a more ideal self and future quality of life by coping with the struggles of midlife through mindfulness, perseverance, positive thinking and support.* Watson’s theory pertains to this study, which is about women caring for their futures by caring for themselves in the present. The implications for nursing are discussed below.

**Implications for Nursing Practice**

This phenomenological study provided an emic understanding of a lifeworld when the participants engaged in weight loss maintenance during perimenopause. The purpose of this study was to understand the experience of weight loss maintenance during perimenopause because so few women have been successful. I believe this study will be of value and possibly inspiring to women who affirm their own commitment to weight maintenance by choosing to make healthier decisions as they respond to the challenges of midlife. I understood that women participated in this study to use their experience in a way that has meaning for other women. Following the initial interview, many of the participants expressed that it had been an enriching experience to look back across their lives and experiences and see how they had faced their weight challenges, how they had overcome some of the related challenges of midlife, and become more self-satisfied because of their weight loss maintenance experience.

The study findings will be discussed next in relation to the discipline of nursing.

**Discipline of Nursing**

The central concepts of the discipline of nursing are health, person, environment and nursing. Specifically, this refers to “the environment within which the person exists, the health–illness
continuum within which the person falls at the time of the interaction with the nurse,” the person who receives nursing care, and “the nursing actions themselves.” (Flaskerud, & Holloran, 1980 cited in Fawcett, 1994, p. 5). The art and science of nursing are based on a framework of caring, respect for human dignity, compassion, and knowledge based competent care. The following discussions about nursing practice, nursing education and nursing research illuminate how nurses can use the findings of this study to benefit women.

**Nursing Practice.**

Nursing is a practice discipline. Use of a theoretical framework provides a systematic and knowledgeable approach to nursing practice and becomes a tool that assists nurses to think critically as care is planned and provided. Nursing practice guided by theory provides insight into different ways to describe, explain, and provide patient centered nursing care. Practice from the perspective of Watson’s Caring Theory framework dovetails with theory and research findings related to the seven essential themes of this study, especially the emphasis on the relationship between the nurse and the patient as a vehicle for health promotion. Meeting a patient as another person and learning about her priority of concerns takes precedence over any other agenda. The nurse tries to understand the patient’s consciousness in terms of how the patient thinks about herself that gives meaning to the patient’s life. The nurse needs to create an environment of trust, understanding and openness so the nurse and patient can work together to meet the patient’s needs. Intentionality, being with the patient with focused consciousness, must exist to convey caring and ultimately promote health.
Nurses who understand women’s barriers to practicing perimenopausal self-care to the extent desired can collaborate with women to find appropriate ways to facilitate self-care within the context and time constraints that women experience. This highlights the importance of Watson’s concept of the transpersonal relationship, where the art and science of nursing exists. A caring model is different from the biomedical orientation.

This study highlighted that women needed to decide for themselves when they were ready to seek guidance about body weight as a health issue. Factors that contributed toward their self-care and examples of self-care were discussed. Issues that may have impeded self-care were also identified.

Another practice issue regarding midlife weight is that compared to pregnancy and childbirth, women in general are not supported sufficiently with information about the transition to perimenopause, which the cited research in this study demonstrated was one of the needs women had. The data suggested that women who are intrinsically motivated to obtain knowledge about perimenopause can proceed fairly independently as the women in this study did. But data from studies cited revealed that women said they would benefit from providers disseminating knowledge and encouraging discussions about the perimenopausal phase of life. There is a need to specifically provide health education to assist women prior to, during and following the menopausal transition regarding body weight. Unfortunately, 76% of nurses do not pursue the topic of body weight with overweight or obese patients (Miller, Alpert & Cross, 2008), so this is an area of practice that deserves attention.

One study cited earlier, which has implications for educating patients, identified what kind of health information perimenopausal women most wanted (Trudeau, Ainscough, Trant, Starker,
& Cousineau, 2011). Women identified four areas of concern. One was that women desired knowledge about post-menopausal health. Three of the four areas involved mental health needs: 1) how to cope with the perimenopausal symptoms of weight gain and maintain a healthy weight, 2) what is the “best way to beat the blues when menopausal changes get you down,” and 3) “when to be concerned about being depressed.” Most participants in this study learned about perimenopause and aging firsthand as they went through it, even though two were nurses. Nurses could become more aware of research findings to use in their own clinical practices. For example, viewing the therapeutic transpersonal nurse patient relationship within the context of hope builds on previous theory and research.

The literature demonstrated that to assist women with weight loss maintenance, nurses need to do more comprehensive assessment. Areas that could be included in advanced assessment are: self-concept, body image, locus of control, body satisfaction, mental health, hopefulness and future goals. Data showed positive linkages between internal locus of control and body satisfaction, psychological well-being, weight loss, and doing exercise. To incorporate some of these concepts into practice, it is suggested that nurses consult with or refer to advanced practice mental health nurses.

Nurses could also assess a woman’s perception of her own mother’s attitudes toward the menopausal transition to help predict which women may require more support, since research found a relationship between the two. Also, a woman’s attitudes and beliefs about this transition influenced whether the degree to which experience of symptoms were bothersome or not. Sensitive, positive and comprehensive healthcare support for perimenopausal women needs to
include women’s subjective perspectives of perimenopause, and integrate the mental health
issues discussed into the context.

There is a need to assess mental health as a standard part of midlife women’s health care
to note information about overall functioning, and current, recent and past mental health,
including any history of trauma. Physical, psychological and emotional changes that women
experience during perimenopause can create uncertainty, stress, anxiety and depressive
symptoms. Perimenopausal women and their providers need to be aware that emotional
variability during the menopausal transition can be large and is not uncommon. There is a
need for providers who are expert at assessing midlife women for various indicators of mental
health, such as eating and sleeping patterns, body image, body satisfaction, self-concept, current
stressors and coping strategies, nature of relationships, as well as for signs and symptoms along
the continuums of anxiety and depression. Attention to mental health needs could foster
perseverance during weight loss maintenance with appropriate interventions. Interventions to
foster mental health would encourage midlife women to explore their beliefs about the
menopausal transition and to engage in activities they find rewarding.

Nurses need to assess and screen for depressive symptoms and patterns prior to and
throughout the perimenopausal transition, as well as for duration and severity. Women who
have a history of mental illness indicates that the nurse provider would anticipate possible
recurrence of symptoms during the midlife transition, and that more vigilance would be
warranted for women who have had high levels of symptoms in the past. Improvement in
symptoms at one time point might not be stable and warrants ongoing assessment, as well as
using interventions with long term effects. Some examples from the literature included interventions aimed at self-management and cognitive behavioral therapy based treatment modalities.

An additional area of concern for practice is a need to assess for and tailor weight loss maintenance interventions to address eating disorders in midlife women, since 13% endorse disordered eating behaviors (Pacanowski, Senso, Oriogun, & Sherwood, 2014). This is warranted given its prevalence and the different rates of weight regain experienced by those reporting this behavior, as well as subsequent morbidities or mortality. Coordinated follow-up for eating disordered behavior is important since treatment may involve a variety of modalities such as hormone therapy, antidepressant therapy and psychotherapy (Pacanowski, Senso, Oriogun, & Sherwood, 2014).

Nurses who want to help a midlife woman achieve better health need to be aware of the woman’s hopes and future goals so that her health related expectations can be better assessed, and interventions tailored to meet more unique needs. It is important to apply psychological theories to understanding weight loss maintenance during perimenopause. Specifically, a need exists for unique emotional support for perimenopausal woman engaged in weight loss maintenance. It is important to learn about the woman’s coping strategies surrounding midlife issues and whether a need exists to learn more. The nurse must ask whether anyone really knows what she is going through and who she receives emotional support from regarding weight loss and weight loss maintenance. The nurse could facilitate finding this type of relationship.

Health care professionals are confronted with ethical beliefs about a duty to promote health and do no harm. A duty exists to educate or counsel an overweight or obese patient about
potential morbidities, costs, and decreased quality of life, but this may conflict with underlying beliefs about a patient’s autonomy and the pursuit of happiness. This respect for human beings is rooted in beliefs about one’s freedom to make free choices with as little interference as possible from sources that limit our choices (Lambert, 2003; Smith, 2009). Some providers feel uncomfortable or think it’s disrespectful to confront a woman about her weight. However, since health professionals have knowledge of the harm that overweight and obesity can cause to the person, her family members and society, adhering to a philosophy of free will may interfere with a provider’s obligation to inform and provide support tailored to needs.

Despite the fact that many Americans are overweight or obese, provider reluctance to engage a woman about her weight may have roots in stigma (previously identified), or a belief that the now ubiquitous nature of overweight and obesity means it is inevitable, except for the genetically lucky, and rationalize that there is no point to intervene. Both viewpoints interfere with access to care and with quality of care provided. Health research demonstrates that overweight exists across gender, age, socioeconomic status, racial/ethnic groups and in geographic regions (Wang, 2007). This is relevant to nursing, which has a long standing tradition of caring for those with chronic illnesses (which occur as a result of overweight/obesity), and for those where disparity exists, such as women’s health and weight loss maintenance. Nursing also demonstrates an evolving dedication toward prevention of chronic conditions, which decrease quality of life, and increase morbidity and premature death. Physical activity and diet are modifiable conditions that nurses and other health care practitioners need to address with patients and the community.

Lastly, an important caveat to consider for nursing practice is that in Watson’s view, in order to care for others, it is equally important to care for oneself using mind/body/spirit approaches to
health. Watson asserted that as caregivers, nurses first “need to love, respect and care for ourselves and treat ourselves with dignity before we can respect, love and care for others and treat them with dignity” (2012 b, p. 63). An accepted hallmark of competent nursing practice includes provision of holistic care; however, holistic activities centered on self are less prevalent for nurses, many of whom are noted to experience job related injuries, burnout related to job stress and subsequent unhealthy lifestyle behaviors (Letvak, 2014; McElligott, Siemens, Thomas, & Kohn, 2009). Chronic stress has been associated with an increase in inflammation along with an increased appetite and preference for high fat and high sugar foods (Reed, 2014). The foods that may be bypassed when we are stressed are the very ones that help to decrease inflammation and subsequent oxidative stress, such as antioxidant nutrients and healthy fatty acids (Reed, 2014). Nurses need to be better prepared to maintain their psychological well-being with strategies that develop behaviors to limit and cope with stress.

Ironically, hospital environments, where most nurses are employed, have not been developed to promote self-care among nurses, yet nurses are enculturated to teach patients about self-care and to provide high quality care to patients. The literature identifies only a small number of hospitals whose administrations subscribe to any of Watson’s tenets (Adventist Health System, 2014).

A nurse scholar (Letvak, 2014) recently wrote an overview of a series of seven articles that address different aspects of how nurses could better care for themselves. Suggestions were: use effective interpersonal communication, have a healthy diet and regular physical activity, maintain a healthy weight, get adequate sleep, and use specific self-care activities to reduce stress. These same self-care activities were identified in the current study as part of what was
necessary for the experience of weight loss maintenance during perimenopause. Nurse self-care is important because at least 54% of registered nurses are overweight or obese and more than one-half of this group lack the motivation to make lifestyle changes (Blum, 2014). The average age of the U. S. nurse workforce was estimated to be 44.4 in 2015, so issues related to self-care during perimenopause are germane (Auerbach, Buerhaus, & Staiger, 2015).

Hospitals and other areas where nurses practice could reduce absenteeism and healthcare costs and improve employee health by provision of proactive programs for nurses regarding weight related self-care. Advanced practice nurses such as clinical nurse specialists or nurse practitioners who specialize in women’s health or psychiatric mental health nursing are able to collaborate and provide such programs. The recent articles mentioned above that were overviewed by Letvak have been published to address how nurses can engage in self-care, which can be put into institutional as well as personal practice (Albert, Butler, & Sorrell, 2014; Blum, 2014; Jackson, Fraser, & Ash, 2014; Nahm, Warren, Friedmann, Brown, Rouse, Park, & Quigley, 2014; Speroni, 2014; Vertino, 2014).

**Nursing Education.**

The study findings have implications for nursing education curriculum development in baccalaureate (BSN) and nurse practitioner programs. The curriculum for BSN students could include courses in women’s health that highlight the perimenopausal woman’s self-care needs. However, textbooks lag behind and do not include adequate content about this topic. There is a need to heighten provider awareness and responsibility about the need for midlife women to avoid excess weight because of the known myriad of related negative health outcomes.
Textbooks could expand content about lifestyle changes to maintain a normal range BMI and include some content about weight loss maintenance. Appropriate nurse practitioner curricula should examine in detail the changes associated with perimenopause and women’s experiences of these changes. One example is that nurse educators could use the qualitative findings from a feasibility study (Trudeau, Ainscough, Trant, Starker, & Cousineau, 2011) to develop curriculum about the specific areas for which menopausal women desire health information.

There is a need to improve students’ knowledge about taking care of their own health. As previously stated, in order to care for others, it is equally important for providers to care for themselves, which is a tenant the American Nurses Association espouses for nurses (Letvak, 2014). One aspect of self-care is managing body weight. Day long learning experiences, typical of nursing education, can be stressful and unhealthy and contrary to principles of learning. Perhaps nursing faculty could lead by example and better design programs that allow and encourage time for self-care practices that help manage body weight.

Lastly, registered nurses and advanced practice nurses need to consult with other professionals in practice, such as credentialed nutritionists, registered dieticians, pharmacologists, psychologists and physicians to help prevent perimenopausal weight gain.

**Nursing Research.**

Issues concerning perimenopausal and menopausal women moved forward with the publication of large national studies such as the Women’s Health Initiative and the Study of Women Across the Nation. However, current nursing knowledge disseminated in the nursing research literature does not include sufficient studies of the phenomenon of weight loss maintenance during perimenopause. Thus far only five studies exist about psychosocial factors
of weight loss maintenance that include any midlife women (Brantley et al., 2014). Nurses and other providers could develop studies to further explore psychosocial factors that affect weight loss maintenance during perimenopause among women with divergent socioeconomic backgrounds, educational levels, baseline health issues and access to resources.

Nurses need more knowledge about how to best help women with weight maintenance during perimenopause. Only a limited number of quantitative studies on this topic exist in the nursing literature. Thus nurses lack understanding of how to engage with women and help them maintain a normal range BMI. How use of coping strategies affect quality of life is an area of research that has received little empirical study but warrants further scientific investigation.

One other suggested topic for further investigation would be to see if interventions geared toward external locus of control help overweight midlife women chose to engage in regular physical activity. Looking at racial differences, as well as who the suggestion comes from would follow-up with previous research. Further investigation is also warranted with overweight women who chose to avoid exercise and interventions targeted to improve their internalized negative societal attitudes about overweight.

