THE RISING PREVALENCE OF BEING OVERWEIGHT:

LIFE CHOICES, INADEQUATE OPTIONS

THESIS

Presented to the Graduate Council of
Southwest Texas State University
in partial Fulfillment of
the Requirements

For the Degree

Master of ARTS

By

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San Marcos, Texas
May, 2001

DEDICATION

I would like to dedicate my thesis to the many individuals who struggle everyday with the multifaceted issues of excess weight in a society that promotes the existence of the problem, yet stigmatizes those who are overweight. Included in this dedication are the special people who participated in this study. The information they shared about their experiences and frustrations, which at times was difficult to reveal, speaks to their courage and willingness to help others. Without these individuals expressing the failure and success they encounter every day, this study would not have been possible.

ACKNOWLEDGEMENTS

I would like to acknowledge Dr. Barbara Trepagnier for her contribution as chair of my thesis committee. Without her resolve and dedication to high standards, I would not have been inspired to keep working toward my academic goals. I also thank her for the many hours of time and the energetic encouragement she provided while I struggled over the thesis completion.

I would also like to acknowledge Dr. Audwin Anderson and Dr. Shirley Ogletree for their encouragement and input as members of my thesis committee. Their comments and suggestions were invaluable.

Lupe Contreras is acknowledged for listening to me and commiserating with me throughout the entire thesis process. Her friendship is a special bond that words cannot describe. Cliff Wright deserves special recognition and appreciation for his love, support, and understanding. During all the times he was overlooked and disregarded because of academic obligations and deadlines, his sacrifice was not unnoticed. I would not have been able to achieve my dream of a master's degree without these outstanding individuals.

March 27, 2001

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This thesis describes an exploratory study of the increasing prevalence of being overweight. Excess weight is socially unacceptable, an economic burden to the health care system, and is a dangerous risk factor for disease, even death. Nevertheless, an estimated 61% of the adult population in the United States is presently overweight (National Center for Health Statistics 2000). Despite the increased attention to the rise of excessive weight gain, prevention and treatment guidelines are narrowly focused and do not address the multiplicity of causes. In-depth interviews reveal personal weight struggles that are often accounted for with justifications and excuses. The effect of others, time constraints, and personal preferences suggest that pressure outside of the individual complicate weight reduction attempts. The study concludes that to decrease the rising trend in the prevalence of overweight, guidelines must include medical concerns in addition to behavioral, environmental, and social factors that differ according to each individual.

CHAPTER I

INTRODUCTION TO THE STUDY

The Problem

Eating. Everyone consumes food in some form in order to live. However, what was once a necessary function for survival has in recent decades become a focal point in the increasing prevalence of overweight individuals. Deciding what to eat leads individuals to an array of abundant food choices. These choices include what type of food to eat, where to consume it, and how much to consume. Decisions about whether to cook at home or to dine out, whether to have food delivered or to pick up something "to go" are also made. Widespread availability of processed foods, large portions, easy living conditions, hectic work schedules, family commitments and fast paced lifestyles are part of everyday existence in the United States that influence eating choices and contribute to the prevalence of being overweight (Grundy 1998; Koplan and Dietz 1999; Williamson 1999). The 1999 National Health and Nutrition Examination Survey (NHANES) indicates approximately 61% of U.S. adults are either overweight or obese (National Center for Health Statistics 2000). The prevalence of being overweight in the United States increased 5.9% from 1991 to 1998 in both sexes, across age groups, educational levels, and in all states (Mokdad et al. 1999).

Being overweight is not only a health detriment, but in many cases contributes to the loss of life. Health care professionals have established a link between being overweight and increased risk factors for coronary heart disease; Type II diabetes; breast, endometrial and colon cancer; and certain musculo-skeletal disorders (Wolf and Colditz 1998). Based on hazard ratios from all subjects the estimated number of annual deaths attributable to obesity among U.S. adults is approximately 280,000, according to the National Center for Health Statistics (Allison et al. 1999). Hazard ratios from only nonsmokers and never-smokers have a higher number of annual deaths attributable to obesity at 325,000 (Allison et al. 1999). Using data from the 1988 and 1994 National Health Interview Survey (NHIS), researchers estimate the direct and indirect costs to society for obesity at $99.2 billion in 1995; of this amount the direct medical costs were approximately $51.6 billion (Kuczmarski et al. 1994; Wolf and Colditz 1998). These estimates do not include the $33 billion spent per year on weight reduction products and services (MSNBC 2001; Shape Up America 1998). As the prevalence of being overweight in the United States continues to rise; billions of dollars spent dieting fails to result in sustained weight loss. Meanwhile, the number of weight related deaths increase and convey the risk to health and well being.

The problem is clear. However, I would argue that the standard recommendation to "eat less and exercise more" fails to consider changes in the living environment and lifestyle conditions of the post industrial era. Eating and exercise choices are embedded in a cultural matrix that complicates them. If the overall picture is not addressed in the solution, the rising prevalence of being overweight is likely to continue.

Study Purpose

The complex issues that surround excess weight control and management bring a serious societal problem into focus (Allison et al. 1999; Grundy 1998; Koplan and Dietz 1999; Mokdad et al 1999; Nestle and Jacobson 2000; Serdula et al 1999; Stunkard 1979). Therefore, the purpose of this study is to explore a variety of social conditions and human behaviors that pertain to the increasing prevalence of being overweight. Social conditions include the realities of life that have emerged in modern U.S. society, the pressures of living fast-paced lives, and the meanings attached to some of the common, everyday behaviors of individuals. I examine previous literature concerning prevalence and trends, costs of excess weight, causation theories, and the proposed solutions that surround the issues of being overweight. In addition, data gathered from in-depth interviews provide insights into the process of individuals making sense of their perception of reality through life choices related to weight.

