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Weight Loss Surgery Decision Process: A Grounded Theory Study

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WEIGHT LOSS SURGERY DECISION PROCESS: A GROUNDED THEORY STUDY

by

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A Dissertation
Submitted to the Graduate Faculty
of the
University of North Dakota
In partial fulfillment of the requirements

for the degree of
Doctor of Philosophy

Grand Forks, North Dakota
December
2009
This dissertation, submitted by Martha Lystad in partial fulfillment of the requirements for the Degree of Doctor of Philosophy from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby approved.

Chairperson

[Signatures]

This dissertation meets the standards for appearance, conforms to the style and format requirements of the Graduate School of the University of North Dakota and is hereby approved.

Dean of the Graduate School

[Signature]

December 8, 2005

Date
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Degree: Doctor of Philosophy

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ABSTRACT

The purpose of this qualitative study was to investigate the decision making process of morbidly or severely obese individuals who engage in weight loss surgery and the role of nurses in this process using a grounded theory research design. Morbid or severe obesity is a chronic illness that is increasing in prevalence throughout the United States. The Center for Disease Control (2007) reported the obesity population of adults doubled from 15.1% in 1976-80 to 30.9% in 1999-2000. The current most effective long-term treatment for morbid or severe obesity is weight loss surgery, most commonly gastric bypass or gastric banding. Furthermore, weight loss surgery may be clinically indicated for the treatment of morbid obesity to reduce co-morbid disease processes and promote health. However, it remains an elective surgery and ultimately a personal decision. Thus, the research questions for this study were: How did the participant come to the decision to pursue weight loss surgery? How were nurses involved in the weight loss surgery decision making process? The grounded theory methodology of semi-structured interviews and constant comparative analysis (including open, axial and theoretical coding) was used for data collection and analysis. Eighteen participants (3 males, 15 females) were interviewed (40 to 90 minutes). The preliminary results of this study provided the foundations for the development of a dynamic model of the participants’ decision making process related to choosing weight loss surgery for their obesity. The core variable identified is ‘critical point of change’. The antecedents
identified include a cycle of obesity and motivating or re-energizing factors within the context of the obesity experience. Information gathering and seeking social support were identified as key actions in the decision process. The common intervening factors discussed were support systems, insurance/financial issues, as well as access and availability of bariatric services. Outcomes of weight loss surgery health changes, using the ‘tool’, sense of hope/help and altered relationship with food and eating. This model may be a tool for clinicians to assess readiness for weight loss surgery, and provide information and support to this population throughout their decision making process. Nurses were not readily identified by most participants as key informants in their decision making process. Further discussion of nurse’s roles within this process may need to be examined.
CHAPTER I
INTRODUCTION

Obesity is a health care problem with national attention. There is a wealth of knowledge about obesity however; the treatment of obesity and more specifically treatment of morbid obesity is complex and not completely understood. Weight loss surgery has been used in the treatment of morbid obesity. Weight loss surgery is typically freely chosen by the individual; it is, however, life changing. To understand weight loss one needs to comprehend the context of obesity and more specifically, morbid obesity from a personal perspective. There has been a gap in the literature and the research data exploring the qualitative nature or personal experience of these patients, as well as their decision making process for weight loss surgery. To reduce this gap, this study examined the decision for weight loss surgery as a treatment of obesity. This study’s findings provided invaluable insight for clinicians providing care for these individuals about the decision making process, as well as add depth to the current literature regarding weight loss surgery. In this chapter the background of obesity issues, current status of obesity and morbid obesity, prevalence of obesity, potential causation or contributors of obesity, consequences of obesity, treatment of obesity, obesity as a vulnerable population, significance of this study, purpose of this study and research questions, terms of this study, philosophical framework and assumptions and delimitations.
Background of Obesity Issues

Current Status of Obesity

In the United States the trend of increasing overweight and obesity has been observed in all population groups and this has contributed to at least four leading causes of death in this country alone (Racette, Deusinger, & Deusinger, 2003). There was an estimated 97 million adults in the United States identified as overweight or obese demonstrating that this is a serious public health problem (National Institutes of Health [NIH], 1998). It has been estimated that approximately 9 million people meet the criteria for clinically severe obesity (BMI ≥ 40) (Peskin, 2003).

Overweight and obesity are complex health conditions that impact not only on individual health, but our health care system and our society as well. It has been well established that obesity is a major contributor to many of the preventable causes of death i.e., high blood pressure, high cholesterol, diabetes mellitus Type 2, heart disease and stroke (Institute for Clinical Systems Integration, 2005; NIH, 1998; U. S. Department of Health and Human Services [DHHS], 2000).

The attributable total costs of obesity amounted to an estimated $99 billion in 1995 and $117 billion in 2000 (ICSI, 2005; NIH, 1998; U. S. DHHS, 2000). According to Spence-Jones (2003), approximately 62 million physician visits each year were obesity related. Individuals in the U. S. alone also spend over 33 billion dollars annually on weight loss products and programs (Davis & Turner, 2001; Spence-Jones, 2003). The economic burden of obesity related conditions has included direct costs (medications and hospitalizations) and indirect costs (absenteeism, disability pensions and loss of productivity) (Drury & Louis, 2002).
However, while voluntary weight loss management seems to be increasing, the success has still been marginal (Sugarman, 2000; Williamson, Serdula, Anda, Levy, & Byers, 1992). Obesity and being overweight has continued to be a factor in many chronic conditions such as hypertension, high cholesterol, diabetes mellitus type 2, osteoarthritis, sleep apnea and some cancers in the U. S. While attempts to lose weight are common among men and women there has been no clear consensus as to what works the best for weight loss management. It has been accepted that increased activity and decreased calories are fundamental in any weight loss program; however, other contributing factors that sustain the behavioral changes have not been clearly identified (NIH, 1998; Wing & Gorin, 2003). With only about 20% of overweight individuals successful at long-term maintenance of weight loss, every effort to identify maintenance factors needs to be explored (R. R. Wing & Gorin, 2003; Williamson et al., 1992).

Individuals with morbid or severe obesity present unique challenges to health care providers and systems. Morbid obesity is manifested by an impaired satiety mechanism, inability to sense fullness after eating, an impaired dysfunctional basal metabolic rate, and abnormal conversion of ingested calories to fat rather than their dissipation by body heat and may be ultimately a result of genetic inheritance (Owens, 2003). This has led many severely obese individuals left to seek drastic or surgical measures to reverse the effects of their obesity and restore their health.

Treatment of overweight and obese individuals recognizes the need for interventions to be multifaceted incorporating physical activity, dietary restrictions, behavior modification, use of medications and in some cases surgery (NIH, 1998). The goal of treating obesity has been to achieve and maintain clinically significant weight
loss, thus reducing co-morbid diseases, impairments, and improving overall function rather than the cosmetic desire for thinness (Racette et al., 2003; Rosenbaum, Leibel, & Hirsch, 1997).

Weight loss surgical methods, gastric bypass surgery or lap band surgery, have been reserved for persons who are considered severely or morbidly obese. There has been a recent increase both in the popularity and the demand for weight loss surgery which currently has been the only treatment that has produced sustained weight loss for the morbidly or severely obese patient (Brolin, 2002; NIH, 1998). While morbid or severe obesity has been investigated in reference to causes, risk factors, and treatment, it has not been studied from the perspective of what is it like for the person experiencing morbid obesity. The current literature on weight loss surgery has focused on the medical, psychological, or nutritional aspects of the individuals. There has been a gap in the research literature about the personal experience of these individuals as they choose the most drastic treatment option available for severe obesity. Qualitative research would be one way to explore or gain this understanding, add depth to the current research and expand practice guidelines for health care professionals. Through greater knowledge of individuals’ experiences in how they come to the decision for bariatric surgery, health care providers can improve interactions and discussions of treatment options and support or assist them through the decision making process.

Defining Obesity

Obesity is the excess of adipose tissue that contributes to risk of other chronic diseases (Racette et al., 2003). Obesity is a result of genetic, behavioral, environmental, physiological, social, and cultural factors (NIH, 1998; Racette et al., 2003; Richards,
Adams, & Hunt, 2000). Obesity has been defined as an excessive accumulation of body fat (MacDonald, 2003). Simply stated, weight is gained when energy intake or food exceeds energy expenditure, however the social and environmental causes that facilitate this imbalance are very difficult to isolate (Jain, 2004; Wyatt, 2003).

The most common method used to define or classify obesity is based on body mass index (BMI), a calculation of body weight (in kilograms) divided by the square of height (in meters) (NIH, 1998; Racette et al., 2003). The BMI formula allows for comparison across age groups and populations and is the recognized means to identify health risks regardless of sex (Hahler, 2002). Overweight is defined by a BMI of \( \geq 25.0 \) kg/m\(^2\) or \( \geq 20\% \) over ideal body weight for women and \( \geq 10\% \) over ideal body weight for men (Hahler, 2002; NIH, 1998; Racette et al., 2003). Obesity is defined by a BMI of \( \geq 30.0 \) kg/m\(^2\) or \( \geq 45\% \) over ideal body weight for women and \( \geq 35\% \) over ideal body weight for men (Hahler, 2002; NIH, 1998; Racette et al., 2003).

In summary, obesity has been recognized as a complex medical condition that is a result of multiple factors. Carryer (2001) defined obesity as “a socially constructed disability” (p. 91). Being overweight or obese is not just a cosmetic problem but has been correlated directly to increased prevalence of many other serious health disorders and co-morbid conditions (Wyatt, 2003). Obesity negatively impacts virtually all body systems, increases risks of physical co-morbid conditions, multiple psychological pathologies and social stressors (Blackwood, 2004).

**Morbid Obesity**

Morbid or severe obesity has been traditionally defined as 100% over ideal body weight or more recently as a BMI, \( \geq 40 \) kg/m\(^2\) or more or a BMI \( \geq 35 \) kg/m\(^2\) with the
presence of co-morbidities (Brolin, 2002; NIH, 1998). Patients with morbid or severe obesity have presented unique challenges to health care providers and systems including patient and staff safety as well as special equipment requirements. Morbid obesity has been characterized by body size that restricts their mobility, health, or access to available services (Hahler, 2002).

Prevalence of Obesity

Obesity is a global health problem with an estimated 300 million people worldwide meeting the diagnostic criteria of obese (Jain, 2004; Racette et al., 2003). In the United States, 64.5% of adults aged 20 years or older are overweight with more than 30 percent obese according to BMI 25-29 kg/m² and greater than 30 kg/m² respectively, an increase from 23% since 1994 (Bish et al., 2005; ICSI, 2005). This means that approximately 127 million adults are overweight with approximately 60 million obese and 9 million severely obese (BMI greater than 40 kg/m²) (ICSI, 2005; Peskin, 2003).

The rates of overweight and obesity have continued to increase in spite of the increasing prevalence of trying to lose weight. According to the 2000 Behavioral Risk Factor Surveillance System, 46% of women and 30% of men were trying to lose weight (Bish et al., 2005).

Overweight and obesity has occurred in all ages and all socioeconomic levels in the U. S. (Wyatt, 2003). There have been particular racial and ethnic disparities in the rising number of obese people in the United States; this includes African American, Hispanic, Pacific Islander and Native Americans (Hawks & Madanat, 2003; US DHHS, 2000). A comprehensive review article by Ball and Crawford (2005) examined weight change over time related to socioeconomic status based on education,
occupation, and income. Education and occupation status reported inverse associations with weight gain while income was more inconsistent for both men and women (Ball & Crawford, 2005). Ball and Crawford (2005) concluded that there are some associations with weight gain (obesity) and socioeconomic status but it has been poorly understood and has not explained all the inequalities in obesity. Research by Zhang and Wang (2004) found a stronger socioeconomic status inequality of obesity in women compared to men. The quality of life and psycho-social problems have been reported to be worse for obese women than for obese men (Jain, 2004; Kolotkin, Meter, & Williams, 2001). All in all, the association of socioeconomic status with obesity has offered some clues to environmental factors that impact obesity.

**Potential Causation or Contributors to Obesity**

Research surrounding the pathogenesis of obesity has included the complex afferent signals that regulate appetite, energy storage, energy expenditure, hormonal and chemical mediators of energy homeostasis as well as genetic factors (Rosenbaum et al., 1997). Between 30 and 50% of the body’s ‘fatness’ is regulated by genetic factors (Rosenbaum et al., 1997; Rossner, 2002). The genetic factors include adipose-tissue distribution, physical activity, resting metabolic rate, changes in energy expenditure in response to overeating and certain aspect of eating behaviors such as food preferences and the hormonal influences of appetite (Rosenbaum et al., 1997). These are the same factors that were once needed for energy storage and survival, and are now considered maladaptive in our industrialized societies. Research to identify single gene causes for obesity has been ongoing. However, multiple gene influences of obesity are more likely
given the complexity of the nature of physiology of energy intake, regulation, and expenditure.

The physiologic factors that have contributed to obesity are complex. Fat or adipose tissue has been the primary form of stored chemical energy. The amount adipose tissue is the cumulative sum over time of the difference between energy (food) intake and energy expenditure (resting metabolism and physical activity) (Rosenbaum et al., 1997). The body naturally tries to keep this balance as close to zero as possible, however, an even a small imbalance over time has a cumulative effect. The physiologic response to control this balance of energy intake and expenditure is through endocrine and neural signals from the adipose tissue, and signals from the endocrine, neurological, and gastrointestinal systems, which are then integrated in the central nervous system.

Our environment is another factor that has contributed to obesity. The dramatic increase in the prevalence of obesity has been attributed primarily to behavioral and environmental factors. Our culture has provided easy access to high fat/ high sugar foods with little or no incentive for activity (Hawks & Madanat, 2003; Jain, 2004; NIH, 1998; Racette et al., 2003, Rosenbaum et al., 1997). It has been difficult to separate the impact of social factors from environmental factors that contribute to obesity. Obesity as a chronic illness has been far from simple; rather it is a complex physiological interaction with genetic factors that interplay with the environment.

Consequences of Obesity

Obesity as a chronic progressive illness can lead to complications in virtually every system and organ of the body. Obesity has been identified as the second leading cause of preventable disease and death next to smoking (U. S. DHHS, 2000; Zhang &
Hypertension is the most common weight related health condition and the rates have increased with worsening obesity (Jain, 2004). Other common co-morbidities include Type 2 diabetes, hyperlipidemia, obstructive sleep apnea, heart disease, stroke, asthma, back and lower weight bearing degenerative joint problems, depression and certain types of cancer (Buchwald et al., 2004). Co-morbidities related to obesity have been responsible for more than 2.5 million deaths per year worldwide (Buchwald et al., 2004). Approximately 325,000 deaths in the U. S. each year among nonsmokers have been attributed to obesity (Racette et al., 2003). According to Thompson, Edelsberg, Colditz, Bird, and Oster (1999) disease risks and cost increased with increasing BMI. Unfortunately, awareness of risks has not always been a motivator for improved healthy behaviors (Parham, 1999).

Quality of life suffers as the degree of obesity worsens (Jain, 2004; Kral, Sjostrom, & Sullivan, 1992). The quality of life impairment has been reported as the most serious component of the disease of obesity (Kral et al., 1992). Early studies about quality of life and obesity had been studied by those seeking treatment for their obesity, not looking at obesity in the general population (R. L. Kolotkin et al., 2001). Subsequent studies have examined health-related quality of life in obese persons seeking and not seeking treatment. Persons with obesity seeking gastric bypass surgery for treatment reported poorer quality of life than those not seeking treatment (Kolotkin et al., 2003). The quality of life and more psycho-social problems have been reported to be worse for obese women than for obese men (Jain, 2004; R. L. Kolotkin et al., 2001).
Treatment of Obesity

The National Institute of Health (1998) produced a summary of the current research on obesity which established clinical guidelines for the identification, evaluation, and treatment of overweight and obesity. This report identified the importance of early intervention in the treatment of overweight and obese individuals and recognized the need for interventions to be multifaceted incorporating physical activity, dietary restrictions, behavior modification, use of medications, and in some cases surgery (NIH, 1998). The American College of Physicians is in agreement with this report and has produced clinical guidelines for the pharmacologic and surgical management of obesity. These guidelines recommended life style and behavioral modification including appropriate diet and exercise as well as the use of medications and finally surgical interventions if indicated for all individuals with obesity (Snow, Barry, Fitterman, Qaseem, & Weiss, 2005). The goal of treatment should be to focus on morbidity of the condition and not focus on cosmetic aspects of the condition.

Vulnerable Population

Simply defined, a vulnerable population is one that is “at risk of poor physical, psychological, or social health” (Aday, 2001, p. 2). Health is a multifaceted concept that is a dynamic process. Age, gender, race and ethnicity, income and education are factors that contribute to the vulnerability of any given group (Aday, 2001). “People may, however, be more or less at risk of poor health at different times in their lives, and some individuals and groups are likely to be more at risk than others at any given point in time” (Aday, 2001, p. 5). Owens (2003) has argued that the severely obese are discriminated
against by society and medical personnel and “are the most underserved and
misunderstood individuals in our society today” (p. 164).

As the number of individuals with obesity (especially severe obesity) has grown
so has this vulnerable population in the United States which has impacted the health care
delivery system. The United States is a culture that values thinness and physical
perfection; for many in this country, this has been an unrealistic ideal. Obesity is a
complex condition with well documented stigma. Individuals with obesity have been
stigmatized in virtually every aspect of their lives (Friedman et al., 2005).

There has been no doubt that obesity is a significant public health concern.
Obesity as a public health issue has been complicated due to social, economic and
informal and formal medical health policies surrounding this population which puts them
at risk for vulnerability. The health care bias and prejudice that has been persistent in our
culture remains an ongoing concern in the treatment of this vulnerable population.

Significance of This Study

There have been many obstacles that people with obesity face the health care
system as they seek care for their chronic illness. The treatment of obesity has been a
growing area of specialty. As the rates of obesity and morbid obesity increase the surgical
rates for weight loss has also grown. In this growing field of care, caution must be taken
to provide quality care to this vulnerable population. The challenge to health care
professionals has been to help the person make informed decisions regarding the
treatment of their medical conditions. This study has specifically examined the decision
making process for weight loss surgery as a treatment option for individuals with morbid
obesity. This study provided an opportunity for persons with morbid obesity to share their
stories and experiences regarding their treatment of their disease. This information has been invaluable in order to establish quality weight loss surgery programs to holistically address the needs of this population.

Purpose of the Study

The purpose of this grounded theory research study was twofold: 1) to investigate the decision making process of morbidly or severely obese individuals who plan to engage in or who have had weight loss surgery and: 2) determine how nurses were involved in this process.

Through the use of grounded theory, an inductive approach, this study used the knowledge gained from participants for the generation of theoretical statements or development of a model reflecting the decision making of this population. The results of this study provided the foundations for the development of guidelines so that clinicians can provide information and support to this population throughout their decision making process.