Several concepts studied in the literature really pertain to mental health, so it would be useful to study how able the average primary care or women’s care nurse is to assess these needs compared to psychiatric mental health nurses or advanced practice nurses. Perhaps understanding weight maintenance struggles during perimenopause requires knowledge beyond a baccalaureate registered nurse level. Questioning knowledge and skills needed to assess and intervene is further highlighted when some self-identified needs of perimenopausal women are considered: 1) how to
cope with the perimenopausal symptoms of weight gain and maintain a healthy weight, 2) what is the “best way to beat the blues when menopausal changes get you down,” and 3) “when to be concerned about being depressed.”

To conclude, more clarity from research and clinical practice needs to be realized about what supportive resources and behaviors are necessary in order to sustain a lower weight, and what strategies may help.

Some nurses do provide weight-related health information to the public. However, as emphasized previously, the data suggests that most nurses need to do more. Some believe nurses need more knowledge about obesity assessment and associated health risks of obesity (Miller, Alpert, & Cross, 2008). Many, but not all, aspects of a holistic assessment and appropriate interventions that represent research findings thus far require advanced practice nurses. How might nurses intervene early in women’s lives to encourage changes that positively affect health in later years? Nurses need to learn what the appropriate moments are to routinely encourage lifestyle changes that would protect women from weight gain as they age. Nurses also need to learn about patient sensitive interventions and perhaps discover more. To accomplish this initiative, nurses may benefit from more education about how and when to pursue sensitive topics such as being overweight and its risks, weight loss, and weight loss maintenance during a professional encounter. For example, nurses could use evidence from research on women based on hope theory to support women with their weight related goals and engage in self-care (Kelsey, 2011).

This study has demonstrated the interconnectedness of seven themes that emerged from successful weight loss maintenance for a small group of perimenopausal woman. This evidence
based knowledge can be a starting point for providers interested in improving weight related health outcomes for midlife.

**Recommendations for Further Study**

Recommendations offered for further study are based upon my analysis of findings and understandings about the experience of weight loss maintenance during perimenopause. The current study had seven participants, six Caucasian and one African American. Six were born and raised in the U.S., and one emigrated from Italy as a child. Three identified culturally as being from a European Jewish background and three as Italian Americans. It is recommended that the study be replicated using a larger and more heterogeneous sample to better understand the experience of weight loss maintenance during perimenopause. Bearing in mind that phenomenological experience always has a social context of being, which includes culture (Crotty, 1977), there may be additional findings from a larger more diverse group that could further illuminate the meaning women attached to their experience of weight loss maintenance during perimenopause. Also, to further understand mid-life aging from women’s perspectives, qualitative studies are needed with perimenopausal and recently postmenopausal women.

There is a need for future research to explore taken for granted practices within healthcare related to midlife women and overweight women. Investigation is warranted about exploring a positive role nurses could play in caring for midlife women, midlife overweight women and midlife women who try to maintain a weight loss, which is based upon a caring relationship. Measuring a caring relationship as a health care intervention is not readily amenable to rigorous experimental research design. However, future qualitative investigation would provide more explicit evidence about qualities required in a nurse for caring, such as knowledge, attitudes,
beliefs, values, empathy, self-care, and communication skills, and whether the nurse and patient perceived that a caring relationship existed, and whether the relationship promoted healthful changes. Further qualitative study may reveal the appropriateness of various aspects of caring measured by the extent to which the care meets the needs of the patient experiencing it. Further qualitative research may also help to understand which relationship based interventions work, when they work and how they work. Variables such as the appropriate timing and the context of caring comments would be important to understand, as well as any other appropriate variables to be measured in future quantitative research. Studies could compare the effectiveness of motivational interviewing vs standard care to engage midlife women in weight loss and weight loss maintenance. This could be useful for comprehensive employee wellness programs. Comparison of qualitative outcomes of care could help build evidence based practice. Research related to a caring relationship that helps meet health needs of overweight midlife women has applicability not only for nursing education and practice but for other health disciplines as well.

Further research needs to identify helpful coping strategies for midlife women to learn and practice either before or when they are engaged in weight loss maintenance. Future inquiry is also needed to understand how being overweight, depressed or anxious effect quality of life in perimenopausal women. It would also be helpful to understand how particular coping strategies affect quality of life for midlife women. Also, understanding how to sustain weight loss over time remains a little researched area. Continued knowledge would promote health and reduce chronic illnesses.

Additional research about the concept of hope as it relates to weight loss maintenance would add to the small body of knowledge. This seems particularly promising in terms of a philosophy
for the context of a helping relationship. Weight loss and weight loss maintenance studies could further explore the construct of hope using one of the available scales to determine correlations among aspects of hopefulness, weight related self-care, BMI changes over time and self-rated health.

**Limitations and Strengths of Study**

This study has strengths as well as some limitations, as is the case with any research. One limitation was the lack of objective data about weight, and perimenopausal status. In this study four data points were accepted based upon self-report: a woman’s age during mid-life when the pattern and character of menses began to change, her weight during perimenopause that prompted a weight loss, her maintenance weight during perimenopause, and how long it was maintained. There is acknowledgment of bias in self-report of weight/height in some studies, as well as acknowledgment of agreement between self-report and measurement in others (Wang & Beydoun, 2007). Self-reported weight/height has been widely used in epidemiological studies, some of which were large national studies (Wang & Beydoun, 2007). This study was based upon the participant’s perception, and therefore was not designed to directly measure weight/height or abdominal girth. To minimize these limitations the researcher calculated the percent of weight loss based upon the participant’s reported values. Also, participants were not made aware of the inclusion criteria prior to the telephone screening for determination of eligibility so they were not able to adjust their values according to study criteria of achieving a $\geq 10\%$ weight loss for one year or longer.

A second limitation was that phenomenological research is not designed to be generalizable to a larger population. Purposive sampling, a feature of phenomenological research, precludes
random selection of participants; however, it allows for selection of participants for their experience of the phenomenon and a richer text (van Manen, 1990). This study sample was a small group of women who shared a common experience and the research sought to understand the meaning. Participants in this study also had other similarities: all were educated beyond high school, most beyond college, and all but one worked full-time. Additionally, all participants were Caucasian, except one, who was African American. However, a small sample size accommodates to the researcher’s capacity to collect and manage data with the labor intensive tools of in-depth interviews and observation (Mackey, 2007). To understand more about weight loss maintenance during perimenopause it would be necessary to conduct this study with women who represent a wider diversity of race, ethnicity, culture, socioeconomic class, educational level, and other demographic characteristics.

The exact findings of this study would not be reproducible because they are an interpretation and reconstruction of the textual meanings of each participant’s narrative during the interview. A different researcher may have elicited different narratives and arrived at alternative meanings. Phenomenological research does not expect exact repeatability, since the narratives and their analyses are based upon perception of an experience at a point in time that has passed, and future perceptions would vary, possibly as would analyses by different researchers. Although, “If the description is phenomenologically powerful, then it acquires a certain transparency…and permits us to ‘see’ the deeper significance or meaning structures of the lived experience it describes” (van Manen, 1090, p. 122). Lastly, the qualitative nature of the results render them difficult to present in a manner that is usable to practitioners as a prescriptive intervention.
Strengths of this study lie in the phenomenological method, which provided rich data from the experiences of the participants and in-depth understanding of the phenomenon, weight loss maintenance during perimenopause. Understanding the life-world of subjective knowers who experienced a maintained weight loss in their everyday existence, contributed to knowledge of their weight loss maintenance. Understanding meaning within their everyday existence and exploring the meaning of weight loss maintenance illuminated an understanding of perimenopausal women in regard to their experience of weight loss maintenance. However, the truth uncovered from lived experience can be transitory, since this reality is dynamic and always changing.

**Conclusions**

This study adds to the literature in emphasizing the importance of self-regulation and psychological factors in weight loss maintenance as goal for midlife women. The study demonstrated the interrelated nature of many cognitive, emotional and behavioral aspects of this process. Initially, during the evolution of the study (Chapter II), Bronfenbrenner’s (1994) ecological model was discussed to understand the variety of influences that impact behavior related to body weight. This perspective was useful from the biomedical perspective of health and illness that nurses entertain. However, the ecological model was not useful for the phenomenological perspective of understanding weight loss maintenance because it does not address existential philosophical ideas related to human behavior. This study was designed to lend understanding to the experience of weight loss maintenance during perimenopause and discover how nurses and other health professionals could assist midlife women who seek knowledge about their weight related health. The research literature emanated from several
different disciplines and lines of research. Findings of this study have implications for clinicians, educators and researchers.

Weight loss maintenance during perimenopause for all the participants entailed a life that embodied seven essential themes: 1) Revealing self and making a commitment toward a more ideal self, 2) Caring for myself released apprehension leading to a hopeful future with good quality of life, 3) Struggling with life’s challenges during perimenopause and maintaining weight loss, 4) Hopefulness promotes positive thinking and feelings and effective coping, 5) A journey guided by enduring faith in self amidst success and failure, 6) Perseverance despite life’s oscillating peaks and valleys, 7) Caring for self and being receptive to support from others. An interpretive statement of these themes was: Weight loss maintenance during perimenopause is a caring journey guided by an enduring faith and commitment toward a more ideal self and future quality of life by coping with the struggles of midlife through mindfulness, perseverance, positive thinking and support.

The analysis of women’s descriptions about the midlife weight loss maintenance experience detailed commonalities and unique differences that need to be considered in order to help them perform self-care long-term by sustaining healthy behaviors.

**Chapter Summary**

Chapter VI related the essential themes and interpretive statement of this study with extant literature, research studies and artistic expressions to further understand meaning in what the participants revealed about their lifeworld. Watson’s humanistic nursing model was presented as an appropriate fit for understanding the lifeworld of weight loss maintenance during perimenopause and as a framework for nurses who have the intent to engage in health promotion
and healing for women. The findings were discussed in terms of implications for nursing practice, and education. Recommendations for future research were posed for nursing as well as other health disciplines to encourage further knowledge development about weight loss maintenance during perimenopause. Also considered in this chapter were strengths and limitations of the study.

**Appendix A**

Definition of terms

The two terms defined in this study are body mass index and perimenopause. The first term, Body Mass Index (BMI), is used by NHANES as the measure of an adult’s weight in relation to height. Specifically it is an adult’s weight in kilograms divided by the square of the height in meters (weight (kg)/height (m²)) (CDC, 2011b; World Health Organization (WHO), 2011). For a 5 foot 4 inch tall woman, the desired weight category is a BMI of 18.5-24.9 Kg/m², which is 108-144 pounds. The overweight category is BMI ≥ 25-29.9 Kg/m² or 145-173 pounds, and obesity is BMI ≥ 30-39 Kg/m² or ≥174 pounds. Extreme obesity is ≥ 40Kg/m² or generally about 100 pounds above the recommended weight. The BMI range for each category is an estimation of one’s percentage of body fat and risk for some diseases (USDHHS, 2011c). Although not significant to this study of midlife women, using the BMI alone is an inaccurate predictor of chronic disease risk because it does not measure percentage of body fat or other risk factors for
poor future health. The BMI has limitations because the value would be greater in muscular people, since muscle weighs more; and in older people with waning muscle mass the BMI may be in a normal range, but the percentage body fat may be too high (CDC, 2010c).

The second defined term in this study is perimenopause. According to the World Health Organization (WHO) Scientific Group (1996) perimenopause is defined as the period of time with fluctuating ovarian follicular activity that precedes menopause (mean age, 51) through the one-year period after final menses. Perimenopause begins with a missed period or an increase in irregularity of menstrual cycles by more than seven days, and later includes up to 11 consecutive months of amenorrhea (Santoro & Chervenak, 2004). Cycle lengths greater than 42 days are usually predicative of the final menstrual period within the next four years (Santoro & Chervenak, 2004). According to Soares et al. (2003) it is likely that perimenopausal women will experience hormonal and consequent clinical changes such as hot flashes or night sweats until approximately two years of amenorrhea, at which time hormone levels tend to stabilize more. Other commonly agreed upon new symptoms that may indicate a woman is perimenopausal include: breast tenderness, worsening of premenstrual syndrome, fatigue, vaginal dryness, urinary urgency, insomnia, and mood swings (Cleveland Clinic, 2010).
Appendix B

Glossary of Terms

**being-in-the-world** – a concept shared by many phenomenologists, who each had differing ideas about what it meant. Husserl said it was pre-reflective conscious of any object in the world; Heidegger said it was the pre-reflective mood or state of mind that arises from being there; Merleau-Ponty wrote that a person is a mind (body-subject) interacting with objects in the world via cognitive perception (Flynn, 2006).

**binge eating disorder** - a sense of lack of control over eating an excessive amount of food in a short, discrete period of time, not followed by emesis or laxative abuse. It is often associated with symptoms of obesity (DSM-V, 2013).
**dasein** - the somewhat mystical focus of Heidegger’s philosophical inquiry, which was about the human way of being open to being in the world without concentration on personal and cultural obstacles or moral and psychological aspects of mortality (Flynn, 2006). Dasein also can refer to a person being there in a familiar world and experiencing a pre-reflective understanding.

**epistemology** - a branch of philosophy concerned with the theory of knowledge that attempts to provide answers to the question, how and what can we know? It involves thinking about the scope of knowledge and about the validity and reliability of claims to knowledge.

**existentialism** – a major humanistic philosophical movement in the 20th century that places the human being at the center of its attention and suggests a way of life with emphasis on individuality, freedom of choice, and personal responsibility in the modern world. It often confronts ethical and psychological issues of human existence (Flynn, 2006).

**hermeneutic phenomenology** – a philosophical orientation common in health sciences, oriented toward understanding participants’ perceptions of a lived experience, whose method is more interpretive rather than primarily descriptive as in transcendental phenomenology. The researcher comprehends another’s experience through a hermeneutic circle via reflection on essential themes that capture the nature of the lived experience and writes a description of the phenomenon balancing the parts to the whole (Creswell, 2007).

**human science** - also called human studies as in the fields of biology, psychology, anthropology and sociology. This is explained more fully in Chapter III Phenomenological Method.