In an effort to limit the scope of this study, overweight children and adolescents were not included, despite their being a relevant issue. The number of overweight young people is increasing along with the adult population. Complied data found 11% of children and adolescents age 6 to 17 were overweight during 1988 to 1994 (Troiano and Flegal 1998). Those who were close to being overweight according to relative weight and height accounted for another 14% of youngsters (Troiano and Flegal 1998). This dimension requires a specific focus that is outside the parameters of this study.

In addition, eating disorders that fall under psychological and physiological mental disorders are not included in this study. Medically recognized eating disorders, anorexia nervosa, bulimia nervosa, and binge-eating disorder affect an estimated five million

people in the United States per year (Averett and Korenman 1996; Fontenot and Raso 1999). Approximately 50 percent of anorexia patients are female and develop the disease in adolescence or young adulthood (Fontenot and Raso 1999). Estimates of the prevalence of bulimia nervosa among college and high school females reach up to 20 percent (Averett and Korenman 1996). Eating disorders are a serious problem that revolves around weight issues and lifestyle choices primarily for adolescents. These disorders fall into categories other than the ones addressed in this study.

In light of the breadth of weight related problems, an attempt to discuss all weight issues would not be feasible. Therefore, the problem of an increasing prevalence in being overweight, impacted by the life choices individuals make regarding their weight on a daily basis, is the focus of this study. The following definitions and recurring terminology will facilitate the understanding of weight related issues and the organization of this study.

Overweight, Obesity, and Body Mass Index

Words, phrases, and categories relevant to this study occur throughout the literature review, in the methods section, and in the theoretical framework of this study. The two popular terms to describe an excess of weight are *overweight* and *obesity*. Being overweight ranges from a few pounds to hundreds of pounds in excess of recommended weight values on medical charts and insurance tables (Flegal et al. 1998). Obesity, on the other hand, is a condition of excess weight of one hundred pounds or more above the recommended weight (U.S. Department of Health and Human Services 1990). The endorsed method to differentiate between overweight and obesity is to use *body mass index* (BMI) tables (Bray and Gray 1988; Flegal et al. 1998; Wolf and Colditz 1998).

BMI, calculated as weight in kilograms divided by height in meters squared, is widely used to define overweight categories. The National Institutes of Health (NIH) and the NHANES both endorse the use of BMI for weight references (National Institutes of Health 1985). BMI tables correspond in most areas to the Metropolitan Life Tables previously used by the NIH Consensus Panel that are still in use today by many physicians (Flegal et al. 1998). (See Appendix A for conversions of height and weight into BMI.)

The lack of a specific meaning and the interchangeable use of terms to categorize and define the levels of excess weight result in research analysis and comparison difficulties (Flegal et al. 1998). For clarification purposes this research will use the terms "overweight" and "obesity" as defined by government health statistics and consumer BMI weight control (Bray and Gray 1988). The standard definition for being in the *normal* weight range is a BMI from 18.5 to 24.9, for *overweight* a BMI of 25.0 to 29.9, for *obese* a BMI from 30.0 to 39.9, and for *extremely obese* a BMI of 40 or greater (National Center for Health Statistics 1987). These weight range categories appear throughout the data analysis section, in the discussion of findings, and in the conclusion. (See Appendix B for standard definitions and risk associated with BMI and waist size.)

Motivations and Motives

In addition, the terms *motivations* and *motives* are referenced in the review of previous theories and in the explanation of this study's theoretical framework. One approach is to view motivations as the organic drives that influence a conditioned response, stimulus, or a generalized need to aspects of the environment that operate at a preconscious level. Hewitt (1997) says that "motivation refers to the forces, drives, urges, and other states of

an organism that impel, move, push, or otherwise direct its behavior" (p. 97). On the other hand, "motives are imputed or avowed as answers to questions interrupting acts or programs...motives are names for consequential situations, and surrogates for actions leading to them" (Mills 1940:905). However, to explain behavior only in terms of preconscious drives, leaves out the actions of people based on their meanings (Hewitt 1997), hence motives are also included in the analysis of this study.

Motives are the spoken reasons and explanations that help control conduct as persons interact with one another. Motives exist because people reason and explain their behavior as an aspect of their conception of themselves (Hewitt 1997). Therefore, verbal explanations of motives (defined as motive talk in examples of aligning actions) become part of individuals' perception and behavior coordination efforts.

Path of Least Resistance

The path of least resistance is a path or pattern that is the easiest to follow with minimal amounts of friction in regard to choices, behavior and lifestyle adaptations (Fritz 1984; Johnson 1997). The direction human beings take is often where energy flows most easily; this applies to self treatment, relating to others, attitudes about life as well as eating habits (Fritz 1984).

I use the *path of least resistance* as a concept to analyze choices and perceptions of weight issues. In this sense the path of least resistance helps to explain decisions based upon the influences of life choices that are "composed of desires, beliefs, assumptions, aspirations, and objective reality itself" (Fritz 1984: 8). Answers to choices arise from each individual's personal needs and cultural values. A path of least resistance will vary depending on people's particular situations, including the influences on them and how

they participate in their immediate culture (Johnson 1997). Decisions made about weight issues as well as food and exercise choices are not always conducive to healthy behavior. Making choices and accepting responsibility for resulting unhealthy patterns of behavior depends largely on personal influences and cultural values. To change behavior, "we have to see how those patterns are connected to paths of least resistance and how people choose whether to follow them" (Johnson 1997: 91).