Research Questions

The guiding research questions for this study were: How did the participant come to the decision to pursue weight loss surgery? How were nurses involved in the weight loss surgery decision making process? Probing questions throughout this project allowed for the participants to tell their stories and explore their experiences regarding their decision to have weight loss surgery.

Definition of Terms

Definitions for obesity and morbid obesity were derived after a review of the literature. For the purposes of this dissertation obesity was a BMI $\geq 30.0$ kg/m². Morbid
obesity was then defined as a BMI $\geq 40$ kg/m$^2$ or a BMI $\geq 35$ kg/m$^2$ with the presence of co-morbidities. The latter definition has been commonly used as one of the criteria for weight loss surgery.

Definition for weight loss surgery was considered after review of the literature. The term weight loss surgery was used interchangeably with bariatric surgery. Weight loss surgery was used to refer to any surgery used specifically to treat morbid obesity. This included but was not limited to laparoscopic banding or Roux-en-Y gastric bypass surgery.

Decision making was one of the key concepts to be discussed in this study. Decision making for the purpose of this study was the overall process the participant engaged in during the determination of the choice to have weight loss surgery.

Philosophical Framework

Symbolic interaction provided the theoretical underpinnings for the grounded theory approach. Symbolic interaction has three basic premises that provide the philosophical assumptions that underline the methodological approach to research.

1) "Human beings act toward things on the basis of the meanings that the things have for them" (Blumer, 1969, p. 2). Symbolic interaction assumes that human action depends upon the meaning that people ascribe to their situations (Charmaz, 1990). So in this study, the participants were asked to share the meaning obesity has for them and describe how the decision for surgery involved the responses to this meaning.

2) "The meaning of such things is derived from or arises out of, the social interaction that one has with one's fellows" (Blumer, 1969, p. 2).
Symbolic interaction assumes that thinking, acting, creative individuals, human being respond to the actions of other after interpreting these others’ intent and action (Charmaz, 1990). Thus, the social stigma of being obese may be part of the social interaction they described.

3) “Meanings are handled in, and modified through, an interpretative process by the person” (Blumer, 1969 p. 2). Symbolic interaction professes that people are in a continual process of interpretation and definition as they move from one situation to another (Eaves, 2001). Symbolic interaction perspective suggests that a person is not merely a reactive organism but an acting organism that has a direction or meaning to its actions and is able to observe and analyze their own actions (Blumer, 1969). The semi-structured interview questions were expected to help the person to speak of their observations and share their analysis of their own actions. They shared these in conjunction with their interpretation of their interaction with the environment.

Assumptions

Several assumptions guided this study. The first assumption was that grounded theory uses the premises of symbolic interaction and allows people to make sense of their world and act and react based on their interpretations of those meanings. The decision to choose weight loss surgery was based on the interpretation of the person’s interpersonal, medical and societal situations. Grounded theory method allowed for the exploration of these meanings and behaviors.
The second assumption was that the participants in this study answered the interview questions openly and honestly. I entered the interviews with the intent to establish an open, comfortable and positive environment through my presence and lack of a judgmental attitude. I entered this study expecting these individuals to tell me their stories with as much accuracy and honesty with which they were capable. I may have had some potential biases from previous experiences both as a bariatric support group facilitator and as healthcare professional treating individuals with obesity. I used journaling and memos to acknowledge awareness of potential biases or prejudices.

The third assumption was that the participants are individuals who choose weight loss surgery through their own fruition. Weight loss surgery may be recommended by health care professionals but ultimately should be a personal decision. This decision may involve every aspect of the person’s life, physical, psychological, spiritual, social and financial. Grounded theory supported the exploration and discovery of processes ingrained in society such as the decision making process.

The final assumption was that individuals who have battled with obesity as a chronic condition may have also suffered from prejudice and bias from healthcare providers and from social or work environments. I may have had biases as a healthcare professional. Grounded theory method uses memos and journaling to help the researcher set aside or acknowledge biases to allow the true essence of the research to emerge.

Boundaries

The boundaries of this study were delineated in the following ways.

1. The gathering of data took place from July 2008 through March 2009.
2. The location of this study was northwestern Minnesota and eastern North
Dakota which is primarily rural.

3. Individuals who were currently in process of getting ready for weight loss surgery or who have had weight loss surgery were included in this study.
CHAPTER II

REVIEW OF LITERATURE

Introduction

The purpose of this grounded theory research study was twofold: 1) to investigate the decision making process of morbidly or severely obese individuals who engage in weight loss surgery and 2) to determine how nurses were involved in this process. While morbid or severe obesity has been investigated in reference to causes, risk factors, and treatment, there are limited studies from the perspective of what is it like for the person experiencing morbid obesity. The dramatic increase in the prevalence of obesity has been attributed primarily to behavioral and environmental factors: our culture has provided easy access to high fat/ high sugar foods with little or no incentive for activity (Hawks & Madanat, 2003; Jain, 2004; NIH, 1998; Racette et al., 2003; Rosenbaum et al., 1997). Behavioral and environmental factors have been contributors to obesity; they do not alone account for the complexity of decision making regarding the nature of obesity or the treatment of this disease.

Researchers have looked at obesity through a variety of lens and divided the way that we look at obesity from the pathophysiological, psychological, social, cultural, particular treatment interventions, and associations such as socioeconomics. A number of studies have looked at outcomes such as quality of life issues, but the research has not examined the experience of weight loss surgery during the individual decision making
process from a personal perspective (Hepertz et al., 2003; Kral et al., 1992; Stunkard, Stinnett, & Smoller, 1986). This literature review focused on the goals of treatment, treatment options for obesity, stigma, decision making and nursing as they related to morbid obesity.

Goal of Treatment

Treatment for obesity has been recommended for all patients with BMI ≥ 25 kg/m², with a high waist index or those with two or more risk factors, and for those with BMI ≥ 30 kg/m² regardless of risk factors (Lyznicki, Young, Riggs, & Davis, 2001; NIH, 1998). The overall clinical treatment goals have included reducing actual weight, maintaining weight reduction long term, preventing weight gain, and controlling co-morbid risk factors (Lyznicki et al., 2001). Most healthcare professionals have argued that, to maintain weight loss, healthful dietary habits and increased physical activity must become a permanent part of their lifestyle (NIH, 1998; Parham, 1999; Racette et al., 2003; Wing & Gorin, 2003).

Weight losses of 10% of body weight and keeping the weight off for at least one year to produce health benefits have been considered clinical success in weight loss management (Racette et al., 2003; Wing & Hill, 2001). Weight loss interventions have had a poor long term success rate of approximately 20% for greater than one year (Racette et al., 2003; Wing & Gorin, 2003). Weight loss maintenance has been a particularly difficult task, however, for the patient with morbid or severe obesity.
Treatment Interventions or Options

Physical Activity

Physical activity is a lifestyle intervention that increases expenditure of energy. Physical activity includes planned exercise but also lifestyle physical activity such as increasing walking or taking the stairs (Wing & Hill, 2001). Planned exercise of moderate intensity of 30 minutes three times a week has been recommended for the general population. Wing and Hill (2001) suggested that weight loss maintenance probably requires one hour per day of physical activity for ongoing success. Physical activity has been an effective intervention for losing weight (Jain, 2004).

Diet Interventions

Dietary interventions certainly are needed in any successful weight loss program. Dietary interventions decrease the amount of energy intake. Strategies include low-fat diets, low-carbohydrate diets, meal replacement strategies, as well as shopping and cooking instructions. Dietary lifestyle changes have produced effective weight loss in adults and should be the cornerstone of any weight loss program (Jain, 2004). While there have been a variety of weight loss diets available successful weight loss maintenance have required changes in both the quantity and the quality of foods consumed (Wing & Hill, 2001). The most successful strategies found by Wing and Hill (2001) included lower caloric intake, reduced portion sizes, reduced frequency of snacks and most consistently the reduction in the percentage of calories from fat.

Medication

There are several medications that have been indicated for the treatment of obesity. The prescription medications include sibutramine, orlistat, metformin,
phentermine, mazindol, and diethylpropion. Even the best of the medications used in the
treatment of weight loss have produced only a five to ten percent weight loss based on
outcome research (Jain, 2004). Currently, no medication has been available to address the
central mechanisms of regulating body weight (Rosenbaum et al., 1997).

Behavior Modification

Behavior modification has remained an important adjunct in any successful long-
term weight loss program with or without weight loss surgery (NIH, 1998; Wing &
Gorin, 2003). There has been a consensus in the literature that behavioral strategies to
improve success should target the unhealthy behaviors, identify new positive behaviors,
and recognize barriers that may interfere with the change in behavior (ICSI, 2000; NIH,
1998; Parham, 1999; Rosenbaum et al., 1997). Behavior modification strategies have
included stress management, problem solving, cognitive restructuring, stimulus control,
contingency management and social support (NIH, 1998). Behavior therapy interventions
should promote diet and physical activity and be used routinely as they have shown to
help achieve weight loss and weight maintenance (NIH, 1998). Self monitoring of weight
has been another strategy reported to help long term success in weight loss maintenance
(Wing & Hill, 2001).

Surgery

Gastric bypass surgery or weight loss surgery has been reserved for persons who
are considered severely or morbidly obese. The NIH (1998) consensus report and the
ICSI (2000) technical assessment update recommended weight loss surgery in carefully
selected patients with clinically severe obesity. Weight loss surgery has been more
effective than nonsurgical treatment of obesity and co-morbidities with individuals with a
BMI of 40 kg/m² according to an extensive review of the 147 research articles done by Maggard et al (2005). Weight loss surgery by itself has not guaranteed successful weight loss maintenance. In cases where weight loss surgery is an option for weight loss, an integrated program must be in place regarding diet, physical activity, and behavioral and social support both prior to and after the surgery to promote long term success (Cummings, Parham, & Strain, 2002; NIH, 1998; Racette et al., 2003). Weight loss surgery regardless of the type with subsequent weight loss has improved health-related quality of life.

Selection criteria for weight loss surgery includes parameters of body weight ≥ 45 kg or 100% above ideal weight, or BMI ≥ 40 or BMI ≥ 35 with medical co-morbidities (Balsiger et al., 2000; Brolin, 2002; Goldberg, Rivers, Smith, & Homan, 2000; ICSI, 2000; NIH, 1998; Sugarman, 2000). Other selection criteria has also included failure of nonsurgical attempts at weight reduction, absence of endocrine disorders that can cause morbid obesity, psychological stability and presence of obesity for greater than five years (Brolin, 2002; Goldberg et al., 2000; ICSI, 2000). Psychological stability has been assessed by the absence of drug and alcohol abuse, understanding the surgery and how it “causes” weight loss, and realization that the surgery itself does not guarantee good results without lifestyle changes (Brolin, 2002). The willingness of the individual to comply with the prescribed interventions is needed with any weight loss surgery or program.

Weight loss surgery has evolved over time and improvements continue to improve the outcomes for this population. Weight loss surgery was first performed in 1954 as the jejunoileal bypass (Maggard et al., 2005). The first gastric bypass surgery
was performed in 1967 which has been revised to the current most common operation of the Roux-en-Y gastric bypass (Maggard et al., 2005). The laparoscopic adjustable gastric band is the most recent procedure approved for use in the U. S. in 1993 for weight loss (Maggard et al., 2005). However, the Roux-en-Y gastric bypass is considered the gold standard for weight loss surgery in the United States. The newer adjustable gastric banding procedure is gaining popularity with similar effectiveness in weight loss success and fewer surgical complications (Mitchell & Courcoulas, 2005).

Weight loss surgery has been the most effective approach in the treatment for individuals with severe obesity (Balsiger et al., 2000; Brolin, 2002; Cummings et al., 2002; NIH, 1998). There has been a recent increase both in the popularity and the demand for weight loss surgery. This has been the only treatment that has produced sustained weight loss for the morbidly or severely obese patients (Brolin, 2002; NIH, 1998). The long-term success rate with weight loss surgery has been the weight loss and stabilization of 50-60% loss of excess weight in approximately 80% of patients (Mitchell & Courcoulas, 2005).

Improvement in health related quality of life has been demonstrated not only short term (six months) but long term (> five years) as well (de Zwaan et al., 2002; Kolotkin et al., 2001; Kolotkin et al., 2003; Livingston & Fink, 2003). Research on weight loss surgery also has suggested that the surgery has positive affects on psychological status (Balsiger et al., 2000; Herpertz et al., 2003; Kral et al., 1992). The psychological benefits of weight loss surgery included improvement in mental profiles, improved self-confidence, increased social activity, and improved interpersonal relationships (Stunkard et al., 1986). Improvement in significant co-morbidities such as improved cardiac
functioning, improvement in hypertension, remission of sleep apnea and remission of diabetes mellitus type 2, have also been documented after weight loss surgery (Mitchell & Courcoulas, 2005). Both psychological and health improvement have added to the person’s quality of life.

Improved quality of life and psychological status persisted in spite of complications related to the surgery. Complications of the surgery have been divided into intraoperative, postoperative and finally those that develop over time. The intraoperative complications included bleeding, trauma to other organs and anesthetic complications (Mitchell & Courcoulas, 2005). The postoperative complications included bleeding, blood clot, lung collapse, bowel obstruction, and distention of the bypassed section of the stomach and perforation (Mitchell & Courcoulas, 2005). Other short-term postoperative complications that have occurred are a marginal ulcer at the anastomosis line, wound infection, and persistent nausea and vomiting from outlet scarring. Other complications that may develop over time included nutritional deficiencies (vitamins B1 (thiamine), B12 (cobalamin), vitamin A, iron, calcium, magnesium, and folate), occasional protein deficiency, an incisional hernia particularly after any open procedure, bowel obstructions secondary to adhesions, and gall bladder disease (Mitchell & Courcoulas, 2005). The nutritional deficiencies can be avoided with proper supplements. The complications of scarring at the anastomosis line, hernia and development of gall bladder disease require additional surgical intervention.

Limitations in the review of studies were that to date there have not been any published report of a random controlled trial comparing modern medical to modern surgical treatment for obesity (Maggard et al., 2005). According to Brolin (2002), there...
are no specific criteria for evaluating the outcomes of weight loss surgery, although they should at a minimum include weight loss and improvement of obesity-related medical problems and overall quality of life. Caution must be used when evaluating outcome results of bariatric surgery because there has not been a set measure or tool used for consistent reporting, not to mention the lack of reports with negative outcomes. Outcome studies that examine the long-term effects of surgery are needed to confirm initial findings of improved quality of life in weight loss surgical individuals (Livingston & Fink, 2003).

Stigma

Obesity as a chronic illness has psychological, social, and cultural components that can not be ignored. There has been an uncompromising stigmatization of individuals with obesity in our culture (Friedman et al., 2005; Rogge, Greenwald, & Golden, 2004). This stigmatization is the result of an attribute or characteristic (obesity) that conveys a social identity that is devalued by society (Puhl & Brownell, 2003). Obesity has historically been seen as “an outward manifestation of self indulgence and spiritual imperfection” (Rogge et al., 2004, p. 305). Individuals with obesity are often characterized as lazy, ugly, sloppy, gluttonous, dishonest, or self-indulgent. The notion that obesity as an illness has been a social construction of medical culture which has identified obesity as a risk for death and disability while labeling it as unnatural, abnormal, and unhealthy (Rogge et al., 2004). The message relayed is that individuals are responsible for their obesity which is a prevailing influence in the medical model and that willpower and self-control are sufficient to treat this illness. This message prevails in
spite of all the medical research that confirms that there are many contributing etiological factors out of the individual’s control such as genetics or physiological imbalances.

According to Friedman et al. (2005), stigmatization experiences have been more common and occurred with greater frequency as obesity worsens. Weight stigma has been commonly accepted in workplace environments because they have been so widespread and accepted throughout our society (Puhl & Brownell, 2003). The day to day stigmatization of individuals with obesity has resulted in negative psychological functioning and consequences such as coping with negative assumptions about themselves, depression, decreased self esteem, negative body image and social rejection based on weight (Friedman et al., 2005). During the treatment process, the recognition of these stigmatizing experiences and their psychological effects need to be balanced with empathy, support, and a focus on the individual’s beliefs and attitudes about their weight (Friedman et al., 2005).

Decision Making

Decision making is a purposive action and reasoning of individuals in a complex and challenging world (Carroll & Johnson, 1990). Decision making takes place across many different social structures and situations including markets and economics, politics, social groups and organizations, business and government agencies as well as health care. According to Carroll and Johnson (1990) the concept of decision making is a combination of mental activities that recognize and structure decision situations that evaluate preferences that produce judgments and choices. These authors perceive decision making as a series of seven stages: recognition, formulation, alternative generation, information search, judgment or choice, action and feedback (Carroll &
Johnson, 1990). This study examined how the participants define their decision making process.

Factors Influencing Weight Loss and Management Strategies

The influencing factors in choosing weight loss strategies may have many variables. Overeating is not only a response to the environment and physiological drives; it is a choice (Davis, Levitan, Muglia, Bewell, & Kennedy, 2004). Decision making is a function of the ventromedial prefrontal cortex and impairments in the cortex may contribute to poor decisions (Davis et al., 2004). While there is a neural drive which prompts physiological drives to eat there is also a choice to eat or not to eat under some degree of cognitive control (Davis et al., 2004). Emotional eating is independent of poor decision making and suggests other factors may contribute to increasing BMIs (Davis et al., 2004). Maintaining a healthy body weight seems to be “dependent on the strength of the cortical inhibitory processes necessary for making good decisions overriding the strength of the drive to consume calories” (Davis et al., 2004, p. 934).

According to Page and Fox (1998) weight management decisions for females were based on size (width) and shape rather than just fatness but not as much for the males. Gender differences in weight management strategies were also identified by Page and Fox (1998). Weight loss was the desired goal more often for females and they tended to employ different strategies than their male counterparts. The main strategies reported by both males and females included eating less fatty foods, eating less than usual and exercising more (Page & Fox, 1998). The males used exercise as their main strategy while the females tended to choose extreme dietary practices such as skipping meals, self-induced vomiting and crash dieting (Page & Fox, 1998). Body composition may be a
predictor of weight concerns but was not isolated from perceived body image or other psychological factors which may have a larger role in the weight management decisions.

Factors Influencing Choice of Weight Loss Surgery

Wysoker (2005) examined the lived experience of choosing weight loss surgery. This article clearly identified weight loss surgery as a life changing event that requires long term commitment from the individual (Wysoker, 2005). The four themes identified through phenomenological analysis were: “last resort,” “surgery provides structure,” “reality sets in” and “positive about the decision to have surgery” (Wysoker, 2005, p. 28). These themes reflected that the individuals need to change behaviors and make ongoing decisions regarding their weight loss and how structure impacted ongoing goals of keeping weight off (Wysoker, 2005). The discussion about what were the influencing factors contemplated by the individual prior to the decision for the surgery were not clearly identified.