**humanism** – refers to philosophical concerns that are person centered such as the pursuits of identity and meaning. Humanism views man as a rational being with language (Flynn, 2006).
inner lived experience - the participant’s perception of her relationship with her environment, which reflects the life and mind of the participant, an understanding qualitative research tries to achieve.

interpretive phenomenology – also referred to as hermeneutic phenomenology

life-world - the meaningful whole of life which includes “all the richness of the realm of human experience” (Polt, 1999, p. 58). The participant’s perception of an experience within the situated context (Munhall, 2007). Husserl introduced this term in later writings to refer to one’s world prior to theoretical reflection (Flynn, 2007).

ontic – term used by phenomenologists to denote concrete characteristics of a particular thing (van Manen, 1990).

ontological - stemming from ontology, the formal study of Being (Flynn, 2007). Ontology is a contrast to earlier philosophical concerns in metaphysics of essence, existence, cause and effect, subject and object, and theories of human nature (Flynn, 2007).

phenomenological research - a type of qualitative study often conducted in the social and human sciences that describes the common meaning for several individuals of their lived experiences of a phenomenon or concept; phenomenology seeks the universal essence or “the very nature of the thing” (Creswell, 2007; van Manen, 1990, p. 163) and is based on a philosophical tradition of a search for wisdom as knowledge (Creswell, 2007). Phenomenology was introduced by Husserl in response to “the context-free generalizations of the positivist approach of the natural sciences” in an attempt to know the “reality of people in their life-worlds” and restore humanism to philosophy (Munhall, 2007, p. 161).
**positivistic paradigm** - a point of view that excludes non measurable (quantified) from knowledge. An epistemological position that suggests the goal of research is to weigh or measure to produce objective knowledge, an understanding that is impartial and unbiased. It assumes that one’s observation and description of a phenomenon in the external world is in fact the correct view (Flynn, 2007).

**qualitative research** - a process of inquiry to explore and understand human and social problems; this methodology allows the researcher to provide detailed viewpoints of participants, suggest complexity, analyze words and meanings, and is conducted in a natural setting (Cresswell, 2007)

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**Appendix C**

**Tables of Health Risk Factors Related to Excess Weight in Perimenopausal Women**

**Cardiovascular risk factors related to excess weight in perimenopausal women**

<table>
<thead>
<tr>
<th>HTN</th>
<th>CHD, atrial fibrillation, and MI</th>
<th>Central adiposity</th>
<th>↑serum lipids: low density lipoprotein, cholesterol and total cholesterol, MetS</th>
<th>↑fasting insulin and Type 2 diabetes</th>
<th>Stroke</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Cancers related to excess weight in perimenopausal women

<table>
<thead>
<tr>
<th>uterus</th>
<th>kidney</th>
<th>cervix</th>
<th>pancreas</th>
<th>esophagus</th>
<th>gall bladder</th>
<th>breast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hodgkin’s lymphoma</td>
<td>liver</td>
<td>ovary</td>
<td>colon</td>
<td>rectum</td>
<td>Multiple myeloma</td>
<td></td>
</tr>
</tbody>
</table>

Osteoarthritis risk and progression related to excess weight in perimenopausal women

<table>
<thead>
<tr>
<th>Hand, foot and knee</th>
<th>functional limitation and disability</th>
<th>chronic pain</th>
<th>dependence and depression</th>
</tr>
</thead>
</table>

Associations with depression in overweight perimenopausal women

<table>
<thead>
<tr>
<th>MI or stroke</th>
<th>diabetes</th>
<th>cancer</th>
<th>arthritis</th>
<th>hot flashes, flushes and sleep disruption</th>
<th>decreased physical activity</th>
</tr>
</thead>
</table>

Appendix D

Physical Activity Recommendations

Current physical activity recommendations for healthy adults to prevent weight gain

<table>
<thead>
<tr>
<th>Research agency</th>
<th>Activity</th>
<th>Length of activity</th>
<th>kcal burned</th>
</tr>
</thead>
<tbody>
<tr>
<td>(CDC, 2015)</td>
<td>moderate and vigorous activity (brisk walking,</td>
<td>150 min/week</td>
<td>~700kcal/week</td>
</tr>
<tr>
<td>Research agency</td>
<td>Activity</td>
<td>Length of activity</td>
<td>kcal burned</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>--------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>IOM, 2001</td>
<td>moderate intensity activity for women</td>
<td>60 min/day = 420 min/week</td>
<td></td>
</tr>
<tr>
<td>ACSM, 2016</td>
<td>moderate intensity activity</td>
<td>&gt;30 min/day &gt;250 minutes/week of moderate-intensity physical activity will prevent weight re-gain.</td>
<td></td>
</tr>
<tr>
<td>CDC, 2010a; USDHHS, n. d. a</td>
<td>moderate intensity activity</td>
<td>30 min/day = 210 min/week</td>
<td></td>
</tr>
<tr>
<td>Healthy People 2020</td>
<td>moderate intensity activity</td>
<td>30 min/day = 210 min/week</td>
<td></td>
</tr>
<tr>
<td></td>
<td>moderate intensity activity (brisk walking, bicycling or vacuuming)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>vigorous activity (running or aerobics)</td>
<td>20 min/ ≥3 days / = ≥ 60 min/week</td>
<td></td>
</tr>
<tr>
<td>USDHHS, 2011 Public Health Service, Office of the Surgeon General, 2010</td>
<td>moderate activity &amp; muscle training (brisk walking, general gardening) and vigorous activity &amp; muscle training</td>
<td>150 min/week</td>
<td>~700 kcal/week</td>
</tr>
<tr>
<td></td>
<td></td>
<td>75 min/week</td>
<td></td>
</tr>
</tbody>
</table>
Research findings of physical activity needed to prevent weight regain among previously overweight or obese adults who have lost weight

<table>
<thead>
<tr>
<th>Researcher</th>
<th>Activity</th>
<th>Length of activity</th>
<th>kcal burned</th>
</tr>
</thead>
<tbody>
<tr>
<td>USDA, 2011</td>
<td>moderate intensity activity</td>
<td>60 min/day = 420 min/week</td>
<td></td>
</tr>
</tbody>
</table>

Research findings of physical activity needed to prevent weight regain among overweight adults who have successfully lost 30 pounds and maintained it for one year

<table>
<thead>
<tr>
<th>Researcher</th>
<th>Activity</th>
<th>Length of activity</th>
<th>kcal burned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catenacci &amp; Wyatt, 2007; Klem, Wing</td>
<td>equivalent to walking 28 miles/week</td>
<td></td>
<td>2500 – 2800 kcal/week (average</td>
</tr>
<tr>
<td>Study</td>
<td>Exercise Protocol</td>
<td>Average Weekly Energy Expenditure</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-------------------</td>
<td>----------------------------------</td>
<td></td>
</tr>
<tr>
<td>McQuire, Seagle, &amp; Hill, 1997</td>
<td>Studied women only</td>
<td>2827 kcal/week</td>
<td></td>
</tr>
<tr>
<td>Catenacci et al., 2008</td>
<td>Brisk walking and resistance training or resistance training plus jogging, cycling, or aerobics</td>
<td>60-75 min/day or 35-45 min/day</td>
<td></td>
</tr>
</tbody>
</table>

| 60-75 min/day | 2621 kcal/week |

Appendix E Participant Recruitment Flyer

Share Your Story
ARE YOU A WOMAN?
Between 42-65 years old

DID YOU LOSE WEIGHT in midlife?
Not due to illness or surgery

HAVE YOU MAINTAINED YOUR WEIGHT LOSS?
Are you willing to share your story with a nurse researcher in a confidential anonymous interview?

If so, please contact nurse researcherkbl@gmail.com or (914) 441-857

Appendix F
Telephone Screening Script
Hello! I am Karren Liebert, the nurse conducting a research study about weight loss maintenance in mid-life women. I am doing this research to complete requirements for a doctoral degree in the Department of Nursing at The Graduate Center/ City University of New York (CUNY). I have a brief seven question questionnaire that should take seven minutes or less to see if you meet criteria for this study. Is this a convenient time?

Appendix G
Telephone Screening Questionnaire for Sample Selection

1. Did you have any weight loss between the ages of 42-62? (No disqualifies her)
   If yes, at what age(s)?

2. Was any of your weight loss during this time due to an illness, bariatric surgery, or weight loss medication? (Yes disqualifies her)

3. Have you had both ovaries surgically removed? At what age? (Yes before age 62 disqualifies her)

4. At the point you intentionally began to lose weight, had your menstrual periods become irregular yet? (Change in frequency duration or amount of flow) (Yes means she was perimenopausal and qualifies for study).
   (Disqualified if was still having regular periods (pre-menopausal), or if periods had stopped for ≥ one year (post menopausal) when began weight loss, or if periods were always irregular and perimenopausal status cannot be easily established).

5. What were your height and weight at the point you began to intentionally lose weight?
   (Researcher will calculate BMI range. Disqualified if not overweight or obese.)
   (To establish baseline for calculation of ≥10% loss).

6. After your weight loss, what weight did you maintain?
   (Researcher calculates if this is a ≥ 10% loss from perimenopausal baseline of being overweight or obese) (Disqualified if maintained <10% weight loss)

7. How long did you maintain this weight loss? (To see if it is actually weight maintenance and to determine if the ≥ 10% loss was maintained ≥ one year).
You have been identified as a possible participant in this research study because you meet criteria for having intentionally lost 10% or more of your body weight in mid-life during perimenopause and maintained this loss for one year or longer. I would be very grateful for your time and the opportunity to hear about your experience.

If you are interested in participating in this research study I would like to interview you sometime over the next few weeks in person at a convenient place with sufficient privacy. Your time commitment would be about one hour for the first interview and less than 30 minutes for the second 1-2 weeks later.

May we set up a time and place for a confidential one–two hour interview to discuss your weight loss maintenance story and review the informed consent form?

Or

Thank you for taking this survey. The parameters I’m looking for in this study are a little different than in your situation.

At this time I am studying:

-women who had a history of regular menstrual periods, had a natural menopause

- maintained at least a 10% weight loss during perimenopause (not due to illness, bariatric surgery, or weight loss medication

- and maintained this loss for one year or longer.

However if you would be interested in being contacted by me if I do a future study about weight loss maintenance with different criteria, I will take your contact information
Appendix H

Letter of information for participants

Weight Maintenance: Women’s Experience During Perimenopause

Background: The prevalence and burden of being overweight or obese is frequently discussed in the media, within families and various community settings. Few studies focus on weight loss maintenance in mid-life women. This study will potentially uncover new ways of thinking about weight loss maintenance, health and quality of life.

Purpose: The purpose of this study is to understand the meaning of the experience of successful weight loss maintenance during perimenopause.

Procedures: Participation in this study will include about a 90 minute audio-recorded interview in person at a mutually agreed upon place with adequate privacy that is convenient to you and the researcher.

You will be asked to tell your story of weight loss maintenance. The interview will follow a conversational approach. Direct and indirect questions will be asked such as:

Please tell me about your personal experience of weight loss maintenance.

What is it about your experience of weight loss maintenance that stands out for you?

At the conclusion of this interview you will be asked a few background questions about yourself that you do not have to answer if you don’t want to. You will also be asked to respond to ten statements about yourself with true or false responses. There is no right or wrong way to answer.
Participation in this study will also include a second brief meeting of about 30 minutes or less for you to review the typed transcripts of your interview for accuracy of what was said and to review themes that represent your experience. During the time the consent is being signed and at any time during your participation in this study, the researcher will answer any of your questions concerning the research project.

**Potential benefits:** The benefits to you of participating in this study may include feeling good about talking about your experiences, and knowing you are helping health providers to understand your experience.

Karren Brown Liebert
Appendix I

Informed Consent for Interviews in Study Weight Maintenance: Women’s Experience During Perimenopause

Researcher: Karren Brown Liebert, R.N., M.S.

Sponsor: Steve Baumann, R.N., Ph.D. 212 481- 4457 sbaumann@hunter.cuny.edu

IRB Administrator: Kay Powell 212 817-7525 kpowell@gc.cuny.edu

My name is Karren Brown Liebert and I am a doctoral student in the Department of Nursing at The Graduate Center of The City University of New York (CUNY). You are being asked to participate in a study I am conducting about the experience of mid-life women who have intentionally lost ten percent or more of their body weight during perimenopause and maintained this loss for one year or longer. You have been identified as a possible participant because during the screening telephone interview, you met criteria for this study: voluntarily losing at least ten percent of your body weight when you were perimenopausal (natural versus surgical or chemical) by means other than bariatric surgery or illness, and you maintained this weight loss for at least one year. It is anticipated that six to twelve women will participate in this study. Your participation is voluntary. Should you decline the offer to participate, there will be no penalty to you.

You are being asked to participate in an initial approximately 90 minute long interview about your weight loss maintenance experience. The interview will take place at a mutually agreed upon convenient location that affords sufficient privacy. With your permission this interview will be audio-recorded and transcribed. After the interview, you will be asked a few background questions about yourself and you will also be asked to respond to ten true or false statements about yourself. A second, shorter interview (about 30 minutes) will afford you the opportunity to review the transcription for accuracy and will seek your feedback about themes identified that represent your weight loss experience.

The risk to you from participation in this study is no more than that encountered in everyday life. The possibility exists however, that troubling feelings may arise if sensitive issues come up during the discussion. One risk is the possibility for example, of feeling sad because of talking about your memories. If this occurs, the researcher has a list of professional resources available that you will be able to contact for assistance. No financial assistance will be available to you should you seek assistance to help you cope with troubling feelings. You should tell the researcher if you are uncomfortable at any time during the discussion. You have the right to decline discussion of any line of thought. You may stop the interview process at any time without penalty. The researcher will stop the interview if you tell or show the researcher that you
are unsure about being interviewed. All information will be held confidential except when codes of conduct or laws require reporting.

Participation in this study may have no direct benefit to you. However, participation in this study may increase understanding of mid-life women’s weight maintenance experience, which could improve health providers’ knowledge for best practice and have an impact on helping other women maintain healthy lifestyles.

I will audio-record the interview with your signed permission. To maintain confidentiality no personal identifiers will be linked to the data. The audio-recording will use an identifying code so an assigned number rather than your name will appear on the typed transcript. A typist may transfer recorded conversations to written words. The typist will be required to sign a confidentiality form. The transcript and researcher’s notes will be kept secure in a locked cabinet with access only to researcher and her faculty advisor. The data may be destroyed in a confidential manner after three years. The data will be used to produce a doctoral dissertation. The results of this study may be published or presented at professional conferences without identifying information. A summary of results will be provided to you upon request.

Questions about your participation in this study may be directed to me, Karren Brown Liebert at 914 441-8574 or nurse researcherkbl@gmail.com or to my dissertation sponsor, Dr. Steve Baumann at 212 481-4457 or sbaumann@hunter.cuny.edu. If you have questions about your rights as a participant in this study, you may contact Kay Powell, IRB Administrator, The Graduate Center/ City University of New York, 212 817-7525, kpowell@gc.cuny.edu.

Thank you for your participation in this study.

____________________________________________________

I have read the contents of this consent form and have been encouraged to ask questions. I have received answers to my questions and give consent to participate in this study. I have received a copy of this form for my records and future reference.