Aligning Actions

Another process individuals use to coordinate their conduct, the conduct of others, and the norms and values of culture is *aligning actions*. This study defines aligning actions as "the ways human beings attempt to maintain alignment or consistency among their individual and social acts, important cultural objects, and their own conception of themselves" (Hewitt 1997:140). The technique of aligning actions is often used when talking about problematic behavior, searching for social support of behavior, or defending conduct that may appear undesirable in a cultural sense (Herman and Reynolds 1995; Hewitt 1997; Scott and Lyman 1968; Stokes and Hewitt 1976). Aligning actions collectively include various methods, tactics, and procedures. Examples of aligning actions are quasi theories, motive talk, disclaimers, and accounts (Hewitt and Hall 1973; Hewitt and Stokes 1975; Mills 1940; Scott and Lyman 1968).

Accounts

This study concentrates on *accounts,* a type of aligning action, defined as "a linguistic device employed whenever an action is subjected to valuative inquiry" (Scott and Lyman 1968:46). Accounts consist of "a statement made by a social actor to explain unanticipated or untoward behavior" (Scott and Lyman 1968: 46). When an inappropriate

or adverse act occurs, individuals are often requested directly or indirectly to explain or give reasons for why such behavior took place, to give an account (Herman and Reynolds 1995; Hewitt 1997; Scott and Lyman 1968).

Two types of accounts identified by Scott and Lyman (1968) of interest here are *justifications* and *excuses*. Justifications are socially approved accounts in which the person asserts the positive value of the behavior in the face of contradictory claims made by other individuals or society (Scott and Lyman 1968). When using a justification, the person accepts responsibility for the act, but neutralizes the situation by denying that it should be seen as wrong or inappropriate (Hewitt 1997; Scott and Lyman 1968). When actions are called into question, a justification asserts positive value to the act and makes a claim that those actions are permissible or required given the occasion or situation (Scott and Lyman 1968). The justification vocabularies or techniques of neutralization include *denial of injury, denial of victim, condemn the condemners, and appeal to loyalties* (Scott and Lyman 1968; Sykes and Matza 1957). Two additional types of justifications, which explain the present state of the individual or the grounds for the activity, are the use of *sad tales* and *self-fulfillment* (Scott and Lyman 1968; Sykes and Matza 1957).

On the other hand, when a person uses excuses, the individual acknowledges that an act is improper or wrong, but argues that blame belongs to someone or something else and therefore the individual should be relieved of responsibility (Hewitt 1997; Scott and Lyman 1968). Excuses are socially approved vocabularies that mitigate or relieve responsibility by *appeal to accidents, appeal to defeasibility, appeal to biological drives,* and *scapegoating* as the source for the conduct in question (Scott and Lyman 1968).

Goffman (1971) elaborated on accounts and added a third type, *apology*. A central element in apology is the feature of "a gesture through which an individual splits himself into two parts, the part that is guilty of an offense and the part that dissociates itself from the delict and affirms a belief in the offended rule" (Goffman 1971:113). Apologies apply to overweight individuals in their efforts to account for excessive eating. The guilt part is shown when individuals use self-abusive and self-critical statements about themselves and their eating behaviors. The performance of a form of penance (vigorous exercise or extreme dieting) is a way to affirm beliefs in rules against overeating episodes (English 1991).

The continued rise in the prevalence of being overweight is a problem highlighted with health and economic costs that touch everyone in the United States. The standard solution to decrease calories and increase exercise does not include an implementation procedure or account for influences from daily life upon choices related to weight issues. Therefore, the solution is inadequate. This became apparent as the participants shared their perceptions of how they make sense of their life choices, sense-making that often includes the Sociological concepts described above. Because this study uses the approach of incorporating direct information dealing with the influences that complicate weight related decisions and adaptations concerning health, food, exercise, and behavior, the goal is to make a significant contribution to the literature.

CHAPTER II

REVIEW OF LITERATURE

The previous literature, consisting of research studies, journal articles, and books takes several different approaches to issues dealing with overweight individuals. These include prevalence and trends, costs of excess weight, previous theories, causation factors, and a variety of solutions to the problems of excess weight.

Prevalence and Trends

The prevalence of being overweight among U.S. adults between the ages of 25 through 74 years changed very little between 1971 to 1974. The prevalence was around 26 percent for men and 29 percent for women during that time. Those percentages began to change rapidly in the 1980's. By 1988 to 1994 for the same age group, 36 percent of men and 39 percent of women were overweight. This is an increase of 38 percent for men and 33 percent for women during that time (Pi-Sunyer 1993). The NHANES show an increase of 14.5% in the number of obese individuals when comparing the years 1976 through 1980 to the years 1988 through 1994 (Flegal et al. 1998). The prevalence increased from 12.0% in 1991 to 17.9% in 1998 and occurred in both sexes, across age groups, races, educational levels, and in all states (Mokdad et al. 1999). (Prevalence trends for 1991 to 1998 appear in Appendix C and changes in those trends for 1991 to 1998 appear in Appendix D.)

The upward trend in the prevalence of being overweight and obese has prompted national health objectives for 2010 to reduce the prevalence among adults to less than 15%. However, the latest data estimates for adults (ages 20 to 74) in the U.S. show an increase in the prevalence of being overweight (BMI 25.0 to 29.9) from 32% to 34% and an increase in obesity (BMI $\geq$30) from 15% to 27% when comparing NHANES II data to NHANES 1999 data (National Center for Health Statistics 2000). These 1999 figures represent an age-adjusted prevalence of being overweight (BMI 25.0 to 29.9) estimated at 61% of U.S. adults, which is 5% higher than the NHANES III (1988 to 1994) measurements (National Center for Health Statistics 2000).