Lifestyle changes are difficult to make. Kearney and O'Sullivan (2003) discussed a distinct turning point in life experience that is necessary to make lasting commitment to new behaviors. When looking at behavior changes in obesity, sedentary lifestyle, smoking and substance abuse, the authors found that critical reappraisal of self and situation lead to a turning point (Kearney & O’Sullivan, 2003). The context or the conditional background and situation in decision making may have many different influences but culminate for a turning point or a decision for change.

Weight loss surgery has been an elective surgery. While persons need to meet the established medical criteria it remains a personal decision. The decision to have the surgery has been a life changing decision. Involvement of the patient in preparing for
weight loss surgery has been necessary because the after surgery commitment requires life style changes for long term success. The decision not only affects life style but affects social relationships and interactions with others. The influencing factors that lead individual’s decision making to weight loss surgery have not been studied from their personal perspective.

Nursing Care of the Obese

The majority of nursing literature regarding the care individuals with obesity and more specifically morbid obesity has been surrounded by the increasing prevalence of weight loss surgery. Articles by Blackwood (2004), Garza (2003), Hahler (2002), Spence-Jones (2003) and Voelker (2004) focused on the special needs of the morbidly obese surgical patient during their hospitalization. These articles provided baseline knowledge of difference in pathophysiology of obesity and special care needs of these individuals for the inpatient setting and short-term time frame surrounding their surgery. An article by Reto (2003) discussed the specific emotional and psychological care that is needed for this population surrounding their surgery.

Interventions that focus on the prevention of obesity have also been limited. The rates of obesity have been increasing in children and adolescents just as they are in adults suggesting that early health promotion and interventions with families may be needed to impact this illness. Other nursing articles discussed the challenges of providing care to the morbidly obese population, because they do have special needs that warrant nurse’s attention. This supported the complex nature of this illness and the need for care and interventions that can address decisions that mitigate the progression of the disease. The current research recognized that physical activity, nutrition education, and behavior
modification remained the cornerstones to any intervention. Yet, research has failed to examine how best to implement these interventions in a lasting and meaningful manner. Perhaps, missing links such as motivation, self-efficacy, timing of education and readiness to learn are the keys to impacting the progression of this illness.

There has been a lot known about the causes and contributing factors of obesity as a chronic illness which could be characterized primarily from an empirical perspective of knowledge and to some extent the ethical perspective of knowledge. Perhaps nursing needs to approach this chronic illness from the aesthetic or personal perspectives of knowledge. Along the lines of aesthetic inquiry are the critical questions of what does this mean? And, how is this significant? (Chinn & Kramer, 2004). Personal knowledge requires the therapeutic use of self and in this case could be investigated by exploring responses and reflections about obesity and the care of that population (Chinn & Kramer, 2004).

Nursing has the unique opportunity to approach this illness from a holistic perspective. Since obesity encompasses the physiologic, emotional and cognitive aspects of the person, research using phenomenological, ethnographic or grounded theory approaches is best able to examine the personal and holistic perspective of obesity.

Conclusions

The research has been conclusive in regards to the complex nature of obesity. There has been no single or simple cure or treatment. For many people suffering with morbid obesity, treatment regimes short of weight loss surgery has been ineffective. Treatment options and approaches for those individuals that are overweight and trying not to become obese have been limited at best and research has shown limited long term
success. While weight loss surgery is not without risks, it has offered long-term solutions to patients who are chronically morbidly obese.

Research has examined weight reduction, medical problems secondary to obesity, functional status and quality of life. However, there has been limited research on the personal experiences of morbid or severe obesity. Research focused on the individual’s perspective and experience with weight loss treatment protocols including dietary limitation, physical activity, behavior modification, medication prescriptions or over the counter drugs, and surgery is also lacking. There is much to learn about obesity as a complex, progressive, chronic illness. It seemed logical that the best way to learn about it was to ask those who live with this disease day in and day out. Research on the personal experiences may provide links of understanding related to what may help motivate weight loss actions and improve self efficacy with or without surgical interventions.

Symbolic interactionism is a broad approach to human behavior and real life problems. This study used the premises of symbolic interaction and applied them to the decision making process for weight loss surgery. This study strived to explore how individuals interpret and act on factors they have indicated during their decision making process. Grounded theory strives to identify antecedents, phenomenon, context, intervening conditions, action and consequences (Strauss & Corbin, 1998). This fits well to examine the complexity of decision making for individuals with the chronic condition of severe obesity.
CHAPTER III
METHODOLOGY

Introduction

The purpose of this grounded theory research study was twofold: 1) to investigate the decision making process of morbidly or severely obese individuals who engage in weight loss surgery and 2) determine how nurses were involved in this process. Grounded theory was best suited to explore and discover the decision making process for weight loss surgery from the participant’s perspective. The foundation of ground theory included constant comparative method, purposive sampling leading to theoretical sampling, inclusion of variation in the sample and theoretical coding (Eaves, 2001). Grounded theory is a qualitative research design with systematic approaches to sampling, data collection, and data analysis which supports the emergence of conclusions or statements for theory or model development. This chapter focused on the description of the research processes (method, sample selection, data collection and data analysis) in this proposed study as well as the protection of human subjects.

Grounded Theory – Strauss and Corbin

Grounded theory is a methodology or a way of thinking about and studying social reality (Strauss & Corbin, 1998). Grounded theory inquiry is used to develop or generate a theory from the data in its context and relate it to the phenomenon being investigated (Creswell, 1998). A theory should provide more than a picture; it should enable users to
explain or predict events which can guide actions or practice, thus, describing a process is an essential part of the investigation and reporting of findings (Strauss & Corbin, 1998). It is a systematic method of data collection and analysis used to develop an inductively derived theory from the data (Eaves, 2001). One of the advantages of grounded theory is that it can be used to explicate feelings, thought processes, and emotions that are difficult to extract from conventional research methods (Strauss & Corbin, 1998). Grounded theory uses the data to “offer insight, enhance understanding, and provide a meaningful guide to action” (Strauss & Corbin, 1998, p. 12).

According to Strauss and Corbin (1998) the process of developing a theory or model requires rich description, classification of events or objects, and the development of statements of relationships. Grounded theory methodology was selected for this research study because it allowed the researcher to inductively generate theoretical statements and theoretical frameworks or models that explicated the process.

Sample and Sampling Procedure

According to Creswell (1998) 20-30 participants were needed to obtain adequate data saturation for grounded theory. A purposive sampling was used at the beginning of this study and moved into theoretical sampling based on emergent findings. Theoretical sampling is sampling from the stance of selecting participants who can contribute to the evolving theory (Creswell, 1998). The sample was obtained from Northwest Minnesota and Eastern North Dakota. The criteria this population met to be in this study were that they are morbidly or severely obese individuals who are considering weight loss surgery or individuals who have had weight loss surgery because they were morbidly or severely obese. The sample was obtained through contact with bariatric support groups (two...
community groups and one hospital based group), community advertising and snowball sampling from support group participants. Part of the purposive nature of sampling for grounded theory was to obtain a sample that reflected a maximum variation of experience of types of surgery and participant variation in choosing weight loss surgery. Sample variation included age, gender, ethnic, social, educational, timing of surgery, location of surgery, types of surgery, involvement in support services or non-involvement in services after surgery.

Support groups were given information in person when possible or from the support group facilitator regarding the research study to elicit interest for willing participants. Contact post cards with the researcher’s address and contact information were handed out or left with the group facilitator. The participant returned the postage paid postcard with contact information to the researcher. Participants were then contacted by telephone by the researcher. If the participant did not wish to return the postcard with personal contact information they contacted the researcher through the researcher’s e-mail address. The research protocol was reviewed with the potential participants individually and included the risks, benefits, and option to participate or withdraw from participation at any time. Participants interested in being in the study were then contacted for interview appointments at a location agreed upon by the potential participant and researcher. A location that was comfortable and allowed for privacy or anonymity and audio-taping was selected. This included the researcher’s office, the participant’s office, participant’s home, quiet coffee shops and the location of support group meetings. The potential participant was given a copy of the informed consent form and had the opportunity to ask questions (Appendix A). If the participant agreed to participate a copy
of the consent form was given to him/her. The interview then proceeded. Audio taped interviews were used to explore with the participants their experience related to their decision to have weight loss surgery. Participants were asked to share their “story” about how they decided to have weight loss surgery and how nurses were involved in their decision using a semi-structured interview.

Community advertisements were placed in several regional newspapers (Appendix B). Community advertisements were used as an additional effort to recruit participants who did not or do not attend support groups. The same protocol for informed consent and individual appointments was used.

Only participants willing to participate and who agreed to have the interview audio taped were included. Inclusion criteria were: persons over the age 18, who were considering or had weight loss surgery (either gastric lap band or Roux-en-Y surgeries) and must speak and understand English. Persons that were in the workup process for surgery and post-surgical were considered for the study. During sample recruitment every effort was made to include a range of participants such as age, gender, ethnic origin and various preoperative and postoperative stages.

Exclusion criteria included persons who refused to consider weight loss surgery as a treatment option for severe obesity and those who were unable to speak and read English. No translators were available for this study, so participants had to be able to read and understand English. If the person had not understood (cognitively) the consent form he or she would have been excluded from the study. Persons were not excluded from the study based on months or years after surgery. There may be concerns about their memory surrounding the decision making process, however, from my experience of
working with and attending support groups, the story of their decision remained strong as they continually revisit the challenges to maintain weight loss even after the surgery.

Data Collection

A semi structured interview guide was created for this study. Some of the questions were developed through participation in facilitating and observation of bariatric support groups. Some of the questions were developed through an earlier research pilot study in which three preliminary interviews were conducted with persons who had already had weight loss surgery. Questions were added after visiting with other support group facilitators and from other expert input.

Interviews included the collection of demographic data. As data was collected and analysis continued, more questions emerged from the findings of these interviews. Thus, the semi-structured interview guide was dynamic and responsive to the purpose of the study and emergent data analysis.

The demographic questions were completed at the time of the interview to obtain participant information; this included age, sex, marital status, educational level, race, date and location of surgery, type of surgery and if any additional surgeries were or are planned (Appendix C). This took approximately five minutes to complete. The interview took as long as the participant wished to share their story which ranged from 40 to 90 minutes. At the conclusion of the interview, the researcher asked permission to contact the participant if any additional questions arose with data transcription or analysis. The researcher would have collected poems, journal entries, written “essays” or photos if the participant wanted to have those included in their story. The researcher took field notes during and after interviews, used memos and theoretical notes for the analysis process.
As noted, other means of data collection may have included participants’ personal reflections such as poems, journal entries, essays, or photos. Unfortunately, no one offered any additional data for this study. This additional data would have added to the richness of the interview data.

Interviews were audio taped and transcribed. Audio tapes were transcribed and checked for accuracy. Audio tapes were stored in locked file cabinets. Audio tapes will be erased once data analysis has been completed.

All interviews were conducted by the principal investigator. The transcriptions of the interviews were done by the researcher. Tapes transcribed were reviewed to insure accuracy and that any identifying information was removed. The only other person reviewing the transcriptions was the researcher’s committee chairperson. All data analysis was conducted by the principal investigator. Data analysis was conducted at the University of North Dakota and the researcher’s home office.

Protection of Human Subjects

This study was reviewed by the Institutional Review Board through the Office of Research Development and Compliance at the University of North Dakota. The researcher will maintain all records in accordance with Institutional Review Board policy and procedures. All participants were given the consent form to read before beginning the interview and retained for their records. Consent to participate in this study was acknowledged by participants engagement in the interview with the researcher. The participant may have withdrawn at any time should he/she change their mind. Participants were given the contact information for the researcher, advisor or professor

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and the Office of Research Development and Compliance through the consent form in case of questions or concerns in the research process (Appendix A).

This study required participants to share personal stories which may lead to some strong emotional responses. This was explained to the participant prior to starting the interview process. The participant was reminded if a strong emotional response was elicited that they may stop the interview if it is too uncomfortable or distressing. The participants were able to choose what they wanted to share with the researcher. A location that the participant was comfortable in which was conducive to audio taping were used for the interview.

Confidentiality was protected through the use of a coded identification system. Coded information was locked in a file cabinet separate from all other data. Identifying information was removed from transcribed information. Data (especially demographic) was reported in aggregate form.

Records and transcripts will be retained in locked file cabinets for a period of three years after the completion of the study. The coding identification will be stored in a separate locked file from transcripts and other documents of data. The researcher will maintain the keys and access to the data will be limited to the researcher and the Office of Research and Development for audit. All audiotapes were erased after transcription was completed and checked for accuracy. All written materials including coding identification will be shredded three years after the completion of the study.

No adverse reactions were noted during the interviews. Any adverse reactions would have been reported to the Office of Research and Development as soon as possible (within 72 hours). If the adverse event required emergency interventions, the person...
would have been given a list of crises hotline numbers or referred to the nearest emergency room for intervention (Appendix D). This would have been at the participant’s expense.

Risks identified to the participants would be emotional or psychological distress in the process of telling their story, which may be a little uncomfortable due to the personal nature of the interviews. If the process appears to be causing the participant significant distress or anxiety, the researcher would have asked if they wish to continue. The participant may withdraw from the interview or study at any time. The researcher reserved the right to terminate an interview if the participant became obviously distressed and would have referred the participant to an established health care counselor. A list of regional mental health providers was available to be provided to participants if needed.

One benefit of this study was it gave the participants a chance to share their experience so that medical professionals can create new knowledge and support decision making for this population. Only through more knowledge will health care professionals be able to provide comprehensive care free from prejudice and biases. Participants of the study received a ($20) store or telephone gift card for their participation in the study at the time of the interview.

Analysis Plan

According to Strauss and Corbin (1998) grounded theory can be used in a systematic approach which is constant and comparative throughout the data collection and data analysis process. According to Strauss and Corbin (1998), objectivity of the researcher in qualitative studies involves maintaining an openness to listen to the participants and truly give them a “voice.” Memos kept the researcher aware of bias,
assumptions and processing. A systematic and standard format for data analysis was used to examine causal conditions, core variables, context, intervening conditions, strategies and consequences (Strauss & Corbin, 1998). The data went through three levels of coding: open, axial and selective (Creswell, 1998; Strauss & Corbin, 1998). Strauss and Corbin (1998) use these three types of coding to consistently and inductively examine data for emergent concepts, categories, and theoretical constructions.

Open coding was where the data are broken down into discrete parts and examined for similarities and differences based on properties and dimensions that may be grouped under a more abstract concept or “category” (Strauss & Corbin, 1998). This first step of description was important to be able to start explaining and predicting from the data. The axial coding was used to assemble the data in a new, more abstract way after open coding. This is done by arranging concepts into subcategories along the lines of their properties and dimensions or how the concepts are connected (Strauss & Corbin, 1998). This step in the analysis is coding for explanations and to gain an understanding of the phenomena (Strauss & Corbin, 1998). The selective coding was the process of integrating the data and refining a theory into the larger explanatory picture. From the data a model and theoretical statements emerged to explain the experience of decision making weight loss surgery from the participant’s perspective. The development of a theory is a complex activity that involves intuited concepts and then formulating them into a “logical, systematic, and explanatory scheme” (Strauss & Corbin, 1998, p. 21). The final step in the process was the writing of the theoretical statements or a model reflecting the decision making of the participants.
The researcher used the computer-based software NVivo for management and analysis of the text data. The computer based program provided a means to organize the storage of data, locate material easily, and aid the researcher in line by line data analysis (Creswell, 1998). The program was not a substitute for reading the data but a means to assist the novice researcher in the management of the data.

The data analysis process included field notes, theoretical notes, memos and journaling self reflections to maintain context and to document process. Participants were obtained through support groups and interviews were conducted. Interviews included some guiding questions to clarify, summarize and validate the decision process of study participants. The interviews were transcribed for the coding processes. The data analysis proceeded to three levels of coding, open, axial, and selective (Figure 1). Open coding started with line by line coding into shorter phrases. Categories were identified for clarification of concepts. These categories were clarified and validated with ongoing interviews (constant comparative method). Axial coding using predetermined subcategories of causal conditions, core variables, context, intervening conditions, strategies and consequences provided an organizing scheme for the research questions (Strauss & Corbin, 1998). The selective coding proceeded to reach core variables and confirm linkages among categories. Throughout this process the researcher wrote memos for mapping process and journal for self reflection. Theoretical notes were maintained in the coding process to guide emerging categories and for validating with participants.
Conclusions

Grounded theory research design was a fit with the purpose of this study since it was intended to explore and discover a basic social process existing in our society, decision making. Grounded theory provided the guiding structure for sampling, data collection, data analysis and reporting of this research study. It provided the researcher...
with opportunities to explore the process of decision making for those who choose weight loss surgery. Through this exploration of personal experiences, health care providers may be better able to intervene, support, and develop guidelines for clinicians providing direct care for this population.
CHAPTER IV
RESULTS

Introduction

This chapter discusses the findings of the analyzed interview data that were gathered for the purpose of exploring the decision making process for weight loss surgery. The purpose of this study was to explore the decision making process of individuals who choose weight loss surgery and the role of nurses in this process. This was explored through a grounded theory design using semi-structured interviews and constant comparative analysis methodology. Interviews were conducted with 15 women and three men lasting 40 to 90 minutes. During axial coding, a structural or paradigm model emerged and these findings were validated with subsequent participants. Once the essential components of the structural model were identified, these interpretations were validated; thus, enhancing the credibility of the study’s findings. The themes were further analyzed for relationships, connectedness and differences moving the results to a more abstract interpretive level thus producing a theoretical model. Word processing and NVivo were used to support the analysis of data. The process outlined in Figure 1 guided the collection and analysis of data; no major alterations of the proposed process were observed.

This chapter begins by identifying demographic information regarding the participants of the study. Types of procedures and location are also reported. The
research protocol as it occurred is presented. Furthermore, this chapter discusses the
responses to the first research question: How did the participant come to the decision to
pursue weight loss surgery? During axial coding their responses emerged into concepts
and constructs including antecedents, intervening conditions, action strategies and
consequences used in grounded theory according to Strauss and Corbin (1990). This
chapter finishes by addressing the participants’ responses to the second research question:
How were nurses involved in the weight loss surgery decision making process?

Demographics of the Participants

This section presents the demographic characteristics of the $N = 18$ participants in
this study. Participant demographics are reported in aggregate to insure the
confidentiality of the participants. Eighty three percent ($n = 15$) of the participants were
women; and $17\%$ ($n = 3$) participants in this study were men. The age range of the sample
was from 29 to 65 years with a mean age of 49.7 years. Eighty nine percent
($n = 16$) of the sample was Caucasian; the remaining $11\%$ ($n = 2$) of the sample ethnicity
was Native American Indian. The completed educational level of the participants ranged
from high school education to doctoral level education. A majority, $61\%$ ($n = 11$), of the
participants were married; $28\%$ ($n = 5$) were divorced. Only $11\%$ ($n = 2$) of the
participants had never been married.