I agree to have my interviews audio-recorded. Circle: YES NO

Participant’s name---------------------------Signature __________________________ Date __________

Researcher’s name________________Signature __________________________ Date __________
Appendix J

Mental Health Counseling Resources

St. Luke’s Roosevelt Mobile Crisis Team M-F 8am-7pm  212 523- 6711 or e-mail elasall@chpnet.org

St. Luke’s Roosevelt Department of Psychiatry and Behavioral Health Private Appointments 212 523-3996

Mt. Sinai Medical Center Counseling Services, 312 East 94th Street, Appointments: 212 423-3000

Bellevue Hospital Center, Outpatient Psychiatry, Intensive Short-term Dynamic Psychotherapy, 462 First Avenue New York, New York 10016  Appointments: 212 562-1011

Montefiore Medical Center, Psychiatry and Behavioral Sciences, 111 East 210 Street, Bronx, N.Y., Appointments:718 920-6215

The Park Slope Center for Mental Health, 348 13th Street, Brooklyn, N.Y.  Appointments: 718 788-2461

State of New Jersey, Division of Mental Health Services, Apointments: 1 800 382-6717

White Plains Hospital, Behavioral Health, 41 East Post Road, White Plains, NY. Appointments: 914 681-1078

Yale Department of Psychiatry, The Consultation Center, New Haven, Connecticut Appointments: 203 785-2117
Appendix K

Life Word Existentials as Guides to Reflection

In this study of weight loss maintenance each participant’s experiences of body, weight and perimenopause related to each of these four existentials.

Lived Body (Corporeality)

Lived body (corporeality) refers to how humans are “always bodily in the world” (van Manen, 1990, p. 103). Often others initially view us as our body. Sometimes we are conscious of how we experience our own body, how we think our body is perceived by others, and how our body may reveal something about ourselves.

Merleau-Ponty’s belief that lived experience always included lived body meant that our mind is not separate from our body and that we can view ourselves as both body subject and body object (1945/1962, p. xii). We have perceptions of ourselves as a subject. However we can also view ourselves as object when we incorporate how we believe others perceive us.

Perceptions of lived body change over time due to our interrelatedness with one another, which influences how we perceive ourselves and how we perceive others.

Lived Other (Relationality)

Lived other (relationality) pertains to relationships between the self and others. Merleau Ponty conceived of relationships as partially intertwined, so that there is always the possibility of overlapping with the other (Reynolds, n. d. The Other). He suggested that the way in which I
subjectively look at another person involves the tacit recognition that I too can be looked at subjectively. Relationality may for example, include ways we are influenced by others. According to Merleau Ponty, openness to the possibility of being influenced and changed by what others bring to bear upon our interaction with them can be a positive experience, not necessarily negative as Sartre, Levinas and Derrida imply (Reynolds, n. d., The Other). Spatiality (lived space) refers to the nature of the spaces that give meaning. Temporality (lived time) is a subjective sense of past, present and future and includes memories, how the past has influenced us, how past memories may be influenced by the present or how the present influences our hopes for the future.

**Lived Time (Temporality)**

According to van Manen, temporal reflection is subjective rather than objective, and includes past, present and future “horizons of a person’s temporal landscape” (1990). Merleau-Ponty’s view was that time is lived time and that time is intertwined with our lived experience (1945/1962). Merleau-Ponty remarked that “we must understand time as the subject and the subject as time.” (Reynolds, J. (n. d.) “Ambiguity”.

**Lived Space (Spatiality)**

Merleau-Ponty believed that spatiality also included the concept of time when he wrote, “Our body inhabits space and time” (1945/1962, p.161). Merleau-Ponty wrote about how some views of consciousness relate to a person’s bodily understanding of the space occupied by the body, which may include where the person experiences her day and whether some spaces are safer than others (Findlay, 2011). Similarly, van Manen said that lived space includes “the ways we experience spatial dimensions of our day-to-day existence” (2011).
Appendix L
Participant Experiences

Lucinda.

“I guess it was around when I was about fifty years old I decided it was time for me to you know try to lose some of that weight I had gained with the kids, pregnancies.” “I never really wanted an outsider to be looking at what I was doing, I just felt like this is something that I wanted to do on my own.” “So I think the first important thing is that you have to be willing to make the commitment to exercise every day or nearly every day.” “The more you eat you know the more you will gain. So I think that for me this is the key and I found that a friend who was willing to motivate me, and I motivated her and we both pretty much run at least five times a week.”

Lucinda revealed her ninety minute story in the interviewer’s sunny office on a bright Spring Sunday morning. We enjoyed a pot of hot tea I prepared to accompany a loaf of warm banana nut bread that Lucinda had baked and presented to me. Lucinda looked noticeably thinner from when I last saw her about two years ago, and appeared to be within a normal weight range now. She was nicely dressed in a casual style, with a different hair style and uncharacteristically adorned with a little make-up. She appreciated my comment about how her look had changed. Her mood seemed upbeat and happy emotions were evident. Lucinda volunteered to be screened for my study after a discussion about my research during a brief social encounter we had.
We sat in comfortable upholstered chairs across from one another, each with a small table to accommodate our tea and banana bread slices. She volunteered that she was delighted as she recalled her weight loss maintenance experience and began by asking, “So where do you want me to start, from the aspect of exercise or the eating side?” I responded by indicating she may begin talking about her weight loss maintenance experience in any way that made sense to her. Lucinda recollected that her weight loss maintenance story began about seven years ago when she decided to take time to care better for herself now that her two sons were entering college. She left full time employment as an attorney, relieved that her husband’s income covered their expenses. “I found out we needed less money you know we could get by … that’s such a relief.

Lucinda capitalized on the time she now had to care for herself by engaging in 1 ½ hours or so of physical activity in her day, a desire which was previously thwarted by struggling with time constraints due to commuting to a full time job, rushing home to two children, and other family responsibilities. “I tried to workout in my lunch hour but I was never successful. And I think the reason was that I didn’t work out enough, you know half an hour at lunch is just not enough.” “…there is not enough time and then you have to shower, blow dry my hair, it was longer then. It took forever that’s why I could only give it an hour at most and then at one point we got so much work we were like we had to eat through lunch, we didn’t have the chance to even leave the office, we were expected to stay and do everything you needed. So people would come in late because they have gone to the gym early, or some people would go to the gym after and I, just because I have a family, I really didn’t feel like I could do that.

Now that she has time, her current 1 ½ hours or so of daily physical activity is quite varied from, “I do sit ups and pushups now in addition to the running” “workout with the weights” “at
least once a week I do this roller dancing” “Israeli folk dancing” “walking with the dog, running errands, doing housework, lawn work” “yoga at home,” and swimming at an indoor pool in a retirement community. Lucinda’s philosophy was “I really think in addition to the running you have to do more, you can’t just sit on your laurels and say okay I have done my forty five minutes outside you just have to constantly stay active.” “When I am staying home and eating and not exercising I feel like I am sort of like stuck in a rut and I feel sort of depressed some of the times. So I feel more energized definitely when I get my body moving.” “I have noticed… my body needs a certain amount of exercise in order to feel good.”

Lucinda also explained some dietary changes that contributed to her weight loss and maintenance, while still eating whatever she likes on occasion “I cut out the morning bread, I don’t eat a bagel anymore… or pasta” “I have been trying to eat more vegetables, fruits” “if I have made my own bread for example I will always cut myself a nice chuck.” During weight maintenance she said, “I don’t seem to be able to eat as much as I used to, like my stomach got shrunk or I am just because I am so aware of it I am afraid to eat a lot so I can’t over indulge, you know the only time I tend to eat more is when I am at home, I am more relaxed I think.”

The preponderance of Lucinda’s comments revealed the importance of her running partner, a supportive caring relationship she has depended on over the past seven years. “Occasionally… she would be unavailable and I felt like oh my god what am I going to do now.” This important relationship began when she sought a running partner to lose weight. “…I didn’t go into the internet, I mean I felt uncomfortable just you know, people might think it's weird looking for a running buddy, … I just asked friends that lived on my block or people that I knew from my social circle… Now it turns out that Angela wasn’t really in my social circle, ironically… she
was my hairdresser. I saw her as you know, a person I went to, to get regular haircuts.” It seems that when Lucinda became open to tackling weight loss she became open to developing new relationships and behaviors to help her.

The running relationship with Angela included conversations Lucinda referred to as “morning therapy sessions.” Lucinda’s interview contained several passages demonstrating reciprocal caring between herself and her running buddy, Angela. “She gained a lot back… Being an Italian they tend to have big family dinners and pasta features in most of them. So I think part of her problem and we’ve discussed this in our runs, it’s that she is dealing with her cultural problem, she can’t really start a new trend in her family without a major upheaval. Her husband might object, her children who all eat with her, she serves her entire extended family all the time for dinner, I was shocked when I heard that. But she has one daughter who lives actually on her property in a separate building, so her daughter is always there. But the other daughter is frequently slipping over as well, so it’s like they never left home even though they are married with kids, it’s strange to me, but they are very close.”

“…the funny thing about her is when she is in public with others who are not in their family group she tends to be very outspoken and like you know people are almost afraid of her. (laughing) That’s the funny part, she is not, she is by no means a pushover. People find her very you know strong, so wild, and yet here with her own family group that’s what I find so interesting, she is like a pussy cat, she can’t raise her voice against them. … she said I am always eating so much when I have my family over… So I said bingo that’s the problem. She will say it, but she won’t realize that she has actually got the solution when she talks about it. I said you could tell them you can’t eat it. I would be more willing to say, that’s not on my diet. You know,
but again, she doesn’t seem to feel like she has the ability because she feels like it would make them feel bad.”

Lucinda said that her husband was “encouraging” about her weight loss and weight loss maintenance with occasional comments about her “snacking” too much, but that basically they agreed not to get involved in one another’s eating or exercise behaviors. Lucinda stated, “…we had that discussion.” She found him to be a poor exercise partner early on, “he can’t run as much as I can for example. So if I started out on a track now I would still be there and he would already be gone.” Lucinda volunteered that positive comments from her younger son about her weight loss was meaningful to her. She was pleased that he became more physically active in college because, “he’s got my kind of body type where he needs to keep active or he’ll start putting on weight.”

Lucinda mentioned a desire to avoid health problems that her parents had such as cancers, diabetes, and osteoarthritis, and believed that maintaining a healthy weight would help. “It's definitely a risk factor for me so I have to be careful.” Lucinda seemed to identify with her mother who had a hip replacement at age 70, “…that may be in my future…I feel some joint pains around my hips.”

Lucinda has been maintaining a weight loss for several years, “an accomplishment” that makes her “feel good.” “The best thing about keeping it off for me? I think is it just gives you a sense of accomplishment. You know it does make you feel like you set a goal and you can reach it so that’s a good feeling.” “…when I look at myself in the mirror I am happier…” “I get compliments…that self- reinforces…of course that feels good.”
As her new self, Lucinda said, “I am like finally discovering those other things I can do with myself other than just sitting and reading, which is pretty much when I was younger reading is all I did.” “So I am able to sing… at nursing homes and… community organizations… Friday night service once a month … synagogue…I am playing recorder with a little band… a guy on clarinet, I am on recorder, two guitarists and our new musical director this young guy who plays this box drum…”

Lenore.

“I got so heavy during my 40’s trying to get pregnant... Now I have to remain in control.” “I realized eventually that I needed to also focus more on my own issues and my health.” “I am disciplined and accomplished in my professional life, so I realized I could be disciplined with my weight.”

My interview with Lenore was arranged through a mutual friend and took place following a lovely candlelit Shabbat supper our friend graciously prepared for the three of us one snow laden wintry evening. I had just driven 1 ½ hours for this meeting, but planned to stay overnight to avoid driving back home that night. Previously, Lenore and I had spoken during the telephone screening interview, but this was our first in person meeting. Following the meal, our friend voluntarily sequestered herself to her bedroom while Lenore and I spoke in the living room for 45 minutes.

Lenore stated about our friend, …“we’ve been friends for so long, she’s heard all about my weight issues, so she didn’t need to leave the room.” I explained that our friend had previously volunteered to provide privacy when the arrangement was being made. Lenore and I
agreed that our mutual friend likely welcomed a rest after preparing food all afternoon, so the interview proceeded amicably.

Lenore began the interview, “Well first of all, I’ve lost nineteen pounds. As you know from our telephone call, I lost a little more than 10% of my weight about two years ago.” I noted that she was tall and appeared only slightly overweight now. She proceeded to discuss how she stays on track to avoid any weight regain with carefully thought out plan consisting of daily monitoring of food intake and body weight. “I put the scale between my side of the bed and the bathroom so I can’t miss it.” Lenore emphatically noted, “I worked too hard to lose the weight than to let poor eating choices cause me to become as overweight as I was again.” Her caution was understandable when she offered comments such as, “One year I gained ten pounds during the holidays so I really have to watch it now. Now my weight is nearly in the BMI range it should be.” Strategies she used at parties to maintain an acceptable weight included, “… I fill a plate with a small amount of everything that appeals to me and take a small taste… small slice of cheesecake and two truffles.” I took small bites. I savored them. In the past I would have eaten seven or eight. Now, I control myself. But I don’t deprive myself.” “I also gave up matzo. This was a great sacrifice. I had to because I would buy the whole big pack with many boxes like you would find at Costco instead of just getting one box at the supermarket. I couldn’t stop eating it. And then with the butter on top. It got out of control… same problem with rye bread and butter.”

She shared several detailed strategies for healthy eating, “I take frozen fish to work and microwave it for lunch…I also eat fish for breakfast….I have carrots, celery, and fresh peppers always prepared in the fridge. I make it easy to grab what’s good for me and not something that will put on weight.” “…tonight at dinner, I didn’t eat the whole portion of stuffed cabbage.” “…I
didn’t eat any Challah tonight. I try to stay away from many carbohydrates. “I eat slowly so I’m more likely to feel full sooner.” Her strategies seemed not only a way of controlling impulses to eat the wrong food, but reflected engagement in a supportive relationship with herself. “I develop strategies to fool myself.” Weight loss maintenance seemed to become less of a struggle over time for Lenore, “It becomes easier the longer I do it- there is less temptation to eat junk.”

Lenore described “peaks and valleys” with her emotions which affected her weight. She had been overweight earlier in her life and during her 25 year marriage. Her weight increased more in her early 40s, “I had difficulty conceiving and subsequently gained weight with in vitro fertilization cycles over several years.” I became depressed for a while… too depressed to exercise. I did have weight loss once the fertility drugs were out of my system, and we were able to adopt.” Lenore hypothesized that the stress of raising a son with mental illness became a factor with her weight, “Oh Yeah!... raising him has kept my cortisol levels high... an uphill battle at times …may have contributed to my weight gain.” “I realized eventually that I needed to also focus more on my own issues and my health.” “I am disciplined and accomplished in my professional life, so I realized I could be disciplined with my weight.”

Her physical activity involved gardening in their one acre property and shoveling snow, but no regular programmed exercise. “I couldn’t spend an hour and a half every day on exercise machines.” “I don’t schedule in daily amounts of a particular type of exercise.”