The following groups show the most dramatic increase: 18 to 29-year-olds (7.1% to 12.1%), those with some college education (10.6% to 17.8%), and those of Hispanic ethnicity (11.6% to 20. 8%) (Mokdad et al. 1999). There is, however, a general pattern of increasing prevalence of being overweight, and the severity of obesity that is consistent across racial and ethnic groups (Must et al. 1999). The rapid rate of increase and the chronic conditions associated with being overweight and obese have resulted in trend comparisons to that of a communicable disease epidemic (Mokdad et al. 1999).

The reported prevalence of being overweight and obese is likely to be a conservative estimate. Underestimated true rates often occur because overweight participants tend to underestimate their weight and overestimate their height in studies that rely on self-reported data (Palta et al. 1982; Rowland 1990). Another factor is that many surveys rely on telephone methods and individuals without telephones are not included in the surveys. The individuals not included are more likely to be of lower socioeconomic status, which is associated with a high rate of obesity (Aday 1989; Bray 1992). Therefore, despite sex,

age, race, education, or location, the prevalence of being overweight continues to increase and become more widespread. Clearly, the weight control methods recommended along with the national health objectives are not adequately addressing the trend in the increasing prevalence of overweight individuals. It appears that "without concerted initiatives to prevent and treat overweight in adults, the health care system will increasingly be overwhelmed with individuals who require treatment for obesity-related health conditions" (Must et al. 1999:1529). The costs of excess weight are measured to the health care system in dollars and to the individual in terms of death and associated health risks.

Costs of Excess Weight

In 1995 the economic impact of obesity (BMI $\geq$ 29 kg/m^2) in the United States was approximately $99.2 billion (Wolf and Colditz 1998). The health risks and economic costs in the 1998 study by Wolf and Colditz defined obesity at a BMI $\geq$ 29 kg/m^2, which they discussed as an underestimate of the costs. Because many increased health risks are seen at a BMI $\geq$ 25 kg/m^2, the economic costs would have been much higher (Wolf and Colditz 1998).

Direct costs. The direct medical costs associated with obesity were approximately $51.6 billion in 1995; this represented 5.7% of the U.S. Health Expenditure for that year (Wolf and Colditz 1998). The direct medical costs associated with obesity are derived from these approximations: 63% from type 2 diabetes, 14% from coronary heart disease, 8% from osteo-arthritis, 6% from hypertension, 5% from gallbladder disease, and 4% from all cancers (Wolf and Colditz 1998). The number of excess physician office visits attributable to excess weight increased 88% from 1988 to 1994 (Wolf and Colditz 1998).

The apparent cause for the rise in visiting the doctor is attributed to an increase in the number of obese persons, in addition to the number of office visits (Wolf and Colditz 1998).

For example, the estimated 25-year cost of obesity (BMI $\geq$ 25 kg/m^2) for a woman in the 40 to 64 year age range was $16.1 billion or $4,132 per individual (Gorsky et al. 1996). These figures reflect the medical costs attributed with a continued overweight condition for an extended number of years. Interestingly, the increase in body weight at almost every age strata has a more negative impact on the activity level of women than of men (Wolf and Colditz 1998).

Indirect costs. The indirect costs of obesity, which exclude coronary heart disease (CHD) and hypertension but include lost output and productivity, was $47.56 billion in 1995 (Wolf and Colditz 1998). From 1988 to 1994 the number of restricted activity days increased by 36% and the number of bed-days increased by 28% for those with a BMI $\geq$ 27 kg/m^2 (Wolf and Colditz 1998). Lost productivity and days lost from work impacts both employers and employees. Compared to 1988 data the number of work-lost days increased by 50% in 1994 (Wolf and Colditz). Obese women contribute 70% of work-lost days, but because of their higher wages, men contribute 36% of the cost of lost productivity (Wolf and Colditz 1998).

Wolf and Colditz (1998) also discussed the possibility of either underestimating the cost of obesity or double counting medical costs. The models they examined assumed that CHD, hypertension, and diabetes occurred independently, although there is some interdependence among these disease states and especially in obese patients (Wolf and Colditz 1998). The authors reasoned any inflation of cost error was offset by other

additional conditions that are related to being overweight, but were not included in their analysis (Wolf and Colditz 1998).

Attributable deaths. The estimated number of deaths attributable to obesity varies with the cohort used to calculate the hazard ratio of the group. The individuals used for study by Allison (1991) and colleagues were adults (18 years or older) living in the United States during 1991. The data source was U.S. cross-section studies in which ill, high-risk, or elderly subjects did not predominate. The six studies chosen were the Alameda County Health Study, the Tecumseh Community Health Study, the Framingham Heart Study, the American Cancer Society's Cancer Prevention Study I, the Nurses' Health Study, and the NHANES I Epidemiologic Follow-up Study (Allison et al. 1999). (Appendix E shows the estimated number of attributable deaths for 1991.)

When using hazard ratios from all subjects, the estimated number of annual deaths among U.S. adults is 280,000, however, when comparing the hazard ratios from smokers or never-smokers the deaths increase to 325,000 (Allison et al. 1999). Individuals with a BMI of more than 30 kg/m^2 account for more than 80% of the obesity attributable deaths (Allison et al. 1999). Because of the relative consistency in estimates from the six studies, the health impact of obesity far exceeded what these researchers presented. The authors concluded that "aside from mortality rate, however, obesity substantially increases morbidity and impairs quality of life" (Allison et al. 1999:1537). The increase in prevalence of overweight individuals, plus rising economic costs accompanied by health risks and death, highlight the seriousness of the problems of excess weight. In addition to the economic and health costs associated with being overweight, the theories about why individuals overeat are also a topic for research. The next section examines various

theorists' views about overeating and the condition of being an overweight individual in society.