Description of Weight Loss Procedures

Thirty-nine percent of the participants ($n = 7$) had had the laparoscopic adjustable
band procedures (AGB); as well as $39\%$ ($n = 7$) had the gastric bypass (Roux En Y)
procedures (GBS). Only $5\%$ ($n = 1$) had the gastric sleeve procedure (GS). Seventeen
percent ($n = 3$) of the sample had not yet had their surgery at the time of the interview; all
three of these participants were anticipating an adjustable gastric band procedure. The
time range for participants who had already had surgery was two months to 120 months.
The average time frame after surgery was 43 months. See Table 1 for the summary of the
type, location and timeframe of the various procedures.

Table 1. Type of Surgery, Location of Surgery, Months Since Surgery.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Type of Surgery</th>
<th>Location of Surgery</th>
<th>Months Since Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>AGB (lap)</td>
<td>Hospital</td>
<td>19</td>
</tr>
<tr>
<td>2</td>
<td>AGB (lap)</td>
<td>Hospital</td>
<td>22</td>
</tr>
<tr>
<td>3</td>
<td>AGB (open)</td>
<td>Hospital</td>
<td>23</td>
</tr>
<tr>
<td>4</td>
<td>AGB (lap)</td>
<td>Hospital</td>
<td>35</td>
</tr>
<tr>
<td>5</td>
<td>AGB (lap)</td>
<td>Hospital</td>
<td>* pending</td>
</tr>
<tr>
<td>6</td>
<td>AGB (lap)</td>
<td>Hospital</td>
<td>26</td>
</tr>
<tr>
<td>7</td>
<td>AGB (lap)</td>
<td>Hospital</td>
<td>10</td>
</tr>
<tr>
<td>8</td>
<td>AGB (lap)</td>
<td>Hospital</td>
<td>* pending</td>
</tr>
<tr>
<td>9</td>
<td>AGB (lap)</td>
<td>Hospital</td>
<td>* pending</td>
</tr>
<tr>
<td>10</td>
<td>GBS (open)</td>
<td>Town</td>
<td>51</td>
</tr>
<tr>
<td>11</td>
<td>GBS (open)</td>
<td>Town</td>
<td>72</td>
</tr>
<tr>
<td>12</td>
<td>GBS (open)</td>
<td>Town</td>
<td>120</td>
</tr>
<tr>
<td>13</td>
<td>GBS (open)</td>
<td>Town</td>
<td>65</td>
</tr>
<tr>
<td>14</td>
<td>GBS (open)</td>
<td>Center</td>
<td>102</td>
</tr>
<tr>
<td>15</td>
<td>AGB (lap)</td>
<td>Center</td>
<td>2</td>
</tr>
<tr>
<td>16</td>
<td>GBS (lap)</td>
<td>Center</td>
<td>19</td>
</tr>
<tr>
<td>17</td>
<td>GS (lap)</td>
<td>Center</td>
<td>7</td>
</tr>
<tr>
<td>18</td>
<td>GBS (open)</td>
<td>Place</td>
<td>66</td>
</tr>
</tbody>
</table>

* designate participant had not had surgery at the time of their interview

The locations of the surgery were given fictitious names. The Hospital program
was described as the most structured program with the most preoperative requirements.
The preoperative ‘mandatory’ requirements included a series of classes on diet, exercise
and behavioral change. At least two of the participants started at the Hospital program but
changed their mind, deciding to have surgery at one of the other institutions. One participant stated issues with having to repeat one of the required classes and a falling out with the bariatric coordinator. The other participant stated it was a time issue related to meeting the insurance deductible for the year and the other program not having as many preoperative requirements to have the procedure before the end of the year. All programs required dietitian consultation, psychological evaluation and surgeon visits. To obtain services from the bariatric programs some of the participants had to travel 150 to 200 miles. Seventeen percent (n = 3) of the sample had sought care at a referral center due to failed initial procedures. Participants’ initial surgical procedure was identified on the Table 1. One was pending a revision to the initial gastric bypass procedure due to failed weight loss. The second person had a replacement band placed after a slipped band. The third person did not have a surgical option after a failed band procedure at the time of the interview.

Research Process

Participants were recruited through two bariatric support groups. One was a hospital based support group and the other group was a community based group. Newspaper advertisements were also used in a regional newspaper. Several participants were obtained through participants, colleagues and family members who mentioned the study to a potential participant. After interest was shown, the researcher contacted the person.

Participant interviews lasted 40 to 90 minutes. All of the interviews were audio recorded with the exception of one due to a tape malfunction. Notes completed during the interview were used as a replacement. Interviews took place in a variety of locations,
which was mutually agreed upon prior to meeting. Three participants were interviewed at
the researcher’s office location. Six participants were interviewed at their work locations.
Four participants were met at a local coffee shop location (quiet corner) and the
community library meeting room. The participants that had interviews at the local coffee
shop shared very similar experiences compared to participants that were interviewed at
other locations. The location did not appear to restrict their willingness to share. The
remaining five participants were interviewed in their homes.

All participants were given a consent form to read and retain prior to participating
in the interview. All participants were all asked if they had questions regarding the nature
of the study or their participation. All questions were answered by the researcher. There
were very few questions and a particular theme was not identified. The participant’s
agreement to be interviewed was considered consent for this study.

Participants in this study were asked to describe what led them to consider weight
loss surgery. Probing questions from a semi-structured interview guide (Appendix C)
were used to explore their thinking process, their feelings and actions during their
consideration of weight loss surgery. Audio taped interviews were transcribed by the
researcher. Transcripts were analyzed using open coding which resulted in the emergence
of common themes from the experiences of the participants. Antecedents, intervening
conditions, a core variable, action strategies and consequences were the structural
categories (axial coding) that emerged in the development of a paradigm model as
described by Strauss and Corbin (1990) (Figure 2). Themes were identified within the
context the participants’ experiencing being obese and relationships of themes and
Figure 2. Structural Model: Decision Making Process of Persons Experiencing Obesity.

concepts were established that supported the emergent theoretical model. The theoretical model will be further discussed in Chapter V.

Findings

The first guiding research question was: How did the participant come to the decision to pursue weight loss surgery? This question was the primary focus of this study.
Participants were asked to share their experience about the process they used to choose surgery. Probing questions examined thinking, feeling and doing strategies that the participant experienced throughout the process.

Structural Model

Context – Being Obese

The context includes the set of properties or conditions that pertain to a particular phenomenon (Strauss & Corbin, 1990). The context of experiencing being obese incorporates self (physical, personal & social), family, culture, healthcare, work environment and society. The experience of being obese for most of the participants touched every aspect of their lives, physical or medical conditions, home life, work environment as well as social activities and choices. Most participants reported obesity or weight issues as a life long struggle which was far beyond a simple formula of calories in and calories out. Being obese was beyond a mere physical condition; its effects extended to personal perceptions and social aspects of living.

Context of Self

Participants described ‘being obese’ as something that they just lived. They further identified physical size as affecting normal daily activities. One participant stated, when you’re heavy you adapt, you just adapt as anyone adapts to their living…. It’s hard to explain, it’s hard to explain to a thin person, you know, what it is like to walk into a movie theater and the first thought is, am I going to fit into the seat? When you walk into a restaurant to look to see if there are arms on the chairs, and, but you don’t realize you’re doing that until you make a conscious effort of [thinking about it].

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Another participant shared her experience looking back on old photos “it was like you were really big ... I mean you live it, that’s what you are and so be it ... but I just lived through it.” Participants discussed that their weight was a daily struggle and not something that they just didn’t think about. One participant shared “weight is something that you think about every single day, when you put on your clothes and they are too tight or you have to wear something that you don’t really feel your best in because your overweight and that’s about what you can find to wear.” Another participant shared “It was never that I looked in the mirror and said ‘oh my God you’re beautiful,’ but I never said ‘my God, you’re gross and you’re the most disgusting thing around’ either.”

Some participants shared how they viewed themselves were not the same as the image that was seen in the mirror or perhaps how others see them. One participant stated, “I have an image in my head of how I used to look when I was younger and slimmer and things like that I like to keep that in my head even though my actual body is not that way. I mean that, so I don’t look in the mirror and don’t give me a side profile.” Another said “When I think about myself, I think about myself at 16 as young and pretty as can be. When I look in the mirror I see a little different story.” Another shared “several years ago I thought I’m getting a little heavy you know, I’d look in the mirror, I didn’t see a fat man.” This demonstrated how the physical self was not always congruent with the personal self. Participants did not recognize or perhaps acknowledge the severity of their obesity unless viewed through a different lens.

Several of the participants discussed how they perceived their weight, how it interfered with their social interactions, and how this condition affected their own self image. Another participant shared an experience about her husband “I always felt really
insecure because uh, I know it’s a man thing, you know, you watch TV and there’s a good looking woman that would come on and their like ‘woohoo’! You know, and it’s like okay, I don’t look anything like that, you know. I still get that feeling now and I’m smaller now then I was then, you know.” Another participant shared “I have not had a man ‘hit’ on me since I moved to this state.” She admitted she was not sure if it was more because of her weight or her age.

For others it was the change in wanting to go out with friends and about being uncomfortable with their appearance or what others would say about them. A participant said, “I’m sure it [weight] is a barrier for having a companion in my life. It keeps me from joining things or doing things with people because I use it as an excuse not to do things too.”

Context of Family

In most cases a person dwells and is raised within a family. Family members may share the same genetic predisposition for obesity. Family members typically, share the same cultural values or perceptions of how it should be as well as shared learned eating patterns. The participants identified family genetics and learned eating behaviors as contributing factors to their condition which is very much part of the contextual nature of the experience.

One participant stated, “I think I’ve always had this bigger gene in me, my mother was bigger, her mother was bigger, so, I thought that would be me.” Another stated, “I think a lot of it is genetics. I’ve got a lot of heavy family. A lot of it is our eating habits. My mom fried foods and all this stuff.”
A participant stated “I think it has a lot to do with how you are raised and part circumstances you can’t control.” This participant went on to share “I’m from a large family [13 children], the diet that you eat sometimes in that kind of situation isn’t probably the best, it’s more fill up the tummies and at the cheapest possible cost”. A participant described one eating behavior, “I know that when I’m full, not hungry, I can still eat. That is why I really wanted the surgery, because I don’t want to be able to eat.”

Some of the participants shared their experiences with family members especially their children. These experiences forced them to look at their weight through someone else’s eyes. One participant reported her weight was a significant factor in her marital relationship. She said “the more weight I gained the more disapproving he became … you know. So, I was married for 19 years and then he found another woman. And the reason he left was because he had to come home to a ‘fat’ woman.” A participant discussed the impact on her children “You don’t think about the effects on your family until your kids get old enough to be in school where they have pressure and they start to look at your size.” Another participant shared about an experience with her daughter “one time when my daughter was probably in kindergarten and we went shopping and her little friend said to [my daughter] … ‘your mom is big and fat;’ and she agreed with her and I thought, oh my, this little kid is seeing that but I’m really not.” Family perceptions impacted their structure and feeling level of self as a person.

Context of Culture

As a culture in the U.S., thinness is admired therefore obesity is often detested. A participant shared her reluctance to go shopping, “I hated to go into a store. I didn’t like the way children would make comments to their mothers, not to me specifically, but to
their parents about me.” One of the participants discussed her Native American Indian culture. She stated “they kind of just accept their body size and the diseases that come with it or whatever that they just accept it as it was meant to be.”

Several participants discussed food as part of our culture. Food was a source of socializing, celebrating, consoling, and grieving. Many participants shared that family and social events included food as central component. This cultural context of food as part of our social nature remains after the surgery and is frequently a topic of discussion at support groups.

Context of Healthcare

Participants shared a range of experiences with healthcare providers. Some participants were introduced to weight loss surgery as an option and then coached through the process by a healthcare provider. Other participants actively sought out information and referrals for weight loss surgery. Some participants shared experiences of prejudicial treatment by healthcare providers.

Some of the participants had supportive and sometimes frank primary care providers that recommended weight loss surgery. A participant shared that her primary care provider recommended a surgical option for her obesity, “I went for a good physical and my doctor [Name], she’s been trying to talk me into this for about 4 years. And, I always thought ahh, it was the cheaters way out.... I’ve come to realize that, you know, no matter which way you go it is a struggle.” Another participant stated “And even my physician said to me – you’re killing yourself. And he’s the one that said you need to, you probably need to have this procedure.” Another participant had a physician who shared “you are the type of person these surgeries are made for, you know, a lifelong
history of obesity, inherited obesity for the most part … it’s for people like you that are morbidly obese.” These participants felt supported and partnered with their primary care provider.

One participant had to seek out the referral for weight loss surgery convincing their primary care provider that weight loss surgery was what they wanted. This participant stated “I went down to see [local doctor] … He said ‘they don’t’ really know what it’s gonna do that gastric bypass as you grow older.’ I said shit, at the rate I’m going, I ain’t going to get any older, doc, I’m at 325 [pounds], my blood pressure is high, my cholesterol is high … So, he said I’ll write it.” Another participant said she had to seek out a different healthcare provider regarding her weight issues. She stated, I know if I had gone to my regular physician, it would have been push yourself away from the table let’s get you on a diet. We’ll refer you to physical therapy; you can set up an activity program…. I felt like even when you go in and you are weight and you’re overweight unless you bring it up half of them [physicians] will not even bring it up.

Someone else shared “I don’t even know if I thought of asking for a referral about the [bariatric] program. I went straight to a meeting and thought this is good.” One participant shared the lack of empathy from others who have not struggled with their weight.

One participant had previous healthcare providers that she felt did not address her health care needs. She stated “Every time I had something wrong with me I felt they would blame everything on the weight. ‘You need to lose some weight you’ll feel better.’ Yeah, and I just looked at them and like what does that have to do with my ear hurting or
you know stomach pains.” The participant went on to share her frustration with seeking medical help stating “I doctored for 2 years with diarrhea ... I had a growth on my parathyroid gland that was causing [it] and I had diabetes at the same time that was masking each other.” Another participant shared “you know, what is really weird is my doctor had never, ever said you need to lose weight, never.”

Within the healthcare system the approach to the treatment is varied. Most participants discussed the relationships with their primary care providers. Participants discussed a full range of experiences from supportive and empathetic to prejudicial and insensitive. Many participants recognized once they interacted with healthcare professionals in the specialty of bariatrics the care that was compassionate and understanding.

Context of Work Environment

The work place was another area people specifically talked about their weight. Weight was a factor in work ability or function as well as opportunity. One participant shared “my boss had also started questioning my ability to do the job anymore ... I was contributing my conditions to getting old. And then, I found out that 60 year old men were supposed to be still able to do that kind of stuff that I wasn’t able to do anymore.” Another participant discussed her need to work “I have about 15 more years that I have to work and I won’t be able to work if I can’t be on my legs/knees.” Another participant shared that her weight affected her being able to be at work. She stated “I missed work a lot and they had to get me a special kind of chair to just to even help being at work.”

Weight played a significant role with self confidence in work situations for several participants. “I avoided a lot of situations. If I had to like work with [Professor], if
I had to do presentations or be there with her on travel I’d just have to grit my teeth and go.” One participant reflected that since the surgery and subsequent weight loss she has a new found confidence in her work and personal life she had not realized that her weight had masked. She shared

I’ve kind of been staying back and just working, underlying using my weight as an excuse just keep on working without saying it versus going back to school cause that’ my next piece. ... I want to go back to grad school. I’ve been putting it off because of the weight thing.

Context of Society

Participants shared their experiences of prejudicial thought from society’s perception that people can always be in control of their weight. One person shared “And they figure we got ourselves here [obese] because we’ve been lazy and stuff like that. ... If you’re not heavy you don’t understand. I’ll put a hundred pound sack on you. Then, let’s see if you want to go walk four miles. It makes a difference.” A similar experience was shared by another participant “You buy something and you really like it, [someone says] that doesn’t look good on you, you’re too heavy for that, comments like that are hurtful. People don’t realize what heavy people go through.” One person stated “I think people who haven’t been through 20 years of trying to diet have no concept of that, whether it is healthcare or not healthcare.” Another person simply stated “I didn’t choose to be heavy, it just happens.”

Participants shared their experience with this societal perception that weight loss surgery is a quick fix for obesity and is used by those who have no willpower. Many participants were concerned that this society’s perception would be directed at them if
they shared the fact that they had weight loss surgery. One participant said “It’s like what are people going to say, because are they gonna think she couldn’t handle it on her own. She’s a failure at that and couldn’t do it on her own she had to go have surgery (last part stated sarcastically).” One participant thought there was more public awareness about weight loss surgery in her community. She stated the sarcastic question ‘why are you having that done?’ has been replaced with a more positive statement ‘you’re having that done, good for you.’ She commented “Like that is why people should be more aware that it’s [weight loss surgery] not a cop out.” Participants felt they were in a ‘catch 22’ situation because of society’s perceptions of obesity and weight loss surgery.

Antecedents

Antecedents or causal conditions are events that lead up to the phenomenon occurrence (Strauss & Corbin, 1990). They are often accumulation of conditions that have different dimensions or properties such as intensity and duration. Antecedents emerged from participants sharing their experiences with their weight loss struggles. Antecedents that will be discussed include cycle of obesity, weight frustration, motivating factors or re-energizing factors, information gathering and seeking support. The obesity cycle participants described encompassed weight as a dysfunction, repeated weight loss attempts, unmet goals and giving up on weight loss strategies.

Cycle of Obesity

Most participants shared a repetitive pattern of weight loss attempts within their experience of being obese. Participants recognized on some level their weight was a health concern. Many shared repeated attempts and numerous diets they used to try and control their weight. It became an ongoing cycle (Figure 3). The components identified in

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this cycle include weight as a dysfunction, weight loss attempts, unmet goals, and giving up on the weight loss strategy.

![Diagram of the Cycle of Obesity]

**Figure 3. Cycle of Obesity.**

**Weight as a Dysfunction**

Weight as a dysfunction was identified by most participants as a reason to try and lose weight. Weight as a dysfunction is the concept that emerged from participants as a self awareness that their weight was interfering with some aspect of their lives, creating a level of dysfunction. One participant stated “I love water aerobics but when they had it at the school, and you got to climb the ladder and now I’m too heavy to go in and out on the
ladder like I used to be able to go, there's no way. So, that stopped me.” Another person shared her weight had her feel miserable (emotionally and physically) “there were things I couldn’t do. One flight of steps and I was out of breath. I couldn’t bend over and pick anything up, I couldn’t get down on the floor or I couldn’t get up.” Someone else also stated “When it became so hard to climb stairs that was another piece that kicked in and I knew I had to do it.” These were acknowledgment or recognition points that weight was holding them back from something they wanted to do.