In addition to the supportive relationship she had with herself, she found our mutual friend a comfort, as well as her husband. “Oh, he is very supportive. My husband always says do it. He has never commented on how my weight affects my appearance. I guess I’d describe him as
accepting. She expressed ambivalent feelings about her current body that included pride as well as dissatisfaction. "When I was heavier I never could have worn tight jeans like this tucked inside these tall boots… Now I feel attractive.\textquotedblright; \textquotedblright;I’m still a little self-conscious about this here. I wish I could afford a plastic surgeon to get rid of this. I’d like to lose about 15 more pounds.\textquotedblright; Sally.

\textit{...until the next thing I knew I was a good probably 25 pounds overweight. I don’t think I ever looked overweight, but I felt it, and I felt uncomfortable.}\textit{\textquotedblright; If you see you’re up a pound or two, you’ve got to adjust accordingly to get back to where you were.\textquotedblright;} \textit{\textquotedblright;I find that when I eat more and I eat a variety of foods that have some fat in them, and have some calories and have some carbs, and you know, it’s a healthy mix with small meals throughout the day, that I actually am able to eat more and lose weight, or maintain my weight rather than when I go on a diet mentality where you have a salad for lunch and then you have like a little piece of chicken with nothing on it, I find that it’s much more difficult to maintain my weigh that way.}

I heard Sally’s weight loss maintenance story over the phone one afternoon when she called me at a prearranged time, when she was in her car waiting for her sons’ karate class to end. The interview lasted 40 minutes. She began by stating she had a couple of weight loss maintenances phases in her life, and volunteered her story.

Sally had been overweight since childhood. \textit{\textquotedblright;I’m 5’3 and a half, but I was about 170 pounds when I was, 13, 14, 15 years-old… I got to a healthy weight by the time I was like 18, 19.}\textit{Sally’s mother and two of Sally’s sisters were also \textit{\textquotedblright;heavy as teenagers\textquotedblright;} so Sally’s mother taught \textit{\textquotedblright;portion control\textquotedblright;} \textit{\textquotedblright;I’d eat half the mashed potatoes, I’d eat \textfrac{3}{4} of the piece of chicken.\textquotedblright;} Her mother also taught her that feeling full did not occur \textit{\textquotedblright;until probably about 10, 15 minutes after
your meal,” so she learned to stop eating before feeling full. Sally thought these strategies worked well for maintaining a healthy weight until her early 40’s “until the next thing I knew I was a good probably 25 pounds overweight. I don’t think I ever looked overweight, but I felt it, and I felt uncomfortable.” She was able to lose the 25 pounds by following Weight Watcher’s with her “severely overweight” husband. Their commitment to Weight Watcher’s began one New Year’s Eve years ago.

Sally began to model her weight maintenance behavior after her mother’s example, “…her favorite was a black and white ice cream soda, and she’d take two bites of the ice cream, she’d take three sips of the soda, and she was done.” “So if I want to have… cake, I’ll have two bites of the cake… instead of eating the whole sandwich and all of the French fries, I eat half of the sandwich and I eat a quarter of the French fries. And then it’s OK.” Sally had invested thought into how to manage her impulses to indulge in high caloric foods and maintain a desired weight. “I don’t deny myself anything, because I find that when you deny yourself, then you’re dieting, and then when you do give yourself something that you want, you tend to eat more of it, because it’s something that you don’t get all the time.” Similarly, “the more I dieted, and the more I deprived myself and starved myself … the easier it was for me to gain weight.” “I find that when I eat more and I eat a variety of foods that have some fat in them, and have some calories and have some carbs, and you know, it’s a healthy mix with small meals throughout the day, that I actually am able to eat more and lose weight, or maintain my weight…”

But the majority of her weight maintenance diet is reflected in the following statement, “You know, a lot of salads helps with the maintenance. And that’s basically what I do.” She also spoke about the importance of maintaining her weight loss by monitoring her weight and
how her body feels. She said that a one-two pound weight gain deserves a response of limiting calories. “If you see you’re up a pound or two, you’ve got to adjust accordingly to get back to where you were.” “I probably get on the scale once or twice a week.” “When I sit down I can feel, if I’m heavier, I can feel my roll on that rib, and it feels uncomfortable…I think I got to take a couple pounds off because I don’t like the way this feels.”

Sally acknowledged that weight loss became more difficult in middle age compared to when she was younger, but that her maintenance behaviors and mind set remained the same. “The maintenance I don’t think is any different…but I think it was harder to lose the weight. I don’t think it came off as readily.”

She divulged negative feelings about being different from her sisters in terms of her body size. “…standing next to them, I always felt like I was the heavy one, I was the fat one, I was the large one, even though if you looked at us nobody has ever said, Oh my God, you know, you’re big. But relative to them…I think it makes me feel better that I’m now closer in size to them.”

Other positive comments about her current body included, “I feel like I’ve accomplished something if I’m eating the way I should… I feel good about it.” “I feel healthier. I feel more confident in myself. I’m actually proud of the fact that I have lost the weight, and you know, everybody noticed that I lost it. So it makes me feel good that people noticed, so I think I’m more inclined to try and maintain it, because it’s something that I do feel good about. And I think that just in terms of presenting myself I feel more confident.”

Tamara.

“I probably put on 40 of the 60 pounds that I lost…when I was away from the meetings [OA], for a while… And again was starting to like eat out of control again.” “I haven’t really lost any
weight in all the time that I’m going now to meetings, the past ten years. But what I do is that I really don’t compulsively eat…” “I really never get on the scale.” “I’m getting more sedentary as I’m getting older.”

When recruitment for participants began for this study, Tamara indicated during a professional workshop that she likely would qualify and would be willing to be screened. After a few attempts to meet over a year or so she was willing. She chose a quiet, isolated hallway outside her shared office.

Tamara’s account of her weight loss maintenance began, “I’ve always had a weight problem most of my life” As a teenager, “I lost a lot of weight…. on the grapefruit diet.” But her weight returned once she began to add other food. During her 20s Tamara lost 20 pounds, regained, then lost 30 pounds with the Weight Watcher’s program. However, once the program allowed her to have a desert, she “…always wanted more. Could never just have one.” “It was just that whole obsession.” Tamara attributed her food issues partly to being from an Italian American family where “food was the main thing” “sitting down for the six hour dinners as a child.” So that again put the weight back on.” Her story continued with more weight gain in her mid-30s during two pregnancies, “I knew that I couldn’t stop eating.”

A turning point occurred when, “…a very wonderful friend came to me and said, “You know, I found this program, Overeaters Anonymous. And why don’t you come?” Seemingly aware that she may have psychological problems related to her overeating Tamara said, “…because I couldn’t afford therapy at the time, I went there.” It was a “very strict program” where she lost 60 pounds over 4-5 months while breast feeding. She maintained this weight loss
into her late 40s. She reflected with a chuckle, “I think back, I was a size 2 Calvin Klein jeans at that point, I could buy size 2 jeans.”

Tamara then recollected another failure at weight loss maintenance, which highlighted the importance of the OA meetings for her success. “I think what happened was I stopped going to the OA meetings…because the meeting that I went to changed the time… trying to squeeze it all in… at a convenient time. So I wasn’t able to continue to go… gradually then I started eating like a crazy person once again.” “I probably put on 40 of the 60 pounds that I lost.” About ten years ago she met a woman at a new job who attended OA. Tamara described this relationship as “divine intervention” because she returned to OA and has attended weekly meetings for the past ten years and maintained the same overweight status. She expressed frustration about her weight, “I haven’t really lost any weight in all the time that I’m going now, the past ten years.” I guess always somewhere in the back of my mind, I think, “Oh, I really need to lose, but I’m not able to do that now.” “I don’t actively do anything about it.” She expressed relief that her regular medical checkups have not yet revealed “metabolic syndrome” “shortness of breath” “the cardiac scare.” A diagnosis of celiac disease revealed less concern about developing a lymphoma than about what it meant for her weight. “I’m very grateful to have celiac disease because I can eliminate the carbohydrate. I can eliminate the wheat, rye, and barley. And when I did that, all those cravings went away.”

Tamara identified some advantages to weekly attendance at OA over the past ten years even though she remains noticeably overweight. “…the gift is not getting heavier and heavier, and being able to wear the same clothes from season to season.” “I can have just one of something, which is a miracle… I’m not obsessed with food… I used to always be thinking
what am I going to eat, what am I going to eat, how am I going to cook it?” “I eat like a normal person. And I probably have lost weight. I really never get on the scale.”

Tamara divulged dissatisfaction with her weight over the past ten years, as well as acceptance, “I would like to be thinner, of course but, 20 years later, I would have to eat like 500 calories a day in order to lose weight. And that I can’t do.” Tamara also revealed disappointment with her unwillingness to engage in physical activity, “I’m getting more sedentary as I’m getting older.” Her relationship with her stationary exercise bike in her living room is to avoid it. “I just don’t do it.” “It’s not a clothes rack or anything else. It’s right there waiting for me in my living room. I could watch television.”

Tamara contrasted her current midlife ten year weight maintenance experience with past ones when she was younger. “It’s been a peaceful experience…this time around… Because the other times, it was always stressful. I couldn’t really maintain it, and …I would disappoint myself.” She said she would think, “Oh my God, now you’re going to have to go on a diet again.” Weight loss maintenance now seems, “Peaceful and serene… having a spiritual connection, and working through your emotions, and accepting your feelings… one day at a time”

Peggy.

“In my 20’s and 30’s, losing five pounds was a piece of cake. And now it’s a struggle to maintain your weight, to make sure that you don’t gain weight. “It is a struggle because it is somewhat of a rollercoaster, and it’s a little bit of a vicious cycle. It feels like PMS is continuous. So with PMS comes compulsive eating, emotional eating, and feeling horrible about yourself, where you don’t want to go to the gym because you feel horrible. The way that I maintain my
weight is to eat right – it’s the old fashion way, there are no tricks, or – eating right and exercising.”

Peggy emigrated to the U.S at age 14 and said that she never saw an obese person until then. She described both of her Italian parents as thin. But she described herself as “chubby’ until age 20 when she began to exercise. “I have two brothers, they were skinny, skinny, skinny, and I was the one that always – I was chubby. You know, you see pictures of me as a child.” When Peggy deviates and gains weight she said, “it’s very challenging to get back into the routine, because you then fall into this mental – you know, there’s depression. And then the vicious cycle of “emotional eating” stating “a lot of times for me food is comforting.” Peggy identified ways she manages to stay on track with food and exercise and her weight goal was clearly defined. I never want to be bigger than a size 10. And I never want to be like over 150. My favorite place is size 8.” “I’m up and down the five pounds here and there.” “I exercise like crazy. I go to the gym, I do some cardio – I do weight training, spinning, and yoga. A woman in her late 70s told Peggy that yoga kept her “thin, focused and centered.” Also, Peggy monitors herself closely, “If I’m being challenged a little bit, I need to really be what I call strict.”

She said of staying within her weight goal “mostly it’s a mental thing” so when craving her favorite fried calamari, she uses “words of affirmation” to tell herself, “As much as you want it in that moment and you’re dying for it, this is going to pass. This moment that you’re having right now, it’s going to pass.” Another successful strategy she uses with herself is to “sometimes give in to the indulgences that I’m craving, because sometimes if you don’t give in they just get bigger and bigger.” To Peggy giving in meant having a small taste, not eating a whole portion, or
binging, “I’ll just maybe taste something instead of eating the whole thing – but that’s huge discipline.” “When I do indulge, I’m indulging on good food. I’ll have a whole steak of swordfish instead of just having half.” Also, she generally “avoids unhealthy carbohydrates” “because they just settle in your middle, which is where women gain weight” “once you start gaining weight there, not only it doesn’t feel good, it’s not healthy.”

Peggy clearly described how she experiences her body as changed once entering perimenopause stating, her metabolism changed, contributing to weight gain, “your metabolism you know, it goes down so much.” “women gradually gain at least 10 to 20 pounds during menopause” “it’s a whole different challenge” “feeling bloated”…you do get stuck when you’re being so good, you’re going to the gym, and nothing happens with your weight.” Peggy heard women say, “I can’t wait not to get my period. Peggy said “for me, it was upsetting that I wasn’t getting my period anymore” “the PMS feels like it doesn’t end.” She adeptly described her emotional reactions to her body weight precipitated by midlife hormonal changes, as, “it’s also an emotional journey… I thought I was young to go through this, so that was hard for me.” I’ve been hearing women for years telling me about hot flashes, not being able to lose weight and you really never know it until you go through it yourself.” “To me menopause equals being in the next phase of life. I just wasn’t ready.” Skipping physical activity affected her mood, “if I don’t go to the gym for a whole week, I feel like almost like depressed – it’s therapy for me if I don’t, then I get down on myself.” At the same time, Peggy recognized that “the more you knock yourself down, the more you’re not going to get there.” She said, “I do a lot of mental affirmation. And just basically try to feel comfortable in my body.” Her philosophy is, “Just increase your activity. Don’t fight so much with the food.”
She mused, “I’m at a weight that I’m happy with maintaining – which there is a point that I’m happy and I’m maintaining and everything is good, I’m exercising, I’m not in a bad place emotionally and mentally – on the weekends I will indulge. Or, if my mother is making lasagna, I’m going to have it. Because it’s a special lasagna.” Emotional strife is another occasion Peggy sometimes deviated, albeit only briefly, “Sometimes you have to give in to the emotion, and just kind of like ride the wave.” On the other hand, Peggy said, “if my emotions are OK, it’s so easy to say no. And I think about how I’m going to feel after I eat the food. I hate how I feel afterwards, so I think of that, think how miserable you’re going to feel, like, you know, like, ugh, bloated and horrible.” Nevertheless, Peggy said “my life is a food journey because I have a relationship with food” and that “I love to eat good food.”

In terms of supportive relationships, Peggy credited a physician she visited in her 30s as essential to her successful weight loss maintenance because he suggested the best thing she could do for her health at that age was to quit smoking, and get herself to the gym if she gained any weight. Peggy reported positive feedback about her weight management from a younger overweight co-worker and it became a mutually supportive relationship, “I want to be like you. I want to know what you eat from morning to night. So I shared with her what I do.” She enjoyed compliments about her weight maintenance from other coworkers and her many clients at the business she co-owns where electrolysis, laser treatments, waxing, nail care and massage are provided.

Peggy shared a parting comment about midlife weight loss maintenance as, “challenging, but at the same time it can be rewarding.” She emphasized that her overall goal in life was
happiness and that her body largely affected this. “Being kind to myself is to feel good, and to eat the good food that makes you feel good. And exercising.”

Ava.

“I have trouble following a regimented eating plan for much longer than a couple of years.” I will eat based on how I feel… even though I know what needs to be done, I just really have to become delinquent for a while.” “I try to control my weight the way that I see fit.”