Previous Theories

Cultural model. To understand how theorists have reconciled and explained the medical and social problems of being overweight, a review of past theories and research framing is helpful. A model for the cultural predisposition to obesity in the United States clarifies the social distribution of being over weight. The conditions of social distribution concern gender, ethnicity, social class, and economic modernization (Brown 1991). The culture theory of explaining the etiology of obesity involves the interaction of genetic traits with culturally patterned behaviors and beliefs (Brown 1991). The concept of culture for individuals may influence how they view their environment and relate to beliefs within their environment. "The frequency of past food shortages, the social distribution of obesity, and the cultural meaning of fatness, when taken together, suggest a biocultural hypothesis of the evolution of obesity" (Brown 1991:51). The role of culture as it interacts with genes and impacts behaviors and beliefs about obesity may combine to contribute to the number of individuals that have a body weight above the ideal (Brown 1991). Behaviors and cultural beliefs also have a role in defining the path of least resistance, which contributes to the process of making life choices regarding food and exercise choices, as discussed during the participant interviews in this study.

Rural-urban differences. Rural-urban differences are commonly used to explain or identify social behaviors. In addition, they underscore patterns of health conditions in the field of sociology. Sobal, Troiano, and Fongillo (1996) conducted a rural-urban obesity study from 1976 to 1980 that analyzing data from the NHANES II. Their findings

revealed that white people in rural areas tended to have a higher prevalence of relative weight, overweight, and extreme weight compared to people in more urbanized areas (Sobal et al. 1996). However, when controlling for age, education, parity, and marital status, the demographic variables explained many of the weight variations compared to area of residence (Sobal et al. 1996). Physical variables such as diet, activity, and smoking did not provide any additional explanation that had not already been explained by demographic factors. Demographic composition provided the primary explanation of rural-urban weight patterns. The social class structure, a lower socioeconomic status, and a lower educational level found in rural areas appears to be a major influence on the likelihood of being overweight (Sobal et al. 1996). Demographic composition of the rural-urban populations explained most, but not all, of the variations in weight, although rural white women and men were more likely to be overweight than their urban counterparts (Sobal et al. 1996). Therefore, variables other than the area of residence, particularly socioeconomic status and age, appear to be important determinants of weight. The authors suggested that further information concerning the differing aspects related to excess weight, is needed to examine how norms, values, and social control vary by rural and urban areas (Sobal et al. 1996).

Internal locus of control. People with an internal locus of control believe that they alone determine what happens to them, while those with an external locus of control believe that fate, chance or other factors determine what happens in their lives. Research has found an internal locus of control correlates positively with success at diets and the confidence to reach a goal weight (Stotland and Zuroff 1990). The relationship between self-esteem and having an internal weight locus of control was found positive only for

women of average weight; for overweight women there was a negative correlation (Tiggemann and Rothblum 1997). The belief that weight is under control of the individual and being overweight is associated with low self-esteem. Concern with weight is less of a priority for men, as there was no interaction between weight, locus of control, and self-esteem (Tiggemann and Rothblum 1997). According to Tiggemann and Rothblum (1996), professionals and educators should emphasize, particularly to women, the lack of control that individuals have over body weight given the fact that weight loss is rarely permanent.

Other gender differences are also present for those individuals who attribute failure patterns to excess body weight. Men with little perceived control over their health had a higher average weight, while women who perceived little control over their health had a lower average weight (Scott 1997). Men tend to explain excess body weight as beyond their ability to influence and yet claim credit for success in physical trimness (Scott 1997). In contrast, I found few gender differences in regard to ability to lose weight, concern with health risks, and the number of outside influences among the males and females that I interviewed.

Restraint theory. Other attempts to explain why dieters overeat focus on principles of the restraint theory. Self-control and the stress developed during high levels of restraint are an important determinant of eating patterns (Herman and Mack 1975). The theory proposes that restrained eaters will actually eat more during a binge if they violate their diet (Herman and Mack 1975; Herman and Polivy 1975). Additional research suggests that the restraint scale and the restraint theory are both in need of refinement (Ruderman and Christensen 1983). Unexpected findings include "unrestrained eaters ate more than

restrained eater, whereas among normal-weight individuals, the reverse was true" (Ruderman and Christensen 1983: 214). As a group, overweight-unrestrained eaters were extremely unconcerned about their weight and eating habits, which led to indications that "restrained eaters are not similar to overweight individuals and do not demonstrate an obese eating style" (Ruderman and Christensen 1983:214). Individuals restrained by a restrictive diet and obese individuals struggling with weight issues have different styles and patterns of eating. Therefore, the stress, which develops from constant self-control, does not lead to over-consumption of food for individuals who are obese (Ruderman and Christensen 1983).

Psychological components. Further attempts to explain eating styles and the relationship to becoming overweight centers on psychological components. Evidence from previous research in the 1950s held that excess weight was a result of personality problems and the acting-out behaviors used to resolve conflicts (Brownell and Wadden 1992; Stunkard 1988). During the 1960s, behavior therapists treated obesity as a learned disorder with conditioning principles explaining patterns of overeating (Brownell and Wadden 1992). Despite the psychological correlates between excess weight, anxiety and depression reported by overweight individuals, reviews conclude that obesity is not associated with risks for psychological problems (O'Neil and Jarrell 1992; Wadden and Stunkard 1985). However, there are limitations to the research approach, scope and fieldwork; leading to the conclusion that details and conclusions warrant re-evaluation (Friedman and Brownell 1995).