Weight Loss Attempts

Participants not only listed specific strategies, they discussed repeated weight loss attempts in an ongoing cycle of struggling with their obesity (Table 2). Most of the participants identified numerous strategies used for weight loss during their struggle. One participant shared her experience “I’d tried Weight Watchers, I’d tried at the beginning I’d tried Adkins…” A participant shared her numerous attempts “I tried everything the hypnosis, Weight Watchers, Curves, and Adkins, it just never amounted to much.” A participant shares minimal success and weight regain “I tried an herbal program and then Weight Watchers with minimal success.” Another participant shared previous weight loss attempts with prescription medications. He shared “I’d been on that Phen-Fen [drug] diet. My wife and I both went on it. I lost, I got down, I lost 60-65 pounds on that. And then, they pulled it off the market and said it was dangerous. So, back come the weight.”
Table 2. Previous Weight Loss Strategies.

<table>
<thead>
<tr>
<th>Strategy Utilized</th>
<th>Number of Participants*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple Diets (Popular diets)</td>
<td>9</td>
</tr>
<tr>
<td>Weight Watchers</td>
<td>9</td>
</tr>
<tr>
<td>Exercise (typically walking)</td>
<td>9</td>
</tr>
<tr>
<td>Structured Bariatric Program</td>
<td>9</td>
</tr>
<tr>
<td>Medication (Phen/Fen)</td>
<td>6</td>
</tr>
<tr>
<td>Adkins Diet</td>
<td>3</td>
</tr>
<tr>
<td>Dietician Consult</td>
<td>3</td>
</tr>
<tr>
<td>NutraSystem</td>
<td>2</td>
</tr>
<tr>
<td>Curves</td>
<td>2</td>
</tr>
<tr>
<td>Counseling</td>
<td>2</td>
</tr>
<tr>
<td>TOPS</td>
<td>1</td>
</tr>
<tr>
<td>Hypnosis</td>
<td>1</td>
</tr>
</tbody>
</table>

*Note that the number total is greater than 18 as all participants used many different strategies for weight loss, however, not all participants reported specific strategies.

Unmet Goals

Many participants described years of struggling with weight loss. A majority of participants discussed limited success with past weight loss attempts. Unmet goals in this cycle included not being able to lose any weight, start to lose weight but reach a plateau short of goal or weight loss but then regain once the weight loss strategy was stopped.

One participant describe her weight plateau after trying Weight Watchers a couple of different times “both times I got stuck on a plateau. I kept gaining the weight back over and over again.” Another participant shared “I’ve tried every diet probably that I came upon, Weight Watchers. I was successful several times but nothing ever stuck.”

Weight regain was a real problem for several participants. “I would lose 40-50 pounds but you fall into old habits or whatever and it just wouldn’t stay off.” Another
participant shared her similar pattern of weight loss and regain "I could never, I'd lose 50-60 pounds and keep it off for a while; but could never get down where I wanted to be. It was a constant yoyo, lose it, gain it back plus more.” Another participant shared her temporary success in the structured bariatric program “I had lost like 36 pounds in the bariatric diet and exercise class and then I gained some of it back.” One participant shared “over the years my baseline weight has gone up too, at first, it was 180. It was there for five to six years then 200 then 220 … just the thought to have to start trying to lose all over again…”

Give Up on Weight Loss Strategies

Participants described a variety of reason to give up on their weight loss strategies. Most participants described a variety of reasons for giving up on weight loss strategies. Occasionally a participant identified specific factors that contributed to giving up on their weight loss strategy.

One participant shared “I’d tried Adkins, but when my body went into ketosis I went ‘psychotic’ and I came home in tears and said – no, I can’t do this.” Another stated “I tried so many times to lose weight but I’d get bored with whatever I was eating or whatever I was doing.” Someone else shared “when I lost that 65 pounds I felt great. Then I figured I don’t have to watch as much. I know what I’m supposed to eat, know what I’m not supposed to eat. It tended to get bigger … you can’t go back to that – old ways of eating.” Another participant shared similar frustrating experience “I maintained for about 6 months, but maintained and did really well. Then something in my head clicked. And I don’t know if it was I gained a couple of pounds or what it was – but like everything shut down.” Another participant shared “I had done Weight Watchers and
then I couldn’t afford it. So, I stopped and that [weight] all came back on plus a few more.”

Weight Frustration

The obesity cycle led to complete frustration with weight loss attempts. One participant described weight frustration as “it’s like a rut and it gets deeper and deeper and deeper. And every time you fail, it’s harder to get out of it.” Another person shared “that’s my problem, I keep gaining it back. I know I can lose weight but I can’t keep it off.” Another participant stated that when it came to her weight “I thought I was hopeless.” Another participant felt like nothing she did would help her keep the weight off “I did feel helpless I figured that there was nothing I could do no matter what I tried.” Another participant reports repeated attempts and strategies to lose weight “I tried every single diet there is out there. I’ve lost, I don’t know, hundreds of thousands, not thousands, but you look at over the years how many times you’ve lost 10 pounds over and over and over and over again.”

Weight frustration is the culmination of repeated weight loss attempts and failures over time. For the participants in this study, this feeling of frustration left them with the sense that their weight is out of their control.

Motivating or Re-energizing Factors

Motivating and re-energizing factors were events or situations that instilled a new found hope or sense of need to take action to reclaim control over their weight struggle. Participants identified a variety of factors that helped them start or restart weight loss strategies. Physical or medical problems, social, family milestone events (grandchildren,
weddings), and personal reflection factors acted as motivating and re-energizing factors to do something about their weight or at least try again.

Physical or Medical Problems

Many participants identified physical or medical factors such as diagnosis of diabetes mellitus, unable to climb the stairs from shortness of breath or painful joints. One participant shared “I was very healthy. But, I had the knee pain, the hip pain, my joints ached. I just hurt all the time. I was depressed, cause from being overweight and hurting all the time and thought what kind of life is that?” Another participant shared his medical problems related to obesity “I had high blood pressure, I had Barrett’s, and diabetes, arthritis and what else? Just about anything and everything you could think of, I had.” A participant reported her concern “I had all the belly fat which we learned that was the most dangerous fat of all, cause it constricts the heart, causes heart damage and stuff.” Another participant shared her concerns as well “My blood pressure was going up to where I wasn’t comfortable with it. I didn’t like that, it was scarring me.” Another participant shared “my mom died when she was 55 from heart disease. And that’s still really a fear – that 55.” She verified she was afraid she would die the same way her mother did at a young age. Another participant shared “I’ve had a brother and a sister that have had to have partial amputees on their feet, the one is on dialysis and my other brother is going to end up on dialysis, those are all things staring me in the face.”

Participants identified that their physical conditions related to their obesity was impacting their quality of life in a negative manner. This recognition was a motivating factor for another weight loss attempt.
Social

Social aspects or external pressures including personal and work relationships were motivating factors for some participants. These aspects compounded with the physical and personal motivating factors helped move a person towards choosing a different alternative to past strategies for weight loss.

A couple of participants described concerns about the ability to maintain their jobs and needing the financial security. One person said "At one time, I didn’t think that, I didn’t think I’d be working today when I first started thinking about the surgery." Being able to work was critical for one participant. She shared "I have to work, I’m the only person who supports me. I have to work so, I have to do something." Another participant shared she now has the confidence to present her lifelong knowledge working with addiction and life’s trauma, she now has the energy and confidence to schedule workshops and lectures to share her knowledge. She had not realized prior to surgery that she had limited her professional growth.

Several participants shared that social support through their work environment helped them with their decision process. They shared it was helpful to see others who had success with their weight loss surgery. One participant shared "I went in because, like our secretary [name] had gone through the process. She was like a year in, I think, maybe two years." Another participant shared the support at work was helpful after the surgery. This participant shared "I went back to work, I was down there at [Factory], I was down there with [Name] and she’d come by and we’d talk about it [the surgery]."
Family Milestones

Some also described personal or family milestones actual and anticipated, positive and negative such as the birth of a grandchild or anticipation of their children’s milestones such as a graduation or a wedding as re-energizing factors. One participant talked about family changes “When my grandchild was born, I thought I want to be able to play with her and get on the floor and be able to move around with her.” Another participant relayed her fear of not being there for her children “I wanted to see my kids getting older and wanted to be around for them, for their weddings, their kids. My mom had past away when I was young and that was hard.” Another participant discussed her fears “My father was very overweight. And, he had serious heart problems. I decided I wanted to be there for my kids and if I didn’t do something the outcome didn’t look that great.” One participant shared her family’s special needs helped her focus on her own health issue, her weight. She said “I look at my six year old grandson, I have him, he’s my only grandchild; he’ll probably be my only grandchild. I have my son and well my daughter-in-law too, those two played a very important part just that I wanted to be there. My grandson has [congenital disorder], but I wanted to be healthy for me.”

One participant shared the death of two cousins related to their morbid obesity was an influential motivating factor for seeking surgery. This participant shared how he had another cousin and her daughter who had the surgery after the deaths in the family. So his immediate family really encouraged him to look at the surgery as an option. So for him family experiences (both the cousin’s deaths and success with surgery) were critical motivation for seeking out weight loss surgery.
Personal Reflections

One participant shared that she was doing a personal journey with her faith. This faith journey helped her reevaluate her personal life goals which in turn helped her be open to weight loss surgery. One participant simply stated “I’m going to be 50 and fabulous, not fat.” A couple of participants talked specifically about some of their challenges to maintain ongoing motivation. One participant said “I’m doing this [weight loss surgery], and I doing it for me. I’m not just doing it cause I want to look good for a wedding – as some people did.”

Motivation was an internal struggle. One participant shared “I had to do everything by myself and I’d lose the motivation. So, I’d just go through the gamut trying to find okay what can help … It’s like you know what to do but you don’t always do it.” Another participant shared how the motivation gets harder “I had always been able to, you know, really work. I have this stubborn streak in me and when I make up my mind to do something it’s like I would do it. It was getting harder and harder to get the motivation to it [diet and exercise].” The recognition that her weight struggle was more difficult as she got older helped motivate her to seek help.

Another person shared her frustration as her weight increased it discouraged strategies for weight loss. She shared “the heavier you get the harder to even exercise, to move around – you don’t feel like doing it.” Several participants agreed once you get the weight going down it acts as a motivator to keep working at weight loss. Some of the participants shared they knew what they were ‘supposed to do’ but lacked the motivation to continue strategies for weight loss on their own.
Informational Gathering

Many participants researched weight loss surgery options on their own. For some this information gathering took place over months and sometimes years. For some this was utilizing key informants such as some one who had already had the surgery, their primary care provider or doctor or a bariatric surgeon. Many of the participants had researched weight loss surgery on-line, through books and articles and talking with others who had had a weight loss surgery prior to seeking help for their own obesity.

One participant shared “I researched it actually for two years on the internet. Is this what I want to do? … I did research for two years before I did it [surgery]. So, I was prepared for it.” Another participant researched the procedure herself “I looked on the internet high and low for good cases, bad cases. Um, [Hospital bariatric program] was very resourceful. And they answered every question that I had.” Another participant reported similar strategies “I did a lot of research on there [obesityhelp.com] [found] a lot of things on-line, but that was my main one that one was really good for me to find out information about the different kinds.”

Seeking Support

Seeking support was something that could be identified throughout the decision making process as well as adjustment after the surgery. Many of the participants described organizing or seeking support through family, friends and healthcare professionals. They discussed the surgery option with family or friends to gain their supportive energy, assisted with motivation and re-energizing factors.
Family Support

For most, family was the key support in the decision process. One participant stated “once I was serious, I asked my husband seriously about it – he was very supportive about it and always has been. He never, ever once has said geez you’re fat or lazy, never, ever said bad things.” Another participant shared it was a family decision “I’d come home, we talked it over, that’ what we’ve always did in the family, my wife and I and the two boys sat down and talked about it. And, they said more or less Dad, if you want to do it – more or less go for it.” Another shared “my sister from Wisconsin who I don’t see very often – she came here to help.” Support came from children as well as another participant shared “my girls are all very assertive women and they’re like ‘mom, we don’t want to hear any more excuses about your weight, you’re not going to complain about it if you’re not doing anything about it. So, do something and we’ll be there to help you.”” Another participant shared a similar experience “My daughters were, both girls, were supportive even though they don’t live here. They were glad that Dad did something finally.”

One participant shared her experience preparing for a second procedure. She shared it was difficult for her family. “My daughter wasn’t there so she never got to see the horrible part of it but my son was there. He was kind of upset about me having it done again … we talked about death and God a little bit because it is scary. I was scared to have it done a second time.”

Supportive Friends

Some participants shared that friends were supportive of their decision. One participant shared “I have a good friend that has been through it too. Well, she went
through it last October about a year ago. So, I know her experiences, too.” One person shared that “I have a girlfriend that had it [LapBand] and she mentioned it to me … she’s doing really well on it – she kind of planted the seed.” Another participant shared advice from a friend from work “she told me, if you’re thinking about it – go do it. I talked about it for awhile.” Another shared her coworker friends and other friends surrounded her with support. She stated “People here at work are very supportive. I work in a good place. And I had a couple of other friends that were very supportive. I was wanting a lot of positive support.”

Not all participants had the support of people they considered friends. One participant shared “I had a friend that when I told her I was thinking about it [surgery] she said ‘I won’t support you if you have it done.’ Cause she’s very heavy too, she’s very large woman. She knew I was going to all the classes and then I got my surgery date. I called her to let her know. She wouldn’t return my call…. I lost who I thought was my best friend over having the surgery.” Another shared that her support system was over all a good one “except for one person and I don’t know how to handle that relationship because it’s kind of a negative relationship but it’s a friend that I’ve had forever.”

Support Groups

Support groups were helpful for several participants. The groups provided information as well as support during the decision process. Support groups provided a forum for people to connect with others who had already had weight loss surgery. One participant stated,

anybody that does decide to have this type of operation really needs to have the support from support groups and education to teach you how to rethink your
eating and that stuff. ... cause every time I go to a support group meeting and
everybody is talking and they say something – oh, I forgot all about that and that
was in week two [structured class] and that was two and half years ago for me.
You know, you don’t remember and you forget things too.

Another participant said “before I had it [surgery] done they actually had a support group
here in [town] and we met at the [store]. So, that’s where I know I learned a lot about it at
this group. It really helped me to decide to do it.” A participant shared “I was part of a
group afterwards ... for a while, to me it’s more beneficial to those that are deciding and
right after. After I got six to eight months out then I was doing really well – I stopped
going.” Some support groups invited healthcare professionals for information as stated by
one participant “The doctor came there to one of our groups, he came there and visited
with us and gave us a lot [information], and answered a lot more questions that we had.
So, yeah, that’s where I got a lot of my information.” Support groups offered information
and support to participants in the decision process. This was also a source of support after
surgery on an ongoing basis for some. Support groups offered a forum in which
participants felt like they were not alone in their battle with their weight.

Most participants described key support persons from their families, friends
and/or support groups. This support was in place both to make the decision to choose
surgery as well as help them throughout the surgery process. Most participants support
was very positive as they made a difficult decision to take back control of an aspect of
their life they felt was out of their control.
Intervening Conditions

Intervening conditions facilitate or constrain the action and interaction strategies specifically related to the phenomenon (Strauss & Corbin, 1990). According to Strauss and Corbin (1990) intervening conditions may include time, space, culture, economic status, technological status, career, history, and individual biography. Intervening conditions discussed by the participants included bariatric program requirements, finances, healthcare insurance and support systems.

Bariatric Program Requirements

Most participants discussed preoperative requirements based on surgeon recommendations while others identified them as insurance requirements. These requirements included psychological evaluation, preoperative history and physicals, preoperative workups such as gastric endoscopy or gallbladder ultrasounds, and six month medical management of weight loss. All program recommended weight loss prior to surgery. Most participants also had an individual preoperative weight loss goal. Participants who had the adjustable gastric banding identified access to providers for their adjustments due to time and distance to travel.

One participant shared “I was in [Hospital’s] program at the start of it. And maybe, they have a better one now. We were going to schedule the surgery they said ‘oh, by the way you gotta lose 40 pounds.’ I chose to fly the coup and go get it done somewhere else.” Another participant shared her feelings about the preoperative requirements “for me when you decide you want to have something done and then your told you have to go through all these other hoops to get it done it’s frustrating.”
Finances

Some participants identified time off work for surgery and appointments both a financial concern as well as obstacle. This was particularly a concern for participants with single incomes.

A participant shared some of her financial factors that affected her participating in the bariatric program “I saved my money to for the diet/exercise program cause that wasn’t covered by my insurance and saved my money for program afterwards. I made sure I had some money in my flexible spending so that I could cover my deductible.” Another participant also made decisions regarding her location of surgery due to time and costs “But when I switched over to [Town] it was more of a time thing rather than anything, cause my insurance deductible was gonna come up again at the end of the year. It was a money thing then.”

One participant talked about expenses varied depending on the bariatric program. She stated “there was a lot of out of pocket expenses like that class they make you go to cost $350. You know, in the Center they didn’t make you do that.”

Some indirect costs that participants shared involved travel expenses for evaluations and for adjustments. A couple of participants shared specifically that it was pretty much a whole day off work on the days needed for appointments due to travel time. So accessibility of the bariatric healthcare services added to the financial burden.

Healthcare Insurance

Participants described various intervening conditions. One common factor was insurance approval process and sometimes initial denial for surgery. Some had very little
difficulty while others describe frustrations being in a state of limbo pending insurance approval or having to appeal the carriers’ initial decision for denial.

One participant shared her commitment to maintain health insurance that would help pay for the surgery. She stated “… for so long I didn’t have insurance so I really couldn’t make the big decision … I had quit smoking, my insurance was going to go up so I knew I had to quit smoking in order to get the money because I couldn’t afford the insurance if I was a smoker.” One of the participant “Now, my insurance company this time is a different company and is making me do six months of dietary [medical monitoring]. So, I’m at the doctors being held accountable every single month for the weight gain or loss.” Another participant shared her experience with insurance obstacles “At first the insurance company, at first they said ‘nope’ they wouldn’t pay for it. That was a big stop in the middle of the road I felt like giving up everything then too. Until that got over, but I guess, like I said the whole process took such a long time.”

Some participants shared some restrictions in the insurance coverage. In one interview we talked about a lot of insurance companies consider weight loss surgery a onetime life time procedure for the participant who had the gastric sleeve. “Actually he [the surgeon] did submit the letter he actually he tried to put that second one in there saying that he would do it. This is the precursor surgery for the Roux En Y and they [the insurance company] said – no.” Another participant shared that her physician sent her to the dietitian for diabetes not weight loss surgery due to better coverage. She stated “Insurance won’t cover for gastric bypass but they will cover for diabetes.”