Ava became concerned about her health following weight gain in her early 40s after she stopped smoking “I had put on a lot of weight for me after I stopped smoking… it was dangerous to my health overall.” Prior to her 40s she was “a little underweight at 135 pounds”. To combat weight gain Ava attended Weight Watcher’s, “to learn how to eat in a sensible way…” Ava has a “lifetime membership” in Weight Watchers. She has attended meetings very two years or so over the past twenty years to get back to her weight goal. Ava revealed her original weight goal, “I wouldn’t let myself go past a hundred seventy-seven pounds because that’s the weight that I gained when I was pregnant. Then I reset it to below 166 and now 155.” Ava achieved a ten percent weight loss during perimenopause but maintains it for only two years or so because she allows herself to engage in weight swings, although the upper weight she allows is now lower than it was when she began weight loss maintenance. “I’ll let myself get to a certain weight, about fifteen pounds more than what I want to be, and then I’ll go back to Weight Watchers and I’ll get started over again.” “I cannot get fanatical about it.” “I have to kind of just free float… when I feel that I have free floated enough and I’m getting into difficulty, then I’ll go back.”

Ava disclosed about “junk eating” she engages in, “I like chocolate” and “I do enjoy pretzels, potato chips, Munchos – anything which is salty… there are days when I could eat that
all day long and not have any amount of food… I really enjoy that.” She continued, “I know I can do some stress eating.” She “gravitates” toward “rice, mashed potatoes, macaroni and cheese and bread” saying that eating carbohydrates is “kind of placating myself.” Ava divulged another reason to overeat, “I can eat really just as a result of not wanting any limits; you know, just wanting to do what I feel like doing on that day…. It’s pure madness. That’s what drives it.” She reiterated, “even without stress, if I feel that I have been good for just too long, I go on somewhat of a binge, gain a certain amount of weight, and then say, “Okay, enough is enough. And then, I will stop it and then I’ll get myself back into some kind of control.” However, she concluded, “overeating and over-shopping, that’s who I am.” “It’s always difficult for me.” Interestingly, despite veering from a healthy eating pattern at times, Ava did appear to be within a normal weight range. And as she later said, “I have never really gotten huge. As long as I can get into my size 10s and my size 12s, I’m okay. When I’m getting ready to go into a 14, now then we’re in trouble.” Weight concerns do not prevent her from eating at social events, “I will go to your house if I know you’re a good cook because I want to eat what the food is. I just have to remember to use a certain amount of control. If I decide not to use control then, I have to decide that the next day, it’s only a salad.” About eating in general she said, “I want to eat everything within control because I enjoy eating. “I just can’t pig out continuously.”

Recognizing that she is aging, Ava said, “When I was younger, I could eat that way and there wasn’t a problem. I could put on weight and I could drop that [snapping fingers] sucker in a couple of days … the resentment is that I cannot do what I did before.” Ava then enumerated several adult responsibilities that prevented her from doing as she wished in the moment, such as, “you’ve got to pay the bills… when you have kids you have to do in relation to what your
family needs, what your children need. As your parents get older…” “I guess in my life, there’s this aggravation about life [laughter] and its rules and its regulations. And so the one thing that I can do is control what I eat… that’s really probably where I do my most acting out.” She concluded this line of thought with, “I’ve never been successful in accepting – not so much learning how to maintain the weight – accepting what has to be done to maintain it.” So one concern Ava expressed about weight loss maintenance is about, “how long I’ll be able to do it.”

She jokingly asked herself, “Have I reached the level of maturity [laugh] that I can?” She referred to herself as “like Peter Pan, a terminal child not wanting to grow up in this respect.”

She expressed another concern, “the other reality is, as I’m getting older I want to try and drag my life out a little bit longer without having to worry about developing a lot of medical issues.” “I don’t have diabetes, I already have hypertension… a number of things scare me health wise… as an African American woman, I am very prone to obesity, hypertension and diabetes…that’s not what I want to have.” “That’s the reason that I keep this struggle going, even though I know the seesaw effect, up and down, up and down it’s not good either.” I see women, with all this weight, the hips and the knees go. I’m going to have to worry about having knee and my hip replacements. She later added, “I’m not at a point of saying the hell with it. It’s not worth it and I’m just going to end up a fat old lady… That I refuse to do. It’s important to have longevity and feel good… it’s quality of life, not just life.” Ava believed that Weight Watchers was helpful to her, “I need that structure and obligation… kind of like Big Brother watches you.” Weight Watchers also reminded her of “going into the confessional.” “In order to be good, there has to be a feeling that there’s somebody who’s watching…an outside authority.” She acknowledged, “…even though you know that’s not so. It really is yourself.” She recognized,
“It’s very unrealistic and it’s very kind of immature and infantile, really, in its own way. But that’s, that’s exactly the way that I feel.”

Weight Watchers provided Ava with support she likened to Alcoholics Anonymous for alcoholics. She said, “I come from a family of, of addicts. They say that you need to make your meetings. It keeps me around people who are dealing with the same exact thing… when you hear people, you can hear yourself, too” And “If you lost pounds, people, make a statement about it. You don’t get a criticism about it. You’re acknowledging yourself what you have done.” The past few years she has attended Weight Watchers with a friend, “We kind of help each other along.” But she added, “I don’t really need to have somebody one way or another. If I’m going to be committed to doing it, I’m going to do it no matter what.

Physical activity has constituted a large part of Ava’s week for many years. As she said, “I’m not sedentary at all. I will walk blocks and blocks. Walking really puts me in a very good mood… the bonus is, is that it keeps my weight down.”

Ava mused, “Talking about it, has made me put it into a perspective I have never really allowed myself to truly do before… making me think about why I do it has made it crystallized… refusing to accept aging… challenging aging and the adjustments that one has to make.” Finally Ava reiterated, “I’m not going to stress myself and make myself crazy trying to maintain my weight. But, “I need to do better than what I’m doing on an ongoing basis.”

Ella.

“I started taking a little bit of a look at myself. I... was either doing a lot of self-sabotaging, or getting control of my life and focusing on me. I decided to focus on me... instead of saying screw everything.”
Ella had begun to have perimenopausal changes during the last few years of her most recent weight loss and weight maintenance experience. The 80 minute interview occurred in my office one Sunday morning after several attempts to schedule a mutually convenient time. She agreed to stop by after her weekly grocery shopping for her family of three teens and a husband. Upon her arrival I commented that she seemed to have lost more weight since I last saw her, which drew a pleased, “Oh, thank you.” She said, “…it’s a pleasure, and it’s actually an honor” to be interviewed because, “My nutritionist actually told me that I should… be a participant in a study.”

Ella recalled in a positive upbeat manner that her most recent weight loss journey has been six years, including just over one year of maintenance. She said she is five feet three inches tall and during six years went from 175 pounds down to 127 pounds with a final comment, “Oh, wow. Yeah. It’s crazy.” However, she revealed a heavier weight from earlier in her life, “I was 225, and now I’m down to 127. I’m 98 pounds down from my original weight.”

Ella began telling her story by saying, “I’ll start at the beginning. I was born with a hole in my heart, so I was very, very thin. And at the age of four and a half, I had open-heart surgery. …then I …was healthy again.” She described an adolescence fraught with, “that stigma in the head of being overweight, and… never any of the sizes that my friends were… always at least 25 pounds or more overweight. I considered myself fat.” She chose a path of “doing some recreational drugs” until her 20s to curb the weight gain. “In high school, I was a size 16 at one point… then a size maybe 10 or 12.” Then her weight became 200 pounds and 225 after her son was born, a range she remained in for almost ten years.
She described her Italian American food culture as contributory to her overeating, “it was just always there, in my face 24/7, and I just never said no to anything,” and herself as “food has always been an issue for me, always. I’m from an Italian background, and, you know”

In the context of having three obese adult siblings, the recent death of her father “from high blood pressure, diabetes, and heart disease,” and another recent death of a close same age “severely obese” friend she was “prompted” to take, “a little bit of a look at myself.” She recollected, “I was either doing a lot of self-sabotaging, or getting control of my life and like focusing on me. And I decided to focus on me … instead of saying screw everything.” So she requested a recommendation for a nutritionist from her doctor, and lost 80 pounds within one year with weekly appointments, food logs and exercise.

Confronted with several major life adversities, her weight crept back up over the next three years to a point that prompted her to return to exercise and the nutritionist. “I was like, 175 is way too close to 200. I don’t want to go there. So I got serious… again.” However weight loss became more difficult for Ella in midlife. “I lost about 10 pounds, but I just couldn’t get under 160.” After several months she began taking a nutritional supplement that a Facebook friend from college told her about. “Within four months, I dropped about 35 pounds. I went from size 12 to a size 4…, 98 pounds down from my original weight of 225.” After telling me this, she had tears rolling down her face. I offered her a tissue for what she described as “happy tears” about maintaining her current weight in midlife, as well as her new found ability to help others by selling the nutritional supplement she takes. “I had so many people coming up to me going, ‘What the hell are you doing? You look amazing.’ I started selling it only because people were asking me so much about it. And that wasn’t my intention. My intention was for me and for me
only. Not to help other people out.” Ella again began tearing. “And so I get very emotional when I talk about it.” Unexpectedly, Ella presented me with a few products from the nutritional supplement line she now sells—an energy bar and some powdered supplements.

Ella’s most recent weight maintenance period of just over a year was characterized by a personal resolution to herself, deliberate physical activity, a deliberate plan for nutritional intake, supportive people, and basking in the enjoyment surrounding her current weight. The mindset she said was necessary for weight loss maintenance was, “You have to have it in your mind that you’re ready to do something about it. Because if you don’t, you’re going to fail. And you have to do it for yourself. Not for anybody else.” The intellectual importance of his sentiment was reflected in terms of family support. Even though Ella stated of her family’s support, “My husband’s great. My son is great, and my stepdaughter and my niece,” she also thought, “I don’t think it would deter me on my path if I did not have it because I have self-esteem”.

“Now I belong to two gyms, and I have crazy amounts of energy. I work out pretty much on a regular basis.” She joined a second gym at friend’s suggestion because unlike the first one, they have classes and trainers and it is a place where she feels they “really care” and she feels, “like you’re part of a family.” Ella recalled a friend’s comment when she told him that she belongs to two gyms, “What? ...Go from one addiction to another. At least this addiction is healthy, you know.”

She remains “connected” to her nutritionist on a regular basis, but during this recent year or so of weight loss maintenance has usually been eating only two meals per day and still following the weight loss nutritional plan. Her family refers to this as her “powder diet.” Ella characterizes this program as, “the products alone, even without taking supplements have tons of vitamins,
minerals, all that good organic stuff that our body needs and craves that isn’t in a normal diet… my green vegetable drink… protein shake… protein and fiber bars… my little accelerator pill… boosts my metabolism, but it has no ephedra. It’s all natural… my cleanse powder detoxifies the liver… Her two meal food intake is limited to, “Greek yogurt with some fruit… I’ll have a healthy lunch, with a little sandwich with turkey or chicken, with a salad, and avocado on the side, depending on what’s available. I like to switch it up because I don’t like to get bored.” When she goes to a party she eats, “whatever they have, even desert,” but waits to become full before getting a second serving, “I wait a few minutes before I go back up. Like last night I did go back up, but I had salad.” In terms of shopping for her family’s food Ella said, “I don’t buy as much crap as I used to… now I can resist. I don’t necessarily crave it anymore.” “It’s the products, because you know you’re getting everything that your body needs and wants.” Writing down a shopping list and sticking with it is important to Ella to avoid unhealthy impulse buying. “I always put the healthier produce items in my cart first.” We talked about how this correlated with eating healthy vegetables or fruits first during a meal.

Ella expressed dissatisfaction about her new weight loss maintenance body, which existed amidst overall satisfaction when she said, “It’s really nice because I do get a lot of attention… attention that I never got before.” “I’ve lost most of my chest, which kind of sucks, but it’s not going to ruin my day. Some of my skin is very saggy, I’m not very happy with it. But, I mean, those two negative aspects don’t outweigh the other benefits from all of this.” Ella continued on with positive remarks about how she now views herself compared to when she was obese. “I’ll look at myself in the mirror and before it was like I would run by a mirror. And now, I can stand
in front of a mirror and sometimes I’ll find myself staring at myself for quite a while. And it’s like, holy shit, this is what I really look like! You know? It’s crazy. It just blows my mind.”

She indicated that the weight loss validated rather than created her self-worth, “Well I always kind of had self-esteem…Because of the weight loss, I feel more positive. I hold myself a little differently… I like getting ready. I like looking good… When you dress better and you look better, you feel so much better.”

In addition to family support, Ella identified relationships that seemed essential to her weight loss maintenance journey, which included her doctor, nutritionist and Alcoholics Anonymous group. “I do go to AA… wonderful group of women that I’m connected with.” And, “I have a lot of support pages on Facebook. I have a lot of friends that have lost weight.” “I am connected with a group on Facebook which is called Isabody Challenge…and I have my personal team group page, which is called Isa for Life.” The later connections were related to her selling nutritional supplement products that she takes, which opened up “a whole new world of network marketing… meeting all these other team members and people that are involved in nutrition. I’ve met so many people, people from formerly being in the NFL, wrestlers… I mean, just so many people, I’ve just had an amazing year.”

Ella’s outlook at the time of the interview was, “I know that I’m healthy now. And I’m not going to die – well hopefully I’m not going to die from, you know. Because I have a good clean bill of health from my doctor.”
Appendix M
First level of reflection and audit trail
Participant Raw Data

Lucinda

The first level of reflection of Lucinda’s experience revealed sentitious phrases of weight loss maintenance during perimenopause with fundamental meanings of: weight story, health concerns, perimenopausal issues, changing thoughts and feelings about myself, and new life habits and relationships to support weight loss.

<table>
<thead>
<tr>
<th>Sentitious Phrases of Lucinda’s Weight Loss Maintenance During Perimenopause</th>
<th>Fundamental Meaning</th>
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<tbody>
<tr>
<td>“When I began to lose weight I had, I guess it was around when I was about fifty years old I just decided it was time for, maybe it was even a little before that I decided it was time for me to you know try to lose some of that weight I had gained with the kids, pregnancies.”</td>
<td>Weight Story</td>
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<td>“My mother’s family had diabetes… It's definitely a risk factor for me so I have to be careful.” “I know it's important for your health to maintain a good body weight because I read that it stays off cancers and diabetes and all these other dread diseases.” “So, so far I am healthy.” “I am taking care of myself.” “So I’m hoping since my parents both had various kinds of, cancers and my mother’s family had diabetes, you know, I don’t think she had it herself. It's definitely a risk factor for me so I have to be careful.”</td>
<td>Future Outlook</td>
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“I mean I have never, I have had myself tested for thyroid issues because you know I found myself this year especially feeling more sluggish, supposedly I am fine, I am normal, so I think it's just with menopause you get less sleep because you get woken up. Laugh.”
“So I think that’s what is causing me to get sluggish.” “…I always thought that maybe the reason I didn’t get too many hot flashes in the, leading up to the menopause was because of the exercise.”
“As we age we get more aches and pains and it becomes an issue if you overdo it, you don’t want to ruin your joints.”