A generation approach is used by Friedman and Brownell (1995) to investigate psychological consequences (depression and anxiety) as being aspects of risk for obese

individuals who face cultural bias and negative attitudes toward excess weight. Meta-analysis done by Friedman and Brownell (1995) suggests a high prevalence of risk factors present in obese patients undergoing psychological treatment. First generation studies identified gender and age as demographic risk factors (Friedman and Brownell 1995). While the prevalence of obesity is approximately the same in men and women, nearly all patients in treatment are female (Friedman and Brownell 1995).

Age is a risk factor in self-concept studies because of the increased pressure for a thin body image in obese adolescents and college-aged women compared to normal weight peers (Friedman and Brownell 1995; Striegel-Moore, Silberstein, and Rodin 1986). Second generation studies also identify dieting, binge eating, and weight cycling (repeated cycles of weight loss and gain) as risk factors which represent a behavioral syndrome for increased psychopathology (Brownell and Rodin 1994; Friedman and Brownell 1995; Polivy and Herman 1985; Yanovski 1993).

Previous conclusions that obesity is not related to psychopathology becomes complicated and inconsistent because of synergistic effects and numerous domains that are in need of further relational studies (Friedman and Brownell 1995). Psychological distress and the link to weight issues is an important area for further study in order to understand the complexities of obesity and the lives of overweight individuals (Friedman and Brownell 1995).

Externality theory. External cues such as taste, sight, smell, and availability of food are the basis for various experiments that propose obese persons are more responsive than normal weight individuals to these cues (Nisbett 1968; Reishsman, 1972; Schachter and Goss 1968). Previous research conducted in laboratories concluded the externality theory

of obesity was a proven view of eating as a physical response to physical or sensory external cues (Schachter 1967; Reishsman 1972). Although these studies showed a response to external, sensory cues, they were not conducted in a natural setting that provides stimulation from external, non-sensory cues (Maykovich 1975).

The effect of social forces and the differences in individual eating behaviors is explored by combining externality theory with social interaction theory (Maykovich 1978). The social identity of obesity, which is felt as rejection and stigma by overweight individuals, is established through interactions with normal weight persons (Maykovich 1978). To lessen the stigma and keep interactions on a predictable level, individuals will follow ordinary patterns of eating when in contact with those perceived as 'normal' (Goffman 1961, 1963).

The Maykovich (1978) study sought to show that an extremely overweight individual would tend to eat less when dining with someone of normal weight. However, her research found that being overweight is a social identity that affects all behaviors, which includes eating (Maykovich 1978). Because eating is a social behavior influenced by a variety of social variables, sensory cues seemed to be curbed by socially inhibiting forces, such as the presence of normal weight individuals (Maykovich 1978). Therefore, the issue of overeating becomes joined with social acceptance and the alliance with normal weight individuals to relieve social stigma and the limitations of social opportunities. The solitary, obese individual felt guilt about overeating, while in-or out-group alignment seemed to alleviate the psychological burden of stigma (Sagarin 1969; Taub and Taub 1974; Maykovich 1978). The validity of externality theory remains in the laboratory setting, because this theory to explain eating behaviors is influenced by social

identity and social influences, which are difficult to replicate in a sterile environment (Maykovich 1978). The conclusions of the Maykovich (1978) study also lend support to the argument that the standard "eat less, exercise more" recommendation is inadequate.

Stigmatization. The sociological dimensions of overweight conditions use behavior strategies that label obesity as a type of deviance and stigma (Crocker, Cornwell, and Major 1993; English 1991; Laslett and Warren 1975; Maykovich 1978). There has been a long history of stigma preference types in the United States. Obesity has been shown as more stigmatized than a criminal record (Homant and Kennedy 1982), crutches, a wheelchair, a missing hand or a facial disfigurement (Maddox, Back, and Liederman 1968; Matthews and Westie 1966; Richardson et al. 1961).

The social stigma that accompanies an excess amount of weight is not an attribute, but a common social identity established through relations and interactions between the obese and those of normal weight (Maykovich 1978). Stigmatization is present in beliefs and associated descriptors of overweight individuals as lazy, dull, unclean, stupid, self-indulgent or having a lack of self-discipline (English 1991; Tiggemann and Rothblum 1988). Complicating these beliefs is information, such as the average family in the United States spends one-third of its income on food, or that eating out is the favorite leisure activity for adult men and women (English 1991). Therefore, when individuals eat as a leisure activity they are following a social norm, not being self-indulgent or having no self-discipline.

Stigma may become, under certain circumstances, a strategy to cope with perceptions of being overweight as a deviant behavior (Laslett and Warren 1975). The stigma concept (Goffman 1963) and Lemert's theory of secondary deviation (Lemert 1967) apply as a

positive strategy for weight loss in some studies (Laslett and Warren 1975). By applying obesity as a negative stigmatizing label, a positive normalization of deviant behavior will take place in the form of changing eating behaviors (Laslett and Warren, 1975).

Laslett and Warren (1975), sought to show that self-help organizations for weight loss do not accept the view that escalation to deviant behavior always follow negative social labels, but instead use a change strategy involving positive features and a normal way of life by acceptance of a stigmatized identity. Through acceptance of a stigmatized identity as an "ex" heavy person, the stigmatization is viewed as positive and an identity the organization promotes as a necessity (Laslett and Warren 1975).