Another participant had no insurance obstacles to speak of “I think it was a month and a half from the time that I really started looking at it until the day of surgery. Yeah, it
went that quick, it went extremely fast. As soon as my insurance said okay, I mean, I said schedule it let’s do it.” One participant reflected on the insurance process of her first surgery “my insurance company hardly wanted to know anything, it actually made everything extremely easy which is maybe a good thing maybe not depending on what you look at now.”

Core Variable – Critical Point of Change

According to Strauss and Corbin (1990) the phenomenon or core variable is the central idea in which the actions and interactions are interplaying which is identified by asking ‘what is this data referring to? – what is the action/interaction all about?’ (p. 100).

This core variable was a critical point of change for these individuals seeking an alternative to break their cycle of obesity. It was deciding on something they had not tried before and for most of the participants surgery was the only strategy that had not previously tried. Most participants described a cycle of obesity which leads to weight dysfunction and weight frustration when combined with motivating and re-energizing factors instilled a personal readiness to take a different action, critical point of change. While a couple of participants describe epiphany moments, most participants report their decision was made after long and thoughtful contemplation of risks and benefits.

Participants shared what they thought were their critical point of change. For some it was the unmet goal in the bariatric program. A participant shared “I lost around 50 pounds in the [bariatric] diet/exercise program and I thought if I could it in the diet/exercise [program] maybe I wouldn’t have to [have surgery]. But, then, I was denied the surgery I went a vacation and in about a six month period there I gained 40 of the weight back and I thought – NO. I need the help.” Another participant had a similar
experience “I had lost 36 pounds or something like that and then I gained some of it back. And then, I was like – NO – I really do have to see the surgeon and I have to get back cause I’m losing my steam and I just need that tool.”

For some participants the critical point of change was a personal journey. One participant shared “I’m not gonna waste the last years that I have not being happy with me ... I’m gonna do what I need to do for me, what’s gonna make me happy.” Another participant shared “I’d been through the whole process over these last three to four years that I’d been working on me to get me to a point to where I was gonna do it [surgery].” Another participant shared her feelings about her weight prior to her surgery “I thought I was hopeless ... [surgery] was my last resort.” Another participant compared surgery decision to an alcohol problem “It’s kind of like being a drunk, you’ve kind of got to reach your bottom so to speak. I’m tired of being drunk, I’m tired of being fat... I seen after how it worked after that I got to thinking about this food deal and then actually the alcohol was easy in comparison with the food. It is easy to eliminate the drinking but you can’t eliminate the food.”

Action Strategies

Action and interactional strategies are processual, purposeful or goal oriented sequences devised to manage, carry out or respond to a phenomenon (Strauss & Corbin, 1990). These strategies take place within the context of the experience. Action strategies identified included choosing type of surgery, choosing program or location for surgery, evaluations for bariatric program as well as joining groups to support decision.
Choosing Type of Surgery

Weight loss surgery includes a number of procedures as well as a couple of approaches. The types of procedures available include gastric bypass or Roux En Y, Lap Band or adjustable gastric band, biliopancreatic diversion and gastric sleeve. These procedures may be performed through an open incision or laparoscopic procedures.

One participant explained his process took a while as well “I wanted to look into the LapBand. And at that time when I checked into it BlueCross wouldn’t cover it. So, I went through, I still went through all the steps and everything and decided to have the Roux En Y. And then during the testing they found out that I had Barrett’s and was no longer eligible for the Roux En Y but eligible for the LapBand. So I waited about a year and they BlueCross gave approval at that time.”

Another participant shared “I debated on the LapBand. But I had talked to a couple of people that were in the classes I was in and one of them sad – a gal that she worked with she had the LapBand in a year’s time she only lost four pounds. And they had it filled to the max. They couldn’t fill it anymore…I didn’t want to take that chance. I had the Roux en Y surgery.”

Another person contemplated the LapBand but did not meet criteria. She shared I was really wanting to do the LapBand and of course I went down to Center and listened to one of their sessions and they want you to be at a minimal BMI type of thing to really have that procedure. I knew that I was off the charts, I knew that it was probably gonna have to be gastric bypass but I really wanted to do the laparoscopic. I didn’t want the big incision…. I went to see him [the surgeon] and

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he talked about the sleeve and he said you can check it out online. I like this less intrusive and less, instead of being disconnected and reconnected.

Choosing Program or Location

As noted earlier in this chapter there was a variety of bariatric locations available in this region. Some of the participants shared that their decision was really due to the referral recommendation or due to preferred provider network. One participant shared “I did my own personal research on it and I became very satisfied with the results, they were the best reports that I’d got all over the area. So, I set up appointments down there [Place].” Another participant shared “I researched what I wanted to know, what the product was at the end. I talked to [name] and you talked to the people and then you make your own analysis, you know, we all do that.” Another participant shared “I went to [Town] because that’s where [Name] went and she was happy with the results.” Another participant shared she went to an information meeting at [Hospital] and she shared “I thought this is good. This would be good.” So a variety of approaches were used to get the information to determine location for surgery.

Evaluation or Program Process

One participant shared part of the workup process was individual therapy. She shared “I worked with a therapist and stuff and we really talked about food and how I really use food in my life … she [therapist] was really glad that I didn’t just jump on the bandwagon like everybody else. I really wanted to work through issues and put thing into place.”

A couple of participants shared that during the evaluation process for the gastric bypass they were diagnosed with stomach conditions that excluded them for the gastric
bypass surgery. Two participants went on to have LapBand procedures after the evaluation excluded them for the Roux En Y procedure they anticipated. Another participant shared that her gastric bypass surgery was delayed because she had gallstones. The bariatric surgeon recommended the cholecystectomy prior to the weight loss surgery. New health information was a byproduct of their gastric evaluation.

Joining Groups

Some joined bariatric support groups or other groups, such as TOPS (Take Off Pounds Sensibly) or Weight Watchers to help with their weight loss. Some of the participants became members of a structured bariatric program which included formal education classes on diet, exercise and behavior change. These groups described by the participants served two purposes: one, they offered support in the process of choosing and going through weight loss surgery and two, they offered information as to what to expect after surgery. One participant specifically benefited from being able to ‘drop in’ at the local support group and found that it was reassuring to listen to others who were having similar issues after surgery. This helped to validate her own experience and get feedback on her own physical changes since surgery.

Outcomes

Consequences or outcomes are a result of action or interaction strategies related to the phenomenon (Strauss & Corbin, 1990). The outcomes of seeking a surgical option then included sense of hope and help for success, personal experiences of weight loss surgery, ‘using the tool’ and resulting health changes after the surgery which included weight loss, complications of surgery and alterations in their chronic illness.
Hope or Help for Success

Most participants describe a sense of hope as they anticipated the surgery that the surgical option would be the external help they needed to maintain the ongoing struggle with their weight. One participant was very emotional when she shared her feelings about ‘taking the easy way out’ “right now, I’m 356 pounds, and you live my life and tell me I’m taking the easy way out when I finally have help. It’s not the easy way out, what they do is give you help.” Another participant shared how the surgery helped her “I’d still be 300 pounds if I hadn’t had it, I’m sure of it. I wouldn’t have lost it without the help of the surgery.” One of the participants shared after the surgery “now I can watch my diet and I can maintain at a couple hundred pounds.”

Weight loss surgery instilled participants with a sense of hope that this time their weight loss would be successful. Many participants shared how the surgery helped them stay on track with diet intake and with weight loss helped them maintain exercise programs.

Personal Experiences of Weight Loss Surgery

Most participants talked about their personal experiences of their weight loss surgery. The resulting consequences from their personal surgical experiences included changes in food tolerances, amount one can eat and one’s thoughts regarding alterations in eating patterns.

One participant shared some of her experiences after her gastric bypass that continue to impact her eating “sometimes I try different foods even now if I try and it don’t like me it builds up such a pressure in there (pointing to chest) that you just have to go to the bathroom. There’s no getting out of it.” One person shared “the foods I eat are
real limited. So, I've had to give up some favorite stuff but I'm okay with that. I'm okay with that because I can buy all kinds of new clothes now.” One participant struggled with diets changes after surgery. She stated “a lot of the stuff they wanted me to eat I couldn’t because it was dairy based stuff and I had horrible diarrhea.”

One participant talked about her surgery and her adjustments to her adjustable gastric band “it still restricts how much I can eat.” Another common change in eating pattern participants talked about was not drinking during meals. One participant shared “we are a culture of drinking with our meals, that is hard for me. As soon as I'm done eating I want a drink. If I do that now I’ll get sick.”

A participant reported “After I had the band I never thought about food. After awhile I would start to feel whoosy and think, oh God, it’s eight hours or seven hours since I had anything to eat.”

All participants spoke of changes in their relationship with food and eating. Some had more restrictions than others however; most participants agreed the changes were manageable.

‘Using the Tool’

Most participants recognized that the surgery alone did not fix their weight problem. The surgery was ‘the tool’ to help them effectively manage their eating which contributed to their obesity. Success after surgery ultimately depended on the participant’s actions whether or not to ‘use the tool’ which refers to following the recommended nutrition intake (quality and quantity) and exercise plan after surgery. Ultimately this resulted in, weight loss, weight maintenance or weight gain.
One participant reported “within a year’s time I had lost over 100 pounds. Um, it went off fast, if you followed the direction of your doctor um, it’ll be successful.”

Another participant was also very successful by following the post op plan “from January 5th to September 29th I lost 124 pounds. Like I say, I didn’t cheat or nothing I stuck to the basics.” Another participant was pleased with her 45-50 weight loss and sees her slow weight loss in part due to her lack of exercise. She recognized that the surgery was only one tool in the treatment regimen for weight loss. Using another tool like exercise would help her success. A participant described how he currently sees himself after his surgery and his perseverance in using the tool “I think I look smaller than I was but not as small as I want to be. I’d like to be 50 pounds or 60 pounds lighter than I am now. I don’t know if that will every happen but I’m still fighting for it to try and make it happen.”

Not all participants had long term success after their surgical procedures. A participant reported her successful weight loss up until she had complications requiring the removal of her adjustable gastric band “I lost 65 pounds all together. I felt great until that last adjustment I had and it went downhill from there.” Another participant was not satisfied with her weight loss results “I started at 418 and only lost 100 pounds which sounds great, but that’s not enough.” This participant sought follow up care and discovered a surgical failure which left the distal opening ‘wide open’ resulting in lack of satiety problems.

Beside the physical changes in eating after the surgery there was also an emotional aspect to ‘using the tool.’ A participant shared she thought she was ready for the surgery. However, afterwards found out the challenge was more than the physical changes and using the tool “I’m just going to do it [surgery] and everything is going to
better. That's a misconception big time! Big mistake, it doesn't make everything better, it doesn't. You think it does, you hope it does, but it don't. It's so much more mind than physical. The physical part the doctor does, you're 'good to go’ but it's more.” Another participant stated that she had to change how she looked at food. She stated “I had to really look at food as really not being my friend I was using it, I was using food to kill me. And I was truly killing myself it was my own self destructiveness.” This emotional aspect of eating that underlies the use of the tool that is recognized by many before surgery and requires an emotional adjustment after surgery.

Health Changes

Most participants described health changes after their procedures. Most of the health changes discussed were positive changes. However some of the health changes were more negative.

One participant shared the changes she noted after surgery. “I couldn’t lay on my left side before the surgery. The hip within five minutes would start hurting. Um, now I have no problems. I love riding horses and with the hip it wasn’t happening. Now, I ride again, just about every day. It’s been a good change for me.” Another person shared “it’s kind of fun going down from a 3XL or 4XL down to where you can go into any store and buy clothing.”

Another participant also describes marked improvement of healthy activity “exercise for me has always been an issue. And um, but, it’s amazing to me how much more I’m able to do, I mean, I still have bad knees, I still don’t have any cartilage in either knee but I’m able to do a lot in a day … the list I made for myself of what I wanted to accomplish before Christmas, I got it all done. A year ago I couldn’t have done it, I
couldn't have done half of it.” Thus a person feels good about self and abilities to accomplish their goals.

Health changes required a participant has to limit sweet or sugar intake “and sweets can be very bad for you if you have too much, like I try to limit my intake to a serving like yogurt and stuff like 13-14 grams because anything over that will give you really bad pains in your stomach like labor pains. I really got to be careful with too much sugar. I still get them to this day.” Another participant shared similar problems “Ice cream is a killer for me. And I know it. What it does is it sets off my hypoglycemia.” Another participant discussed her glucose levels change rapidly and requires her to monitor regularly. She shared “I do have a meter that I test my blood sugar regularly … I’ve gotten to know the signs and there has been times when it’s gotten really low. It will do it just like that (snapping her fingers) just drops – 23 was the lowest it got.” One of the participants also shared the disruption to the digestive system. “The biggest issue is your gas … I mean it, you got to get rid of it but you talk about smell, like a foul sewer.”

Another participant shared complications of a wound dehiscence after surgery. The participant shared “I ended up with the incision, I suppose it was about that long [approximately four to five inches]. It popped right open, and I mean that’s gross…it’s got to heal from the inside out. And so, they put the boot strap on me and gave me a bunch of three inch gauze pads and put a big pad on the top.” This participant went on to share numerous surgeries after gastric bypass including hernia repair and ‘tummy tuck,’ removal of kidney stone, kidney stent and prostate surgery, cardiac stents and shoulder surgery. “I ended up with nine surgeries in two and half years … Overall, it’s kind of
hard to make a real assumption but, ... I believe if I hadn’t had the gastric bypass I wouldn’t have to worry about these other ones cause I don’t believe I’d be alive.”

The structural model Decision Making Process for Persons Experiencing Obesity is the result of the data analysis (line by line and axial). The components of grounded theory according to Strauss and Corbin (1990), context, antecedents, intervening conditions, core variable, action strategies and consequences were used as organizing categories. These categories were examined as they related to the first research question addressing the decision process for weight loss surgery.

Nurses and Healthcare Professionals

The second guiding research question was: How are nurses involved in the decision making process for weight loss surgery? This question specifically addressed nurses’ role in the process. As the research progressed the role of other healthcare professionals was discussed as nurses were not readily identified in the decision making process.

Most participants struggled with identifying nurses in this process. Some were able to identify the surgeon’s nurse as a critical contact for questions for the doctor. Even participants involved with a structured bariatric program with a nurse coordinator struggled to identify nursing involved in the decision process. Several participants identified their primary provider as being a key person for information and support. For two of the participants this primary provider was a nurse practitioner. A couple of participants also identified the surgeons performing the surgery as critical informants in choosing surgery as well as choosing which type of surgery. Dietitians and exercise therapists were identified as supportive once they had already made the decision.
Psychologists were identified as part of the evaluation process but were not identified as key to choosing surgery. For several participants with adjustable gastric bands the physician assistant who does adjustments and co-facilitates the support group was seen as instrumental in the ongoing practice of ‘using the tool’ once it was in place.

A participant shared “My doctor was Dr. ‘Experience’ and of course she had it [gastric bypass surgery]. And she said fabulous things and looked great and whatever. She really helped me make the decision.” In the area of healthcare professionals the persons with the most influence on having the surgery are the bariatric surgeon and the person’s primary care provider. These providers were key resources for information or support in the decision making process.

Summary and Conclusions

In this chapter I addressed the findings to the research questions of how did the participant come to the decision to pursue weight loss surgery and how were nurses involved in the weight loss surgery decision making process. In this chapter I reviewed the research process and the demographics of the participants. I also introduced the structural model of Decision Making Process of a Person Experiencing Obesity. This model was grounded in the experiences of the 18 participants who had made that decision. I explained how the obesity cycle and weight frustration in conjunction with motivating factors lead to a critical point of change. I explained intervening conditions act to hinder or aid in the decision process. The action strategies in the process support the critical point of change. This chapter also identified a sense of hope or help, personal experiences of weight loss surgery, ‘using the tool’ and health changes as consequences of choosing weight loss surgery. Bariatric surgeons and primary care providers are
critical in the decision process for choosing surgery. The structural model and the cycle of obesity were reviewed with six participants in this study. They were asked for their input and comments. The explanation and model had face validity with the participants. Each participant had a particular aspect of the model that was more influential for their experience, however in general the model was representative of the decision process.

The structural model cannot completely represent the complex decision process of this life changing surgery. Therefore, Chapter V presents a theoretical model that discusses the interconnectedness of cycle of obesity, weight frustration and motivating or re-energizing factors as they relate to the decision for weight loss surgery. Chapter V also provides discussion points regarding the findings of the study.
CHAPTER V
THEORETICAL MODEL

Introduction

The purpose of this study was to investigate the decision making process of morbidly or severely obese individuals who chose weight loss surgery and the role of nurses in this process. This chapter moves the Structural Model: Decision Making Process of Persons Experiencing Obesity described in Chapter IV (Figure 2) to a theoretical model. The categories of context, antecedents, intervening conditions, core variable, action strategies and consequences were the basis for the Structural Model: Decision Making Process of Person Experiencing Obesity (Figure 2). In this chapter I will present and discuss the emergence of this first grounded theory model Choosing Weight Loss Surgery (Figure 4).

A theoretical model moves the axial model to a more abstract level and also presents the interactive dynamics of the core variable with its properties and characteristics (Figure 2). The theoretical models Choosing Weight Loss Surgery (Figure 4) and Outcomes of Choosing Weight Loss Surgery (Figure 5) reflects the decision making process for weight loss surgery and its outcome as discussed by the participants of this study. Choosing surgery involves a personal journey, a heightened valuing of self and a garnering of information and support. This process includes personal suffering imposed by self and others in society, as well as the encounter and overcoming of
obstacles throughout the process. The decision to have surgery is followed up with ongoing decisions and actions to complete the process. While Figure 4 is presented in a linear fashion the process is not necessarily linear as multiple intervening factors, obstacles and decisions are frequently revisited within the cyclical processes.

Figure 4. Theoretical Model: Choosing Weight Loss Surgery.

Moving Towards Critical Point of Change

Central to moving towards critical point of change, the core variable, was the individuals accumulation of hopeless feelings and negative behaviors in the cycle of obesity which led to weight frustration. These, participants described it as a daily struggle with weight which led to a growing sense of lack of control over their own weight and
feelings of hopelessness. Recognition of weight frustration also included awareness of the need to break the cycle of obesity; thus moving the participants to consider alternative options to past weight loss attempts. Participants had to seek out a replacement to current weight control strategies. The state of weight frustration was an essential component of seeking a healthier process to control their weight.