“The motivation to exercise every day is obviously feeling good, looking at you know, being able to wear clothes that look good and feel good. I feel more attractive to people.”

“When I look at myself in the mirror I am happier and I think when people see me I get compliments with either what I am wearing or my hair whatever.
When I walked in today, you said, the first thing you said was I like your hair, so of course that self-reinforces, you know, of course that feels good.” “…it is something from within.
I have noticed that I need to, my body needs a certain amount of exercise in order to feel good.”
“After I gave up that job or worked full-time I finally opened myself up to doing things where I felt like I could do things that I like doing and not just things that were paying for everything that I needed in life.” “I am doing a lot of more creative stuff.” “I play the recorder with a little band…” “I have been making earrings.” “I sing in a choir now.”
“I don’t seem to be able to eat as much as I used to, like my stomach got shrunk.”
“It does make you feel like you set a goal…a sense of accomplishment.” “…it’s hard to say if somehow I woke up and I was thin would I still feel that way, I don’t know. That never happened to me so.”

“The more you eat you know the more you will gain. So I think that for me this is the key.” “It's really a matter of individual responsibility for your choices of eating and exercising.”
“smaller portions” “I am the one who is buying the food.” “I did change my diet to some extent. I cut out the morning bread. I rarely eat pasta.”
“The banana bread I brought, I do indulge in it every now and then. I make apple pie and I will eat it.” “I am afraid to eat a lot so I can’t over

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| “So I think that’s what is causing me to get sluggish.” “…I always thought that maybe the reason I didn’t get too many hot flashes in the, leading up to the menopause was because of the exercise.” | Thoughts and feelings about myself |
| “As we age we get more aches and pains and it becomes an issue if you overdo it, you don’t want to ruin your joints.” | |
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| “When I look at myself in the mirror I am happier and I think when people see me I get compliments with either what I am wearing or my hair whatever. When I walked in today, you said, the first thing you said was I like your hair, so of course that self-reinforces, you know, of course that feels good.” “…it is something from within. I have noticed that I need to, my body needs a certain amount of exercise in order to feel good.” | |
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“Indulge.” “...even though I am eating healthy snacks like nuts I know you can overdo with that.”

“I do try to make half of my plates salad or vegetables, and then a protein about the size of my fist and generally cut out the carbohydrates.” “I am not really depriving myself.” If something is going to taste really good I am going to eat more of it and that’s another thing I decided.” “When I make my own bread I butter it, it's just that’s how it is.”

“One thing I really haven’t done is weighing myself everyday. I never liked doing that because it would just make me crazy. So I just don’t go on the scale, I could tell from my clothes if they’re fitting right.”

“Some people believe in checking in with somebody and having yourself monitored weekly or whatever, but I never really wanted an outsider to be looking at what I was doing, I just felt like this is something that I wanted to do on my own.

You have to be willing to make the commitment to exercise every day or nearly every day.” “Working your body is a positive because it helps all your systems stay in sync.

“The key is not to feel bad if you have one or two bad days.” “…you just have to wake up the next day and get back on track.”

“I found a friend who was willing to motivate me, and I motivated her and we both pretty much run at least five times a week.”

“Definitely I need another person.” “I have discovered that if Angela is not available for several days in a row, I tend to slack off. I need that other person to get me going.” “Occasionally I would get a phone call from her or I would call her and she would be unavailable and I felt like oh my god what am I going to do now...” “I am sure she felt the same way when I would say the same thing… we have these morning therapy sessions I call them.” “I am sure that’s why it's been easier for me to maintain this because it's not just mindless running around the track.” “…she gives me ideas on how to approach my brothers. How to talk to them, in a way that won't make them go crazy and she has some good ideas.”

“She really doesn’t tell me what I should or shouldn’t be eating because she doesn’t feel it's her place.” “…she is in a rut because she has this family ethnic group problem… I said you could tell them you can’t eat it.”

“I once suggested that to her. Why don’t you bring cut up fruit? And then you could eat that. And she did do that a few times but they must have made her feel uncomfortable about it, they tease her, so if she, you know it's not easy for her.”

“Daniel has been supportive; he is glad that I am running, he says it’s is great... he’s got my kind of body type where he needs to keep active or...
he’ll start putting on weight.”

The second level of reflection involved interpretation of the sentitious phrases which revealed thematic statements, saturation of themes and meaning in Lucinda’s story.

### Thematic Interpretation of Lucinda’s Story

<table>
<thead>
<tr>
<th>Awareness of always being overweight</th>
<th>Weight story</th>
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<tr>
<td>Future health concerns related to weight</td>
<td>Future outlook</td>
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<tr>
<td>With aging comes bodily concerns</td>
<td>Aging</td>
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<tr>
<td>Awareness of more attractive self in presence of others</td>
<td>Thoughts and feelings about myself</td>
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<td>Taking responsibility daily for keeping healthy weight</td>
<td>Habits</td>
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<td>Encouraging self to continue, not give up</td>
<td>Sticking with it</td>
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<tr>
<td>Needing support and giving support</td>
<td>Relationships</td>
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</table>

### Lenore

The first level of reflection of Lenore’s experience revealed sentitious phrases of weight loss maintenance during perimenopause with fundamental meanings of: weight story, future health, perimenopausal issues, changing thoughts and feelings about myself, and new life habits and relationships to support weight loss.

### Sentitious Phrases of Lenore’s Weight Loss Maintenance During Perimenopause

| “Well first of all, I’ve lost nineteen pounds. As you know from our telephone call, I lost a little more than 10% of my weight about two years ago.” | Weight story |
| “I realized eventually that I needed to also focus more on my own issues and my health.” | Future health concerns |
|——|——|
| “I’m still a little self-conscious about this here. I wish I could afford a plastic surgeon to get rid of this.” | Aging affects my appearance |
| “When I was heavier I never could have worn tight jeans like this. Now I feel attractive in these jeans.” “I look younger with the weight loss.” “I want to enjoy life, but I don’t want to be overweight.” “Now I have to remain in control.” “You have to take charge.” | Thoughts and feelings about myself |
| “My main focus became controlling my eating. And it worked with taking off the pounds.” “I weigh myself every day. Every single day.” “It’s not like I feel I’m being obsessive, but like I need to know the daily fact to guide my eating to help myself.” “I develop strategies to fool myself.” “I always have plenty of food… So it’s easy to grab if I am hungry. I never let myself feel hungry.” “…at the… party I fill a plate with a small amount of everything that appeals to me and take a small taste.” “I took small bites. I savored them.” I rely on many of the strategies I learned at Weight Watcher’s years ago. “I don’t deprive myself.” “I try to stay away from many carbohydrates.” “Also, when I’m full, I stop.” I eat slowly so I’m more likely to feel full sooner.” “…we don’t keep ice cream or candy in the house… so I’m not tempted.” “…first I eat a bunch of veggies until I’m nearly full… eat fish for breakfast to get the recommended morning protein… I take frozen fish to work and microwave it for lunch.” I don’t schedule in daily amounts of a particular type of exercise | Habits I follow |
| “I want to enjoy life, but I don’t want to be overweight.” When I’m hungry, I eat.” I never let myself feel hungry.” “Monitoring and control is now a way of life.” | Sticking with It |
“…we’ve been friends for so long, she’s heard all about my weight issues.” “…my husband is very supportive…accepting.” “We’ve been married 25 years.” “When our son comes home I tell him to keep his chips and junk stuff in his room.” “The weight loss has really helped me in my most recent job search.”

<table>
<thead>
<tr>
<th>The second level of reflection involved interpretation of the sentitious phrases which revealed thematic statements, saturation of themes and meaning in Lenore’s story.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness I needed to lose body weight in midlife</td>
</tr>
<tr>
<td>My future health becoming a concern</td>
</tr>
<tr>
<td>At one time I was accustomed to being very active with a sport. I got so heavy during my 40’s trying to get pregnant, I wasn’t physically active.</td>
</tr>
<tr>
<td>Feeling organized and in control, younger and more attractive</td>
</tr>
<tr>
<td>I develop strategies</td>
</tr>
<tr>
<td>Daily monitoring and control of eating</td>
</tr>
<tr>
<td>Existing with supportive connected relationships</td>
</tr>
</tbody>
</table>

**Sally**

The first level of reflection of Sally’s experience reveled sentitious phrases of weight loss maintenance during perimenopause with fundamental meanings of: weight story, health concerns, perimenopausal issues, changing thoughts and feelings about myself, and new life habits and relationships to support weight loss.
### Sentitious Phrases of Sally’s Weight Loss Maintenance During Perimenopause

<table>
<thead>
<tr>
<th>Phrase</th>
<th>Fundamental Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>“About two years ago New Year’s Eve, my husband and I – and my husband is severely overweight – decided to go on Weight Watchers I lost 25 pounds… since then, I have basically continued to live the Weight Watcher philosophy… portion control and the point system.”</td>
<td>Weight story</td>
</tr>
<tr>
<td>“My mom had been heavy as a teenager.” “I’m 5’3 and a half, but I was about 170 pounds when I was, you know, 13, 14, 15. Two out of my three sisters were heavy as teenagers.” “My husband’s knees are starting to hurt, and eventually it’s going to catch up with him.”</td>
<td>Future Outlook</td>
</tr>
<tr>
<td>“My doctor’s always yelling at me, I am not physically active the way I should be.”</td>
<td>Aging</td>
</tr>
<tr>
<td>I don’t exercise, unfortunately: I guess raising two kids is enough exercise, plus work.” “I get up at 5:30 as it is right now, and I don’t get home or get to relax until probably 9 o’clock at night, just because of my schedule with work and my kids… I have to be realistic, regular exercise is not going to be in my repertoire. There just isn’t time at this point in my life.”</td>
<td>Aging</td>
</tr>
<tr>
<td>“I’m very organized and proactive” “I feel much better… healthier, I think I look better, and I think it gives me a more positive attitude.” “In terms of presenting myself I feel more confident.” “I feel like I’ve accomplished something if I’m eating the way I should and watching.” “I don’t exercise, unfortunately and I don’t like to exercise. So, it’s a chore for me.” “For me, it’s just easier to monitor my food than it is to monitor the physical activity.”</td>
<td>Thoughts and feelings about myself</td>
</tr>
<tr>
<td>If you see you’re up a pound or two, you’ve got to adjust accordingly to get back to where you were or the next thing you know you’re up 15 pounds. So I like to stay within a pound of where I got to.” “it’s really just the monitoring of what I do.” “my mother just always taught us portion control.” “I don’t deny myself anything… but you’re not overindulging either to the point where those calories start to add up and you start to gain weight.”</td>
<td>Habits</td>
</tr>
</tbody>
</table>
“my philosophy is you shouldn’t wait to maintain or to stay status quo until you’ve gained five or six or seven or eight pounds, ’cause then it becomes much more difficult. “if I know that I’ve eaten more than I should over a couple days, I will get on the scale, and then I will weigh myself every, probably, other day, rather than every day, until the weight comes off. And then I probably get on the scale once or twice a week.”

“It’s not a diet, it’s really a change in lifestyle, if you look at it that way, it’s easier to maintain.” “It makes me feel good that people noticed, so I think I’m more inclined to try and maintain it.” …a lot of salads helps with the maintenance.”

“I’m going to sort of plan the rest of my day around what I’m going to eat later.”

“I’m a creature of habit, and I eat a lot of the same things.”

“I find that when I eat more and I eat a variety of foods that have some fat in them, and have some calories and have some carbs, and you know, it’s a healthy mix with small meals throughout the day, that I actually am able to eat more and lose weight, or maintain my weight, rather than when I go on a diet mentality where you have a salad for lunch and then you have like a little piece of chicken with nothing on it, I find that it’s much more difficult to maintain my weigh that way.”

“I maintain very well, he does not maintain very well” I try and cook healthy at home… and maintain what we’ve done in terms of Weight Watchers. But I can’t monitor what he’s eating when he’s not home.” “I got to the point where I was like, “I can’t do this anymore. He’s got to do it, he’s got to want it on his own.”

“A lot of people in the office building are on WW. The gentleman who does the food preparation in my office building- a lot of his stuff is Weight Watcher friendly.”

The second level of reflection involved interpretation of the sentitious phrases which revealed thematic statements, saturation of themes and meaning in Sally’s story.

| I have a personal history of obesity and a family history of obesity | Weight story |
| I want to keep off the 25 pounds I lost to stay healthy | Future outlook |
| I don’t want arthritic knees or other weight related problems when I get older
Motherhood responsibilities interfere with regular exercise | Aging |

Following my plan long term
Relationships
Weight loss makes me closer to my ideal professional self

Thoughts and feelings about myself

Monitoring myself and my weight to maintain desired weight

Habits

Think of it as a positive lifestyle change and not as deprivation

Sticking with it

Relationships bring support, disappointment, altruism

Relationships

**Tamara**

The first level of reflection of Tamara’s experience revealed sentitious phrases of weight loss maintenance during perimenopause with fundamental meanings of: weight story, health concerns, perimenopausal issues, changing thoughts and feelings about myself, and new life habits and relationships to support weight loss.

**Sentitious Phrases of Tamara’s’s Weight Loss Maintenance During Perimenopause**

<table>
<thead>
<tr>
<th>Weight story</th>
<th>Future outlook</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I’ve always had a weight problem most of my life.” “35 years ago, the food plan for Overeaters Anonymous was a very, very strict food plan” “I lost 60 pounds in a very short period of time…maintenance, not successful then, either.” “started to eat out of control again” “I did maintain that weight loss probably for the longest time, like eight years.”</td>
<td>Weight story</td>
</tr>
<tr>
<td>“I have celiac disease… if you continue to eat gluten, you could get lymphoma.” “I haven’t really lost any weight in all the time that I’m going to OA now, the past ten years. “And I’m very grateful to have celiac disease because I can eliminate the carbohydrate.” “I don’t have, thank God, metabolic syndrome.” “most of my weigh is below my waist. Which is probably a good thing, health-wise.”</td>
<td>Future outlook</td>
</tr>
</tbody>
</table>
“it’s like the cardiac scare.” “Thank God I don’t have any other medical condition except the celiac.” “I don’t have any like shortness of breath, or… blood pressure is low; go for all the cardiac check-ups and everything is fine.”