Laslett and Warren (1975) concluded that individuals may change from deviant behaviors to more normal behaviors on some dimension, but may retain a stigmatized identity connected with that same dimension (Laslett and Warren 1975). The theoretical conclusion is that a "normal or deviant identity, way of life and behavior are empirically separable phenomena, erroneously analyzed under the umbrella 'secondary deviation'" (Laslett and Warren 1975: 79). Therefore, self-help organizations view the social stigma of deviancy applied to obesity not as negative, but as positive when applied to "ex" obese individuals as change agents who facilitate weight loss (normalization) in others (Laslett and Warren 1975).

Pervasive social stigma has many affective consequences for overweight individuals (English 1991; Crocker et al. 1993). Unlike individuals with non-visible stigmas, overweight individuals do not face the decision of whether or not to inform others of their condition; it is easily identified in a face-to-face interaction. Self blame resulting from being identified as overweight accounts for a majority (93%) of feelings of being out of

control, responsible, and guilty (Harris, Waschull, and Walters 1990). Ironically, a stigma can be self-protective because it provides an explanation for negative responses and reactions of others as well as reasoning for low self-esteem on the part of those stigmatized (Crocker et al. 1993; Dion 1975).

Overweight individuals usually experience less negative affect if they recognize the extent prejudice and discrimination have in producing negative outcomes (Crocker et al. 1993). Stigmatization of overweight individuals is also subject to their understanding of what and how others view their attempts to manage weight problems (English 1991). Overweight individuals who have internalized the judgements of others view themselves as forced frequently to offer explanations about their excessive weight; these explanations are in the category of accounts (English 1991).

In his study, English (1991) explored three types of accounts (excuses, justifications, and apologies) as explanations offered to counter stigmatization. He found the most common excuse used by overweight individuals is the mode of defeasibility; there was not complete knowledge, voluntariness, or total consciousness during the activity (English 1991). An admitted lack of will power is a character flaw, but excused because it is beyond the control of the overeater. Another way to reduce personal responsibility is to blame attitudes toward food and eating patterns on early childhood socialization (English 1991). In addition to excuses, two types of justifications used by overweight individuals are *sad tales* and *uniqueness of situation* to make overeating appropriate (English 1991). Because justifications explain eating behavior, they lessen the consequences of being stigmatized by excess weight.

The features of *apology* used by overweight individuals are "vilification" of self and "performance of penance" (English 1991:342). Self-abusive or self-critical statements become part of the apology as an element of vilification of self to account for overeating (English 1991). The performance of penance may take the form of extreme dieting, fasting, or purging the body with laxatives or diuretics (English 1991; Russel 1979; White and Boskind-White 1981). This is further demonstrated in research exploring deviant eating patterns in public and explanations about binge eating. Binge eating constitutes primary deviance behavior because it involves internal conflicts, negative feelings, and is usually concealed (Harris et al. 1990; Kissileff, Jordan, and Levitz 1978; Stunkard et al. 1980).

English (1991) saw the stigmatization as a way to understand how "fat people" view and attempt to mange their weight problems. The excuses, justifications, and apologies explored by English became explanations for eating behaviors and weight problems that are obvious because the size of overweight individuals their stigmatization is fully visible. English (1991) concludes that overweight individuals rely on accounts as a reaction against stigmatization and as an explanation for their condition. On the other hand, the individuals I interviewed use accounts to explain how they are able to make sense of influences (effect of others, time constraints, and personal preferences), and the effects of these influences on their weight and their ability to function on a daily basis.

All of the theories reviewed have valid points for consideration when examining excess weight and the associated social difficulties. However, researchers continue to uncover contributing factors that affect the understanding excess weight. Some of the points touched upon in the theories explaining excess weight are found again among the

causes associated with being overweight. These reoccurring factors serve to highlight the interconnected issues and complexities surrounding excess weight. As society changes, so do the factors and the explanations for causes of being overweight.

Causation Factors

In general, being overweight will result when a person eats more calories than they expend through activity (Serdula et al. 1999; Koplan and Dietz 1999). This simple "calories in versus calories out" statement does more than explain the reasoning behind excess weight. When a person becomes overweight, responsibility rests solely on the person who "eats more" and "exercises less." Despite historical conceptual changes to the cause of being overweight, the individual bears the responsibility to control eating and to exercise. However, today the balance between energy intake and output is influenced by many factors. More food is available, the fast-food industry has grown, more socializing with food and drink takes place, along with less opportunity to burn excess energy (Koplan and Dietz 1999). Metabolic and genetic factors, behaviors affecting dietary intake and physical activity, along with environmental, cultural, and socioeconomic components are only some of the influences on an individual's weight (U.S. Department of Health and Human Services 1999).

Genetics. Genetic factors, discussed previously as a predisposition component in the cultural model, are also important as causation factors for weight control and understanding individuals who are excessively overweight. Genetics seem to affect responses to knowing when one feels full, regulation of appetite drive, how much fuel muscles need, or how effectively the body turns extra calories into fat (Grundy 1998; Vogel 1999). Genes and families of genes affect what makes some individuals more

susceptible to weight gain than others (Grundy 1998; Vogel 1999; Yanovski and Yanovski 1999). Chemicals in our brains trigger food cravings, appetite and pleasure responses (Grundy 1989; Yanovski and Yanovski 1999).

The environment can affect the role these tendencies play, with diet and exercise remaining as significant factors (Vogel 1999). Therefore, genetics alone is not the single cause responsible for the rise in the prevalence of being overweight. "For body weight, there is a significant interaction between genes and environment" (Yanovski and Yanovski 1999:1504). The environment in which people function daily has gone through remarkable changes, as well as the scientific understanding of how different genes and body types control weight. Because of interactions between genes and the environment "it is virtually impossible that changes in the genetic background of Americans over the past 2 decades are solely responsible for the trend of increasing body weight" (Yanovski and Yanovski 1999:1504). Therefore, "the bottom line is that genes alone don't make people fat" (Vogel 1999:95). What genetics does account for is the tendency that some people will be susceptible to weight gain and others will be susceptible to an ability to burn energy more efficiently (Vogel 1999). Burning energy is also related to the amount of physical activity engaged in by individuals.