At the same time participants struggled with weight frustration they also were engaged with motivating or re-energizing processes involving the medical community, social and family circles as well as personal needs. The motivating or re-energizing situations included driving forces from medical or physical problems, social shortfalls or job concerns, family milestones or personal growth needs. Experience within these processes and situations supported their desire to find different options for weight loss by seeking support for a decisional change, by sharing their needs, concerns, and gathering information. Seeking information included resources such as books or articles, internet websites and sources, health care professionals, and friends or family. This search often included someone who had weight loss surgery. Seeking support involved finding people to support their decision which included friends, family, health care professionals and others who shared the experience. The participants in this study presented this consistent interactive process of deciding to break the old cycle of obesity, utilizing motivating processes, and seeking information which moved them towards and supported the critical point of change.

Engaging in Critical Point of Change

The critical point of change for most participants was a result of a motivational change with energy being directed to a new process of turning weight frustration into a
positive process of seeking information and support to assist with the development of hope and new actions. The critical point of change was the pivotal moment of awareness that a decision needed to be made to try an alternative to past attempts. Many participants felt the only option left was a surgical option, because of their endless and diverse attempt to lose weight.

The culmination of this whole process was participants reaching a personal readiness, to alter their lifetime relationship with food. To reach personal readiness was a personal journey with common components present among participants. Some participants did describe an epiphany moment during their journey.

Once the decision to have surgery was made the person then needed to make a series of other decisions about having surgery. The subsequent decisions included what type of surgery (LapBand, Roux En Y, gastric sleeve; open or laparoscopic), where to have the surgery done (Hospital, Town, Center or Place) and whether or not to join a support group. Ultimately, the person decides to follow through with the decision and act on that decision by having surgery. The seeking of supportive resources fortifies the energy to reach a conclusive decision.

The decision process presented some people with obstacles including insurance coverage restrictions and requirements, finances, access issues to bariatric specialists due to distance and work schedules, and individual workup requirements. The degree of obstacles was dependent on the bariatric program, private insurance and financial support. For many of the participants meeting the bariatric program and insurance requirements or financial obligations often extended the timeline from decision to enacting the surgery. Bariatric programs and healthcare professionals offered new
supports by way of personalized information, support groups and coordinators; thus further energizing and helping them through the process. There were no distinguishing differences in the participants who had not had surgery (n = 3) at the time of their interview other than they were uncertain of the outcomes. Perhaps more significant is the participants who had failed procedures (n = 3) who were willing to have a second surgery to obtain their weight loss goals.

Outcomes of Surgery

The outcomes of having bariatric surgery were summarized into four categories; health changes, using the ‘tool’, sense of hope or help and altered relationship with food and eating (Figure 5). Health changes for the most part involve positive changes related to subsequent weight loss and improvement of their co-morbid conditions while negative changes related to unpredictable physiological changes after surgery. Using the ‘tool’ refers to the fact that the surgery was not the end point but a means to help with weight loss and maintenance.

The surgery itself did not take care of the weight problem but was an additional means along with diet, exercise and behavior modification to aid in weight loss strategies. The surgery gave most participants a sense of hope as well as the help they needed to regain control of their body and their weight. The final outcome of bariatric surgery discussed by participants included personal experiences with an altered relationship to food and eating. These also included complications from surgery and living with the changes the surgery brought to their physical self and the emotional adjustment to these changes.
Figure 5. Theoretical Model: Outcomes of Choosing Weight Loss Surgery.

Summary

The weight frustration is the point in the repetitive obesity cycle where a person recognizes the presence of support that s/he is in a rut and validates that s/he is not in control of one’s weight. Weight frustration can be empowering if paired with different motivating and re-energizing factors that spur the person to seek new alternatives and support systems while gathering information for different strategies to relieve the weight frustration. In this theoretical model the core variable critical point of change (Figure 4) is the pivotal moment when the person is ready for a permanent commitment to a surgical intervention for weight loss and a major alteration in their relationship with food and eating. Thus, a new strategy, surgery, which gives the person control over their weight, evolves through the journey. The outcome of the surgery depends on the individual’s support system, motivational and energizing forces and personal development. It is necessary to point out that while this Figure 4 is presented in a linear fashion that is not
always the case. This theoretical model provides some understanding into the complex
and interrelated processes occurring during decision making. Clearly, having more
control over their weight by way of surgery or having ‘the tool’ is only a piece of the
larger story of managing their relationship with food and eating. Obviously it is no longer
a state of counting calories in and out.

Conclusions

The theoretical models of Choosing Weight Loss Surgery and Outcomes of
Choosing Weight Loss Surgery are not necessarily helpful for predicting consequences
but rather for the provision of information about the process and its influencing factors
related to the decision to have surgery. The models Choosing Weight Loss Surgery and
Outcomes of Choosing Weight Loss Surgery remain untested through empirical methods
but represent some critical factors and processes that persons with morbid obesity face
when moving out of the obesity cycle due to weight frustration and seeking options for
weight loss surgery. There is a range of experiences within the identified process of
choosing weight loss surgery given the multiple factors that influence the decision
process; the theoretical models identify the significant and consistently present processes
and experiences. In Chapter VI there will be a discussion of findings and implications for
future research, education and clinical practice.
CHAPTER VI

DISCUSSION OF FINDINGS AND IMPLICATIONS FOR ACTION

Introduction

The purpose of this study was to investigate the decision making process of morbidly or severely obese individuals who chose weight loss surgery and the role of nurses in this process. This chapter discusses the findings presented in Chapter IV and Chapter V regarding the decision making process for weight loss surgery. What follows in this chapter are discussion points on research protocol and rigor, sample, and implications for education, practice and future research.

Research Protocol

The research protocol was followed as outlined in Chapter III. Participants were recruited through two support groups (one community based group and one hospital based group) and through snowballing referral of friends and family. Advertisements were also run in a regional newspaper. Through this effort participants had a more varied experience as not all individuals were members of support groups thus presenting a variety of support systems enhancing variation of the sample. The sample also included participants that utilized a variety of settings for surgery as well as different types of surgery. The process of choosing surgery had commonalities in spite of the different locations and/or different types of procedures, thus supporting the rigor of “fitness” and maximum variation of this qualitative study.
This grounded theory study used a semi-structured interview guide to assist participants in sharing their decision making process of choosing weight loss surgery. Some general background questions were added as the study went forward to gain more understanding of their history about past weight loss strategies leading up to the consideration of weight loss surgery. This need for additional historical questions evolved as it was obvious that the past greatly impacted the present and planned future options. Consistency and auditability of this study was accomplished through constant comparative processes through immersion in the data and the logical flow of models from raw data collected revisiting data over and over again. The process and models from raw data to completion were reviewed by my advisor for the confirmation of logical flow.

Data analysis was completed according to the diagram outlined in Chapter III (Figure 1). All interviews were taped, transcribed by the researcher, and organized in NVivo. This process was used to establish consistency, support immersion and enhance auditability during the coding process. The focus of this study was the participants’ perspectives as they shared their experience choosing weight loss surgery. The truth value of this study was obtained through ongoing verification with the participants by using summative statements and clarification questions during interviews. Descriptions, categories and concepts as they emerged from the data were verified with individual participants during interviews. According to Guba and Lincoln (1981) “there can be no generalizability (even from the scientific point of view) unless there is first a reasonable level of internal validity” (p. 115). Confirmability is more valued in qualitative research. The Cycle of Obesity as well as the tentative theoretical models Choosing Weight Loss Surgery and Outcomes of Choosing Weight Loss Surgery were shared during the
interviews as they unfolded with participants confirming aspects of the model that were pertinent to their own situation or experience. The “fitness” of this study was discussed with key informants as the categories and concepts emerged from previous participants; there was remarkable similarity in the data as far as their descriptions about the decision making process.

The researcher as an instrument is not completely free of bias but recognizes and defines them within the process. Some of the biases recognized were the belief that weight loss surgery is appropriate and effective in properly selected candidates and the surgery is not an end point but a beginning. Also, choosing weight loss surgery is a difficult decision due to multiple factors involved and the long term outcomes. In this study, memos and journaling were used to recognize biases, make theoretical connections, note emergence of diagrams, models, and clarify and validate understandings with participants and my research advisor.

Sample

The demographic characteristics of this study were similar to the national trends in bariatric surgery. Predominately, bariatric surgery has been a treatment for women with the current trend of more than 80 percent of surgeries undergone for women (Santry, Gillen, & Lauderdale, 2005). In this study eighty three percent (n = 15) of the participants were women; and seventeen percent (n = 3) of participants in this study were men. The national trend has seen an increase in rates of surgery in persons 50 – 64 with an average of 41.7 which is slightly lower than the average of my participants (Santry et al., 2005). The age range of the sample was from 29 to 65 years with a mean age of 49.7 years.
However the wider age span in this study allowed and supported the potential of greater variation in thought and experience.

Eleven percent of the participants (n = 2) in this study were Native American Indian. The recruitment region of this study has a greater than 90% white population which was representative of the participants in this study. The national trend report did not address race variation; however, it did identify socioeconomic disparities based on private insurance status (Santry et al., 2005). There was ethnicity variation in this study although all the participants had health insurance coverage. According to one study looking at trends in gastric bypass patients, the authors found a discrepancy between the distribution of obesity in the population and the profile of patients who received gastric bypass (Shinogle, Owings & Kozak, 2005). This may suggest that persons whom fit the necessary profile for weight loss surgery, especially those with lower income levels and education level, may not have the access or the availability of weight loss surgery due to socioeconomic factors (Livingston & Ko, 2004). Also since information seeking was key to reaching a critical point of change, education and socioeconomic status may inhibit this population’s ability to access information and reach the critical point of change.

The national trend has reported an increase in all bariatric surgical procedures 13,365 in 1998 to 72,177 in 2002 (Santry et al., 2005). The majority of these procedures were the gastric bypass (80-90 %) (Santry et al., 2005). The trends in bariatric surgery have shown an increase in the number of laparoscopic procedures which may be the reason for more adjustable gastric band procedures in this study. The participants in this study who had already had surgery had a much higher rate (58 % or n =7) of the adjustable gastric band compared to the trends reported by Santry et al (2005). All of the

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participants (17% or n = 3) waiting for surgery in this study also anticipated having the adjustable gastric band. These changes may reflect the changes in insurance coverage of weight loss surgery procedures or a regional trend in bariatric surgery.

Theoretical Model Discussion

This study focused on choosing weight loss surgery which for the most part is an elective procedure. The decision making process ultimately comes down to making a choice, to have weight loss surgery or not. The decision to have weight loss surgery in reality is only the beginning. That decision requires a day to day commitment to a prescribed eating plan; literally changing their relationship to food and altering what meaning food and eating provide to the person such as emotional comfort or protection.

Participants in this study used a variety of methods during the process to help them with their decision. For the most part the findings of the strategies used to come to a decision were not surprising. The participants repeatedly experienced the weight loss and gain of the cycle of obesity, reached weight frustration with awareness of the need to change approaches, and became motivated to seek information and support to do something different. Yet, it is still the person’s decision to make. This process also demonstrates the foundations of symbolic interaction.

The human being is not a mere responding organism, only responding to the play of factors from his world or from himself; he is an acting organism who has to cope with and handle such factor and who, in doing, has to forge and direct his line of action. (Blumer, 1969, p. 55)

Understanding the factors that the participants identify in this decision making process specific for weight loss surgery may provide insights to earlier treatment and
interventions before the occurrence of co-morbid conditions or major physical disabilities that are irreversible.

Ogden, Clementi, and Aylwin (2006) in a descriptive study examined patients’ experiences with obesity surgery. Ogden et al. (2006) identified four themes in this phenomenological study; 1) personal weight history, 2) the decision making process, 3) impact of surgery on eating behavior and relationship with food, and 4) the impact of weight loss on health status. Weight cycling and failed diets in individual’s weight history were identified as precursors to motivating or trigger points of change (Ogden et al., 2006). Ogden et al. (2006) described general motivation primarily the negative effects of their weight and specific triggers such as physical symptoms of obesity as factors that spurred the patient to seek out a surgical option. These factors are similar to motivating and re-energizing factors identified in this study that moved a person to seek information and support for alternate options to previously tried weight loss strategies. Ogden et al. (2006) identified a range of motivating experiences related to being overweight and obese which were concerns about weight, health, and physical symptoms as they related to excess weight. These factors were identified as part of the process to seek out weight loss surgery. This does not seem surprising when the effects of obesity extended beyond the physical condition to the person’s images of self and social functioning; encompassing the whole person of self.

Ogden et al (2006) described general motivations from the negative effects of being overweight or obese and triggers to action (contacting general practitioner or the surgeon) as factors in their decision making. Ogden et al (2006) concluded that a person’s history of weight cycling and failed dieting, concerns about weight and health in the
midst of current symptoms of excess weight weighed the heaviest in the decision to have weight loss surgery. In this study, medical problems, personal, family, and social/job concerns were the motivating and re-energizing factors that moved the person closer to choosing weight loss surgery; whereas the experience of weight frustration acted as the trigger to seek support and information regarding treatment options. The decision to have surgery was a culmination of weight frustration, motivating or re-energizing factors, information gathering and seeking support; a process impacted by multiple factors.

The past experiences of individuals also described being out of control of their weight and seeing surgery as an option to regain control through this external means (Ogden et al., 2006). These personal histories correspond to the obesity cycle and its components (weight as a dysfunction, attempt to lose weight, unmet goals, and giving up on weight loss strategies) identified in this study.

Ogden et al. (2006) described adjustments included initial shock of the physiologic changes after surgery and the fundamental change in their relationship with food and eating as a result of that change. The concept of being able to control one's weight (assumed as an individual's responsibility) often fosters negative blaming images from others in society including healthcare providers especially when the person is unsuccessful. Weight loss surgery changes the aspect of control over food and eating. These findings are similar to this study as the participants described outcomes after surgery as positive and negative health changes, the surgery as a 'tool' external to their person, and gave them a sense that they had hope and help to control their weight which they believed they had lost.
As a consequence of surgery hunger decreased and there was shifts in their relationship with food such as food as a biological necessity in contrast to food as a psychological support (Ogden et al., 2006). The weight loss from surgery resulted in improved confidence and body image, and factors contributing to quality of life (Ogden et al., 2006). This study did not specifically address surgical outcomes but participants shared that the outcomes of surgery were health changes (positive and negative), using the ‘tool’ (weight loss, weight maintenance, and weight regain), sense of hope and help (regain control over weight and body) and altered relationship with food and eating (food tolerance, limited amounts and changed eating patterns). These outcomes identified by the participants expounded on the consequences of surgery described by Ogden et al. (2006); presenting a more wholistic understanding.

Foster, Wadden, Phelan, Sarwer and Sanderson (2001) examined perceptions of treatment outcomes. Foster et al (2001) discussed the importance of patients having realistic expectations to help determine outcomes of treatments for persons with obesity including weight loss surgery. It is well established in the literature that the best nonsurgical treatment options for obesity produces an average of 10 percent weight loss. Foster et al (2001) reported that “when goals remain out of reach and progress toward them is unsatisfying, people experience negative affect, aversive self-focus, and impaired performance which often lead to abandonment of their goals (p. 2133).” This is descriptive of the Obesity Cycle (Figure 3) and weight frustration identified in this study. The experiencing of this cycle and the personal recognition of weight frustration is the beginning point of the decision making process.
Change Theory

The Transtheoretical model is a framework that conceptualizes processes underlying readiness for change in a variety of health behaviors. The Transtheoretical model may provide helpful strategies in counseling individuals considering weight loss surgery. This model includes stages of readiness including precontemplation, contemplation, preparation, action, maintenance and termination.

The Transtheoretical Model stages of change or readiness for change may have application to this study. The Obesity Cycle may be considered precontemplation stage, the stage prior to considering change in current weight behavior. Weight frustration and recognizing motivating or re-energizing factors may be considered the contemplation stage, the stage where change is considered but no action taken. Seeking information and support fits well with the preparation as well as actions taken in preparation for the actual surgery. Finally, the action of enacting surgery and following the post operative recommendation and then the maintenance stage of change completes the process. The termination stage does not seem to apply at this time as the participants shared ongoing processes to maintain post operative eating recommendations. Certainly, applying the Transtheoretical Change concepts to the proposed theoretical model of Choosing Weight Loss Surgery with specific intervention for weight control may be helpful in the assessment of and movement towards readiness to act in the decision making process to seek weight loss surgery. The model puts flesh to the bones of transtheoretical change process.

Tod and Lacey (2004) explored factors that encouraged or discouraged overweight people from low income groups to access weight loss services in a study in...
England. Tod and Lacey (2004) also identified persons seeking weight loss (in commercial programs) as vulnerable for a variety of reasons which includes experiences with humiliation, health scares and loss of self confidence; thus sensitive to judgment or blame from others including health care providers. The study examined stages of change, triggers to action, and barriers to action as well as denial from previous bad experiences. Specific triggers for the need to take action identified as embarrassment and humiliation, health problems or warnings, fear, critical life events (weddings, birthdays or holidays) and body image (Tod & Lacey, 2004). These triggers to action (health belief model) are similar to weight frustration and the motivating and re-energizing factors (medical, personal, family, social and job) identified in this study which moved the person to a critical point of change.

**Health Belief Model**

The Health Belief Model has also been used for weight management. The Health Belief Model evaluates motivation for change through identifying perceived susceptibility, perceived severity, perceived benefits, perceived barriers and self-efficacy (U.S. DHHS, 2005). These concepts provide an assessment guide for specific health problems such as obesity. Kelly (2004) suggested that if the person’s health beliefs do not support the management of their obese state they are less likely to be successful in the weight loss strategies. Kelly (2004) discussed the application of stages of change and the health belief model with weight management. This article recognized that behavioral change in weight management is complex and includes factors of exercise, nutrition and responses to environmental stimuli (Kelly, 2004). These factors are compounded when eating behaviors, body image and emotional factors are distorted. Applying key
components of the health belief model (perceived susceptibility, perceived seriousness, perceived benefits to action, barriers to action and cues to action) can assist in determining readiness for change and recognition of effective roles for primary care providers (Kelly, 2004).

Kelly (2004) developed specific questions to address the perceived susceptibility and seriousness as well as benefit of action, barriers to action and cures to action. The use of specific problem focused questions such as these can provide relevant information to healthcare providers treating overweight and obesity. The responses to such questions support the creation of individual plans for follow-up and interventions. These questions may be useful for determining readiness for change specifically related to choosing weight loss surgery. Perceived susceptibility may be; does your weight pose other health risks? Perceived seriousness may be assessed by asking if you don’t lose weight what will be the outcome for you. Perceived benefits to action may be evaluated by asking what benefits can you identify from losing weight. Barriers to action may be evaluated by asking what hinders your weight loss. Cues to action may be assessed by asking what helps or supports you to lose weight.