<table>
<thead>
<tr>
<th>Aging</th>
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</thead>
</table>
| “I would like to be thinner.”  “I would like to be maintaining at 125 pounds, rather than at 160 pounds.”  “I don’t feel like I’ve achieved anything other than no more food obsession.”  
I think I’ve given up the fantasy that I could ever go back to size 2 jeans.  “It’s been a peaceful experience.  Because – this time around, that I’ve been maintaining the weight for a really long time… other times, it was always stressful.  I couldn’t really maintain it, and…I would, disappoint myself.  Like, “oh my God, now you’re going to have to go on a diet again.” accepting your feelings… living it one day at a time.” |

<table>
<thead>
<tr>
<th>Thoughts and feelings about myself</th>
</tr>
</thead>
<tbody>
<tr>
<td>I’m not an exercise person I just don’t do it.  “Three meals a day, and a snack.  And I can have one dessert”  But what I do is that I really don’t compulsively eat. I can have just one of something, which is a miracle.”  “I go to the OA meetings, I do the readings, do the writings, I do everything that they tell me to do.  I have a sponsor, I do everything… I do tell my sponsor every day what I’m going to eat the next day.”  “I really never get on the scale.”  “… I would have to eat like 500 calories a day in order to lose weight… at this stage in my life.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Habits</th>
</tr>
</thead>
<tbody>
<tr>
<td>I go to OA. I do everything that they tell me to do.  “Even though it’s not what I would like it to be, I’ve been this weight for a long time.”  “the gift is not getting heavier and heavier, and being able to wear the same clothes from season to season, which, when I was younger, did not happen.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sticking with it</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Today I focus more on my relationships with people than on the food.”  “Being Italian-American… if I go to my sister’s house on a holiday I say, can we just get away from the food?”  I do tell my sponsor every day what I’m going to eat the next day.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I go to OA. I do everything that they tell me to do.  “Even though it’s not what I would like it to be, I’ve been this weight for a long time.”  “the gift is not getting heavier and heavier, and being able to wear the same clothes from season to season, which, when I was younger, did not happen.”</td>
</tr>
</tbody>
</table>
The second level of reflection involved interpretation of the sentitious phrases which revealed thematic statements, saturation of themes and meaning in Tamara’s story.

| I’ve always had a weight problem most of my life | Weight story |
| So far my weight has not caused health problems but it could | Future outlook |
| No complaints about aging | Aging |
| Dissatisfied but at peace with my weight | Thoughts and feelings about myself |
| Following OA helps decrease compulsive eating | Habits |
| Following strict food routines and OA | Sticking with it |
| Speaking up about what helps me | Relationships |
| Needing support from OA, friends and family relationships | |

**Peggy**

The first level of reflection of Peggy’s experience revealed sentitious phrases of weight loss maintenance during perimenopause with fundamental meanings of: weight story, health concerns, perimenopausal issues, changing thoughts and feelings about myself, and new life habits and relationships to support weight loss.

**Sentitious Phrases of Peggy’s Weight Loss Maintenance During Perimenopause**

<table>
<thead>
<tr>
<th>Sentitious Phrase</th>
<th>Fundamental Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I was a heavy child growing up. Through my 20’s and 30’s I always exercised, I ate right.”</td>
<td>Weight story</td>
</tr>
<tr>
<td>“Once you start gaining weight during perimenopause, not only does it not feel good, it’s not healthy. “Now, going through the perimenopause it’s a whole different challenge, you get stuck.” “You’re hormonally challenged… all that that’s going on chemically affects you mentally. It felt like...”</td>
<td>Future outlook</td>
</tr>
</tbody>
</table>
PMS was continuous and didn’t stop. So with PMS comes compulsive eating, emotional eating, and feeling horrible about yourself, where you don’t want to go to the gym because you feel horrible.”

“You’re not only battling with your body changing and your metabolism going down – it’s also an emotional journey.” “It was upsetting that I wasn’t getting my period anymore. Because it felt like – I’m too young for this.” “I just wasn’t ready.” “Now especially it’s more challenging to take the weight off.” “I have the initial beginning of osteopenia and I have arthritis.”

“When I get off of the routine it’s very challenging to get back into the routine, because you then fall into this mental – you know, there’s depression.” “If I don’t go to the gym for a whole week, I feel like almost like depressed – it’s therapy for me.”

“There are no tricks, it’s eating right and exercising.” “I watch what I eat, I do a lot of mental affirmation, and I exercise like crazy.” “a lot of protein and vegetables.” “If I’m at a weight that I’m happy with maintaining, on the weekends I will indulge.”

“It is a struggle because it is somewhat of a rollercoaster, and it’s a little bit of a vicious cycle.” “A lot of it is definitely discipline with the food and the exercise, but mostly it’s a mental thing.”

“What works for me is words of affirmation, and really saying to myself, This moment that you’re having right now, it’s going to pass. And even sometimes give in to the indulgences that I’m craving, because sometimes if you don’t give in they just get bigger.”

The second level of reflection involved interpretation of the sententious phrases which revealed thematic statements, saturation of themes and meaning in Peggy’s story.

<p>| I learned how to control my weight in my 20’s. | Weight story |
| Wanting health as I age | Future outlook |
| Hormonal imbalances cause ups and downs | Aging |
| Midlife brings weight challenges and health challenges | |</p>
<table>
<thead>
<tr>
<th>Battling depressive feelings midlife</th>
<th>Thoughts and feelings about myself</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating right and exercising regularly</td>
<td>Habits</td>
</tr>
<tr>
<td>Mental affects emotional and behavioral</td>
<td>Sticking with it</td>
</tr>
<tr>
<td>Relationship with myself must be supportive</td>
<td>Relationships</td>
</tr>
</tbody>
</table>

**Ava**

The first level of reflection of Ava’s experience revealed sentitious phrases of weight loss maintenance during perimenopause with fundamental meanings of: weight story, health concerns, perimenopausal issues, changing thoughts and feelings about myself, and new life habits and relationships to support weight loss.

**Sentitious Phrases of Ava’ Weight Loss Maintenance During Perimenopause**

<table>
<thead>
<tr>
<th>Weight story</th>
<th>Future Outlook</th>
</tr>
</thead>
<tbody>
<tr>
<td>“When I was young I kept my weight at one thirty. “I just started putting on weight when I stopped smoking before I had my son.”</td>
<td>“By the grace of God I have been healthy over the years.” “It’s one thing to have longevity but it’s important to have longevity and feeling good.”</td>
</tr>
<tr>
<td>“Every two years, I start inching up.” “I’ve never gotten huge” “I have gone down to what my, my ideal weight is and I have kept it. “So now, I have to get back to that and then keeping it.” “I have to go back to Weight Watchers. I’ve never been successful in accepting what has to be done to maintain the weight.” “when I’m getting ready to go into a 14, now then we’re in trouble.”</td>
<td>“As, an African American woman I am prone to, obesity, hypertension and diabetes. I don’t have diabetes, I already have hypertension.”</td>
</tr>
</tbody>
</table>
“When I was young, I could put on weight and I could drop it in a couple of days.”
“I really only have ten pounds to lose, maybe between ten and fifteen. It’ll take me forever to lose it, you know.”
“Do you want to get old and then not be able to walk?”
It’s quality of life, not just life.”

“I’ve never really [laugh] thought about it in this way. I’m kind of like Peter Pan, like child not wanting to grow up in this part, sometimes refusing to, challenging aging and the adjustments that one has to make.”
“In my life, there’s this underlying [laugh], aggravation about life [laughter] and its rules and its regulations. And so the one thing that I can do is control what I eat. I do most of my acting out with food.”
“We can’t do really want we want to do. When you have kids, you can’t do everything that you want to do. You have to, you know, like kind of do in relation to what your family needs, what your children need...”
“I need WW just as some people need AA.” “I come from a family of addicts.”
“I can eat really just as a result of not wanting any limits.”
“It’s just wanting to do what I want to do when I want to do it. I mean, that, that’s all that it amounts to. It’s very unrealistic and it’s very immature and infantile. But that’s, that’s exactly the way that I feel at times.”
“Doing what I want to borders on being excessive. The twenty-five-cents bag of chips won’t do it. It has to be the ninety-nine-cents bag of chips. It has to be – as much as I want to eat during the course of that and during the course of that week.”
“The goal that I have chosen for myself this time is to see if I can truly get into a place where I will accept this and I’ll be reasonable.”
“To me, life is always unfolding.”

“I don’t eat, McDonalds or Burger Kings, I eat healthy. You know, vegetables and stuff like that.” “But I will overeat.” “I won’t have seconds.” “Don’t take the macaroni and cheese, lasagna, potato salad and rice” “Oreo cookies are just as addicting as cocaine.”
“When my clothes start to feel too uncomfortable, then I know without even getting on the scale...”
“If I decide not to use control, I know that I’m going to pay for it, and then, I have to decide that the next day, it’s only a salad.”
“I’m not sedentary at all. I do a lot of walking; it keeps my weight down.” “I’ll see how I did during the week.”
“I will refuse to let myself get past a certain point and then I will go to Weight Watchers.”

I need to do better, on an ongoing basis. Not just when I want to lose it, but it on an ongoing basis.

“I can go for a year or so” “I’ll reach a point where I just really want to do whatever it is that I want to do.”

“these binges that I go on really throw everything out the window.”

“I know the seesaw effect is not good up and down, up and down.”

“ Even without stress, if I feel that I have been good for just too long, then, I will, go on somewhat of a binge, gain a certain amount of weight, and then say, “Okay, enough is enough.” And then, I will get myself back into some kind of control.”

“The goal that I have chosen for myself this time is to see if I can truly get into a place where I will accept this and I’ll be reasonable.”

“To me, life is always unfolding.”

“Making the WW meeting is about commitment.”

“you fall off the horse, just jump back on.”

“I’ve never gone above a hundred seventy-seven pounds. The highest that I have gone in the last five or six years is maybe one seventy. That’s as far as I go”

WW meetings keep me around people who are dealing with the same exact thing. It’s that support.” “there’s a comraderie.” “When you have somebody there you kind of help each other along.” “I like hearing people with success, it’s reinforcing. “The moment that I hit the hundred and fifty-five pounds, I’ll let you know.”

The second level of reflection involved interpretation of the sentitious phrases which revealed thematic statements, saturation of themes and meaning in Ava’s story.

<table>
<thead>
<tr>
<th>Began gaining weight during childbearing years but never obese</th>
<th>Weight story</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excess weight and yo yo weight can become unhealthy. I want to be healthy.</td>
<td>Future outlook</td>
</tr>
<tr>
<td>As I get older my weight could interfere with QOL</td>
<td>Aging</td>
</tr>
<tr>
<td>Resisting feeling controlled</td>
<td>Thoughts and feelings about</td>
</tr>
<tr>
<td>Habits and downfalls</td>
<td>Habits</td>
</tr>
<tr>
<td>----------------------</td>
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</tr>
<tr>
<td>Sticking with it on my own terms is a struggle</td>
<td>Sticking with It</td>
</tr>
<tr>
<td>Supportive relationships help</td>
<td>Relationships</td>
</tr>
</tbody>
</table>

Ella

The first level of reflection of Ella’s experience revealed sentitious phrases of weight loss maintenance during perimenopause with fundamental meanings of:

**Sentitious Phrases of Ella’s Weight Loss Maintenance During Perimenopause**

<table>
<thead>
<tr>
<th>Phrases</th>
<th>Fundamental Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>“as I progressed into my adolescence and my teenage years I started to get heavy.” “I always had that stigma in the head of being overweight. I considered myself fat.” “I basically stayed in the 200-plus range from when my son was born, up until 2008. So that’s almost ten years. In 2008 I started this journey on weight loss. I was 225, and now I’m down to 127”</td>
<td>Weight story</td>
</tr>
<tr>
<td>‘I was born with a hole in my heart… And at the age of four and a half, I had open-heart surgery. … “I know that I’m healthy now. And I’m not going to die – well hopefully I’m not going to die from, you know. Because I have a good clean bill of health from my doctor.” I’m 98 pounds down from my original weight. So I’m pretty content where I’m at.”</td>
<td>Future outlook</td>
</tr>
<tr>
<td>‘My father and mother … weren’t’ very healthy. My father suffered from high blood pressure, diabetes, and heart disease. … my brothers are obese, my sister was obese. … it’s in my line, so, you never know. I put on a little bit of weight after neck surgery, because I wasn’t as active. I had to have emergency hernia surgery. I don’t ever want to look like that again. I didn’t feel healthy; I had asthma. You know. I couldn’t breathe.</td>
<td>Aging</td>
</tr>
<tr>
<td>“I always need to hear something 1,000 times before I do it. It’s just, the procrastinator, the rebel.”</td>
<td>Thoughts and feelings about</td>
</tr>
</tbody>
</table>
“If I didn’t have self-esteem I think it would affect me if they weren’t supportive.”
“The hell are you doing? You look amazing. It’s very enjoyable. I’d be crazy not to enjoy it…” “now it’s like, I can stand in front of a mirror and sometimes I’ll find myself staring at myself for quite a while. And it’s like, holy shit, this is what I really look like! You know? It’s crazy.”
“It just blows my mind…. I like looking good… it’s nice. It’s really nice.”
“You have to do it for yourself. Not for anybody else.”
“I’m healthy now.”

“Seeing a nutritionist… doing my food log. “Writing down a shopping list is very important… I always put the healthier items in the grocery cart first.”
“Eating right. I used to buy a lot of crap. And I used to eat it. But now I can resist.”
“I don’t go back for seconds and thirds or I wait a few minutes before I go back up.” “But I had tossed salad.” Sometimes I’ll eat supper. But most of the time, I’ll just have lunch with a little sandwich with turkey or chicken, with a salad or something, or maybe avocado on the side. Mid-morning… Greek yogurt with some fruit…a protein or a fiber bar. …long walks, going on the elliptical, going to the gym whenever I could.”

“I belong to two gyms. I’ve been working out like a fiend.”
“Now I take Isagenix every morning… powder diet.”

“It’s really nice because I do get a lot of attention… that I never got before [at the gym].” I do go to AA… they’re very supportive. I have a wonderful group of women that I’m connected with. …you feel like you’re part of a family… they could just do a class and not really care, but they care.” I have a lot of support pages…friends that have lost weight. I am connected with a group on Facebook which is called Isabody Challenge…my personal team group page, which is called Isa for Life” “family is supportive.”

The second level of reflection involved interpretation of the sentitious phrases which revealed thematic statements, saturation of themes and meaning in Ella’s story.

<p>| I have been very overweight most of my life | Weight story | Habits | Sticking with it | Relationships | myself |</p>
<table>
<thead>
<tr>
<th>Worrying about dying early</th>
<th>Future outlook</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worrying about dying early</td>
<td>Aging</td>
</tr>
<tr>
<td>Now people finally notice me for looking good</td>
<td>Thoughts and feelings about myself</td>
</tr>
<tr>
<td>I accept new strategies as I learn more</td>
<td>Habits</td>
</tr>
<tr>
<td>Now I am somewhat fanatical about weight maintenance</td>
<td>Sticking with it</td>
</tr>
<tr>
<td>Feeling very connected and supported with weight loss maintenance and helping others</td>
<td>Relationships</td>
</tr>
</tbody>
</table>
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