Additionally, in a review of the Health Belief Model, Daddario (2007) concluded the level of perceived threat or risk of obesity is a key motivator for changing behavior. Self efficacy and/or confidence in a change to lose or maintain healthy weight was a key resource in making the change; however, poverty affects the development of self-efficacy further enhancing negative affects of socioeconomics. Weight frustration, motivating and re-energizing factors, gathering information and seeking support are the precursors to change identified in this study.
One can readily relate this study's model to the Health Belief Model. Weight frustration, a person's perception of the impact of being obese, is considered "perceived severity". The motivating and re-energizing processes (medical problems, personal, family and social or job concerns) depending on whether positive or negative could be either perceived susceptibility or a perceived benefit. Perceived barriers (insurance, bariatric program requirements and finances) are overcome through gathering information and seeking support from family, friends and healthcare professionals. Once the person has established his/her confidence (self-efficacy) the decision is made to proceed with surgery.

Daddario (2007) concluded that the health belief model is effective and useful in addressing weight management especially when used in conjunction with other theories. Daddario (2007) concluded according to the results of previous work, core education needs to address patient's understanding of the seriousness of obesity dysfunction and related co-morbidities.

Working with a variety of theories may be necessary given the multiple factors that influence the decision process of choosing weight loss surgery. Using theories that have been used in past research and expanding the application to new populations may further the understanding not only of the theory but the health problem of obesity as well. This may help healthcare professionals recognize the chronic nature of obesity and assist with intervening at a variety of levels (individual and community) to get a handle on this expanding health epidemic.
Implications

Obesity as a chronic illness is a challenge to healthcare institutions and professionals. This study examined the decision making process for a surgical intervention option for chronic obesity. Within the study the role of nurses was examined. The findings in this study suggested limited recognition and involvement of nursing in the decision making process. The implications to be discussed include education, nursing practice and future research.

Education

One of the first and foremost needs for healthcare professionals is recognition that overweight and obesity is a chronic medical condition. Education regarding the complex nature of obesity is needed to move beyond the myth that weight is a simple formula of calories in and calories out. Sensitivity training is needed for all healthcare professionals to avoid prejudicial treatment of persons with obesity.

Healthcare professionals working with individuals that are overweight or obese should be educated on current treatment options. Since being overweight and/or obese is so prevalent, this virtually includes all primary care providers. This is particularly important for first line healthcare professionals to offer early treatment and referrals utilizing other healthcare professionals including dieticians, exercise trainers, counselors, and bariatric specialists.

Health promotion and prevention actions are needed to decrease the need for treatment interventions once co-morbid conditions develop as complications of excessive weight. There is also a critical need for primary prevention by school and public health nurses in elementary schools regarding overweight and obesity especially in light of the
growing prevalence of childhood obesity. Further work with policy development promoting primary prevention is needed at institutional levels appropriate for vulnerable and diverse populations.

Patient education is also needed addressing the chronic nature of obesity, the risk of co-morbid health conditions as well as options for treatment and sources of support. Patient education that focuses on relevant facts pertain to the treatment of obesity is critical for individuals to make a confident decision. In the barrage of information in the media, internet and the public regarding weight loss surgery, healthcare professionals are tasked with making sure the information is reliable and realistic. Providing education in nonjudgmental manner that encourages patient centered care promotes patient confidence in choosing treatment options. Nurses have key positions in the healthcare system to provide this education in a proactive manner.

Nursing Practice

Overweight and obesity are under recognized by many healthcare professionals either due to lack of knowledge, lack of time or denial of health problem. The lack of diagnoses, limited medical options and ongoing healthcare prejudice continue to delay a discussion of treatment options with persons having obesity. Nurses are often in a position to assess the weight and BMI of patients. Implementing nursing assessment to obtain weight histories on persons with BMI \( \geq 25 \) including current and previous weight loss strategies is the first step to identify the obesity cycle or weight frustration. The utilization of eating questionnaires and development of assessment tools for determining readiness to implement appropriate weight loss interventions are in dire need as well.
Interventions and options for weight loss may be suggested and reinforced appropriately in individuals with BMI ≥ 30 only when weight is addressed as a chronic condition. By using assessment questions to determine readiness for change specific for weight management and opening the door to a larger discussion healthcare providers especially nurses will be able to suggest appropriate interventions and education to meet the individual patient’s needs (Table 3 for questions based on a modified health belief model). Individuals with obesity need knowledge of options for the treatment of their disease and support of their incentives to obtain a healthy weight. Another avenue for nurses to be involved in the care of patients with obesity is the development of policy to insure equitable and quality care for this vulnerable population. Policy development is also needed within insurance companies to provide coverage for weight loss procedures and treatment for individuals with obesity. This should also include policy development or initiatives at state and federal levels given the growing public health concern of obesity. Letters of support for change need to be initiated by patients, healthcare professionals and relevant national organizations to insurance companies and institutions providing treatment for obesity.

Nurses were really not identified as key resources by the participants in this study. Some participants when coached that the bariatric coordinator was a nurse then they recognized the contribution. The role of nurses in bariatric programs may need to be re-evaluated. Nurses in many circumstances are the first contacts in the healthcare system and could be fundamental in raising awareness of BMI. Nurses are in a key position to initiate conversations with patients who have a BMI ≥ 30 and provide education about excess weight risks, and weight reduction before further escalation of the problem.
Table 3. Applying the Key Components of the Health Belief Model to an Overweight/Obese Patient.

<table>
<thead>
<tr>
<th>Component</th>
<th>Questions to ask the patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived susceptibility</td>
<td>How do you think your weight contributes to your health risks?</td>
</tr>
<tr>
<td>Perceived seriousness</td>
<td>If you don’t lose weight, how will that affect your health? How does your weight affect other aspects of your life?</td>
</tr>
<tr>
<td>Perceived benefits to action</td>
<td>What health benefits could you experience from losing weight?</td>
</tr>
<tr>
<td>Cues to action</td>
<td>What helps you when losing weight? What approaches support your weight loss strategies?</td>
</tr>
<tr>
<td>Barriers to action</td>
<td>How have you attempted to lose weight in the past? What keeps you from losing weight?</td>
</tr>
</tbody>
</table>

Future Research

The following recommendations for further research were identified from the model and from the literature. While the decision making process may be straightforward there are other questions and issues that need investigation such as the following:

- The need to identify critical points of change early on in the weight gaining process when less dramatic interventions and/or prevention strategies would be more effective, thus reducing the potential of developing co-morbid conditions, and organ or tissue damage due to excess weight.
- Further research of urban populations to determine applicability and “fit” of the obesity cycle and decision making process with this population, and other ethnic groups.

- Need to expand the diversity of ethnic populations to determine if the theoretical model is applicable to their decision making process in choosing weight loss surgery.

- Need for more in depth examination of how cultural, social and economic factors influence the acquisition of a support system, and access to or availability of healthcare specifically regarding the treatment of obesity.

- Development and testing of specific assessment tools that determine readiness for change and the measuring of self confidence for successful outcomes related to choosing weight loss surgery.

- Investigation of the decision making process for weight loss surgery in individuals who have considered surgery and decided against surgery. This may provide insights into which factors are the most critical and a determination of the missing elements needed for follow through with the decision to have weight loss surgery. This work could also identify significant barriers not identified in this research that impede moving forward with surgery.

Research options regarding the decision process for weight loss surgery are endless as there are multiple factors that influence choosing weight loss surgery. Research in this area of nursing practice is necessary to move healthcare professionals toward evidence based practice.
Conclusions

Process of choosing weight loss surgery was the focus of this study which identified critical point of change as the core variable. While the choice remains ultimately up to the individual, healthcare professionals as well as other cultural and societal factors help and hinder that decision; this process exists in a lived context. Individuals in the position of choosing weight loss surgery are vulnerable. Many have struggled for years and have used a variety of attempts to control their weight; cycle of obesity. Weight frustration was altered by support of their family, friends and healthcare professionals (which fueled their energy to choose a different alternative). Accessing information with support and daring to have hope that they would be successful are also significant properties of the core variable.

Many of the participants dealt with prejudice from friends, family, healthcare professionals and society. Enacting their choice of weight loss surgery, allowed most of them to regain hope, restore function that had been lost, grow in self confidence and regain control over their physical self. The decision to have the surgery was a new starting point and a commitment to ongoing weight loss strategy. Participants in this study demonstrated personal courage and fortitude in the execution of their decision. Providing support and education appropriate to individuals needs and related to their stage of change are key in helping this vulnerable population to be successful in this process of deciding, doing and effectively living with personal change.

Nurses need to assertively engage in promotion and prevention approaches, advocate for policy change and further investigate issues or questions that need researched answers. The process, findings and outcomes reported in this study answered
the proposed research questions. It is the hope of this author that nurses will benefit and patients will ultimately profit from this work of examining the decision process in choosing weight loss surgery.

For the participants in this study choosing weight loss surgery has been a personal journey as this dissertation has been my journey. The road has been long and not without twists, turns, obstacles and detours. It is my hope that in some small way this dissertation will advance the understanding of this process to ease the journey for others considering this life changing process.
APPENDIX A
Informed Consent Form

The Weight Loss Surgery Decision Process: A Grounded Theory Study
Martha Lystad, MS, RN, PhD Student (Phone number 218-463-2245)
Eleanor Yurkovich, EdD, RN Advisor (Phone number 701-777-4554)

My name is Martha Lystad and I am a doctoral nursing student at the University of North Dakota. My faculty advisor is Dr. Eleanor Yurkovich. I am also a Family Nurse Practitioner in a Rural Health Clinic in Northern Minnesota. I am studying the treatment of obesity, and more specifically the experience of choosing weight loss surgery from the client’s perspective. Weight loss surgery is becoming more common in our region and I’m concerned about care issues that influence people in the decision making process used to choose weight loss surgery.

You are invited to participate in this research study. The purpose of this study is to ask you about your experience in choosing weight loss surgery. What you share will help health care providers better understand the decision making process from your experience. The only way to completely understand the decision process is to ask people who have been through the experience. The best way is to ask you to share your experience.

If you agree to talk with me, I will ask questions about how you decided to have weight loss surgery. The interview will need to be audio taped and I will take notes as you share your story with me. The interview will take about 1 hour and not usually more than 2 hours. Your name will be anonymous and your transcript will be identified through a coded system to maintain your privacy. This code will be place on tapes and transcripts. At no time will your name appear on any of these materials. The audiotapes will be erased or destroyed 3 years after the data has been analyzed. Prior to the tapes being erased, they will be stored in a locked file cabinet separate from the coded identification list. The list with the identifying information would be used if I would need to re-contact you. The identifying information will be stored in a separate locked file cabinet from tapes and transcripts. All written materials will be shredded 3 years after study completion.

If you chose to participate in this interview process, you may also choose to stop or not answer a question at any time without penalty of loss of services that you are entitled to. I will also reserve the right to end the interview at any time without penalties to you if I believe the interview is causing you stress or a great deal of anxiety. There will be a store gift card for the amount of $20 as compensation for your participation in the interview.

There may be some discomfort in sharing your story because of the personal nature of this experience. The risk to you will be minimal and includes your time and the personal nature of your disclosures regarding your weight loss surgery experience. You are asked to share only what you feel comfortable sharing. All results will be reported as group, so your personal identity will not be disclosed and only general descriptions of locations such as ‘northern plains states’ will be used.

At the end of the interview, I will request your permission to contact you at a later date. This will be in case I do not understand something that was said during the interview. This would be a briefer interview and not typically more than 30 minutes. I will request how you wish this contact to be made at the end of the interview.
You will receive a copy of this form to keep. I will mail you a summary copy of the results if you wish to have your own copy. If you have any questions about this project you may contact me, my advisor or the Office of Research Development and Compliance at any time, before, during and after this study. Your participation indicates you have read and understand the above information and have agreed to be interviewed by the researcher and will also participate in a short second interview if necessary.

The following page lists the contacts for any questions regarding this study.

Principal Investigator
Martha Lystad, RN, MS, FNP
402 3rd Avenue NE
Roseau, MN 56751
(218) 463-2245 Home
(218) 463-1365 (M/F) Work
(218) 782-2400 (T/Th) Work

Committee Chairperson
Eleanor Yurkovich EdD, RN
Professor
College of Nursing
Nursing Building Room 309
430 Oxford St Stop 9025
Grand Forks ND 58202-9025
(701) 777-4554

Office of Research Development and Compliance
University of North Dakota
P. O. Box 7134
Grand Forks, ND 58202-7134
(701) 777-4279

Institutional Review Board
Altru Health Systems
Altru Hospital – 6th Floor
1200 South Columbia Road
P. O. Box 6002
Grand Forks, ND 58206-6002
APPENDIX B
Recruitment Advertisement

A University of North Dakota doctoral nursing student is seeking interested participants for her research dissertation study.

The purpose of the research is to look at how individuals come to a decision to have or not have weight loss surgery.

Individuals who have decided to have weight loss surgery or have had weight loss surgery and are willing to talk about their decision making process and experience are needed. Individuals (men or women) must be 18 years old and be willing to meet for a taped interview expected to last approximately one hour. Interviews will be scheduled at a mutually agreed upon time and private place.

A $20 gift card will be given in appreciation of your time.

If interested please contact Martha Lystad RN, MS, Doctoral Nursing Student (218) 463-2245 or email martha.lystad@und.nodak.edu
APPENDIX C
Semi-structured Interview

Identification Code: __________________________

Demographics:
Age: __________________________
Sex: __________________________
Educational Level Completed (years): __________________________
Marital Status: __________________________
Race: __________________________
Type of Surgery: __________________________
Date of Surgery: __________________________
Where Surgery was performed (Institution): __________________________

<table>
<thead>
<tr>
<th>Core Questions</th>
<th>Examples of Probing Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tell me your story about your experiences and your decision making process to have weight loss surgery.</td>
<td>What was your thinking process that you used to decide on having weight loss surgery?</td>
</tr>
<tr>
<td></td>
<td>What were your feelings about the surgery before your decision?</td>
</tr>
<tr>
<td></td>
<td>Was there a particular event or feeling that confirmed your decision to have the surgery?</td>
</tr>
<tr>
<td></td>
<td>What obstacles did you have to overcome in your decision to have surgery?</td>
</tr>
<tr>
<td></td>
<td>What are the actions you took to assist you in making this decision to have surgery?</td>
</tr>
<tr>
<td></td>
<td>Tell me about what supports you had in place to support your decision.</td>
</tr>
<tr>
<td></td>
<td>What resources did you have before choosing weight loss surgery?</td>
</tr>
</tbody>
</table>

| Tell me what experiences you had following your decision to have weight loss surgery. | Are there things you wish you had known or done before deciding to have weight loss surgery? |
|                                                                                   | If you could change something in the process of choosing weight loss surgery, what would that be and why? |
|                                                                                   | How have others responded to you since your decision to have weight loss surgery? How do you feel about that? |
|                                                                                   | Would you do it again? Why or why not?                                                        |

<table>
<thead>
<tr>
<th>If you knew someone who was in the process of making the decision to have weight loss surgery, what do you think they need to consider?</th>
<th>What obstacles would you share since making the decision to have weight loss surgery?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What are the supports you noticed that helped you choose weight loss surgery?</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
</table>
| If you knew someone who was in the process of making the decision to have weight loss surgery, what do you think they need to consider? | What were your feelings that you might share as you explored the decision to have weight loss surgery?  
What changes would you share that you have made since your decision to have weight loss surgery?  
What were your feelings that you might share as you explored the decision to have weight loss surgery?  
What changes would you share that you have made since your decision to have weight loss surgery. |
| What do doctors, nurses or other healthcare professionals need to know about making the decision to have weight loss surgery? | What resources did/ do you use to support your current decision for surgery?  
What was the role of nurses in choosing weight loss surgery?  
How did nurses help or hinder your decision to have weight loss surgery?  
Did nurses serve as a resource in choosing weight loss surgery? If so how? |
| Is there anything else you would like to add to your story, positive or negative about your weight loss surgery decision? | What else would you like me to know about your experience?  
Or your decision to have weight loss surgery? |
# APPENDIX D
## Emergency Contact Numbers

<table>
<thead>
<tr>
<th>Hospital or Emergency Numbers</th>
<th>Mental Health Institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital or Emergency Numbers</strong></td>
<td><strong>Mental Health Institutions</strong></td>
</tr>
<tr>
<td>Altru Hospital</td>
<td>Northwestern Mental Health Center</td>
</tr>
<tr>
<td>Grand Forks, ND</td>
<td>Crookston, MN</td>
</tr>
<tr>
<td>701-780-5000</td>
<td>218-281-3940</td>
</tr>
<tr>
<td>First Care Medical Center</td>
<td>The Stadter Center</td>
</tr>
<tr>
<td>Park River, ND</td>
<td>Grand Forks, ND</td>
</tr>
<tr>
<td>701-284-7500</td>
<td>701-772-2500</td>
</tr>
<tr>
<td>Kittson Memorial Healthcare Center</td>
<td>Center for Psychiatric Care</td>
</tr>
<tr>
<td>Hallock, MN</td>
<td>Grand Forks, ND</td>
</tr>
<tr>
<td>218-843-3612</td>
<td>701-732-2500</td>
</tr>
<tr>
<td>LakeWood Health Center</td>
<td>Crises Lines</td>
</tr>
<tr>
<td>Baudette, MN</td>
<td>Northeastern Human Service Department</td>
</tr>
<tr>
<td>218-634-2120</td>
<td>Grand Forks, ND</td>
</tr>
<tr>
<td>LifeCare Medical Center</td>
<td>701-775-3100</td>
</tr>
<tr>
<td>Roseau, MN</td>
<td>800-845-3731</td>
</tr>
<tr>
<td>218-463-2500</td>
<td>National Suicide Prevention</td>
</tr>
<tr>
<td>North Valley Health Center</td>
<td>800-273-8255</td>
</tr>
<tr>
<td>Warren, MN</td>
<td>Twin Cities Crises Line</td>
</tr>
<tr>
<td>218-745-4211</td>
<td>Toll free MN 1-866-379-6363</td>
</tr>
<tr>
<td>Northwest Medical Center</td>
<td></td>
</tr>
<tr>
<td>Thief River Falls, MN</td>
<td></td>
</tr>
<tr>
<td>218-681-4240</td>
<td></td>
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<tr>
<td>Northwood Deaconess Health Center</td>
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<tr>
<td>Northwood, ND</td>
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<tr>
<td>701-587-6060</td>
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<tr>
<td>Unity Medical Center</td>
<td></td>
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<tr>
<td>Grafton, ND</td>
<td></td>
</tr>
<tr>
<td>701-352-1620</td>
<td></td>
</tr>
</tbody>
</table>
REFERENCES


Institute for Clinical Systems Integration. (2000). *Technology Assessment Abstract Gastric Restrictive Surgery for Morbid Obesity* (Publication No. TA#14 (2nd Update)). ICSI.