Societal changes. Changes in society and culture partly explain the decline in physical activity and increase in weight gain (Grundy 1998). Most jobs today are sedentary in nature or require machines that do the work for us, reducing the physical aspect of work. On many occasions leisure time is spent watching television or sitting in front of a computer instead of engaging in an outdoor physical activity. Urban decay and high crime rates make evening exercise or outdoor options unavailable or unattractive for

some due to safety concerns (Grundy 1998; Serdula et al. 1999). The stresses of adult life, with social and family responsibilities, are common examples of social and cultural factors that can lead to overeating and weight gain (Grundy 1998).

There are many articles written about why people in the United States are overweight. However, the social and cultural forces that impact the lifestyle of overweight and obese individuals seem to promote ideals that encourage a lack of weight management. This lack of control means "America isn't fighting obesity, it's adjusting to the problem– indeed, institutionalizing it" (Fumento and Soriano 1997:11). The institutionalization of obesity happens every day in the United States; high calorie foods are promoted to the degree that weight gain is more likely.

Food choices. The type of food available is another causation factor that underlies the increase of overweight persons. Processed food is stripped of micronutrients and is concentrated with refined carbohydrates, sugars and fats that in the end are more expensive and less nutritious (Shell 1996). People perceive diets as temporary restrictions, reduced-calorie foods means calorie-free to many, and the cost of eating right is more expensive (Elmer-Dewitt 1995). A burger and fries may be more expensive than cooking meals at home, but calorie for calorie, the burgers are cheaper than a salad bar or dining at a fancier vegetable-serving restaurant (Elmer-Dewitt 1995). Time-wise, when the ease of eating out and stopping at fast food restaurants are compared to chopping vegetables and cooking in your own kitchen, junk food becomes the choice for many (Elmer-Dewitt 1995). By combining the foods available with labor saving inventions, such as automobiles, elevators, cell phones, drive-in windows, remote controls, and computers, the weight-gaining equation comes into focus.

The food is not only available, it is advertised. The food and restaurant industries spend $36 billion a year on advertisements and trade shows to ensure consumers are aware of who offers the latest promotions, the biggest portions and the newest products (Elmer-Dewitt 1995; Gallo 1998). The food industries advertising and incentives budget overpowers the $1 million annual educational 5-A-Day fruit and vegetable campaign and the $1.5 million spent on cholesterol educational programs by the National Heart, Lung, and Blood Institute (Cleeman 1998; Nutrition Week 1992).

Production techniques and technical advances have resulted in a readily available and overabundant supply of food in the United States (Ault 1998; Dortch 1997; Fumento and Soriano 1997; Grundy 1998). "Food, which once served primarily as a cure for hypoglycemia, has become an entertainment medium"(Ehrenreich 1995:78). Working couples eat out more, and restaurants offer larger portions and increasing opportunity for socializing and eating. The low-fat/no fat fad, the growth of portion size, and manufacturers accommodating individuals with expanded products and sizes all contribute to a disregard for moderation or setting behavioral limits (Fumento and Soriano 1997).

The most apparent causes are on the surface, and many times fail to consider the multiple influences interconnected beneath, influences that also contribute to the issues of being overweight. Weight gain is no longer the simple balance problem between food intake and physical exercise it has been viewed as in the past. "Obesity is a complex multifactorial chronic disease . . . our understanding of how and why obesity develops is incomplete, but involves the integration of social, behavioral, cultural, metabolic and genetic factors" (National Institutes of Health 1998: xi). A medicalization of excess

weight has taken place in recent years, which adds to the perplexing aspects. Although the medical risks of obesity are apparent, the result from classifying obesity as a disease lead to a single "cure" focus and complicate the integration of social and cultural factors. The cause for being overweight is not a single entity, but due to an interaction of many factors (Grundy 1998; Kuczmarski et al. 1994; Nestle and Jacobson 2000; Yanovski and Yanovski 1999). Equally important is the recognition that, because being overweight stems from a variety of causes, the responsibility for excess weight is also complex and does not belong to an individual alone. "Understanding the underlying reasons for the increased prevalence of overweight in the United States and elucidating the potential consequences for health outcomes challenge our understanding of the etiology, treatment, and prevention of overweight" (Kuczmarski et al. 1994: 211). The influences of culture, society, and our personal psychological make-up all contribute to what motivates individuals to choose some foods, diets, and lifestyles over other available choices (Grundy 1998; U.S. Department of Health and Human Services 1999; Vogel 1999; Yanovski and Yanovski 1999). A necessary inclusion in the list of motivation influences is the effect of others, as brought out during the interview of participants in this study.

Proposed Solutions

When it comes to the issues of food choices, exercise regimes, the associated health risks, and the continued increase in prevalence, there does not appear to be any clear solution to excess weight. This does not mean that one can not find an over abundance of "cures" for becoming and being overweight. For example, past solutions for overweight individuals, similar to the causation factors, have concentrated on personal responsibility for excess weight by proposing changes in diet and physical exercise.

Diet and exercise. Beginning as early as 1952, the American Heart Association published diet and exercise modification guidelines that would aid in the reduction of health risks from obesity (Harvard School of Public Health 1952). From 1970 to the present, a number of federal agencies and private organizations have also issued guidelines that focus on reducing food intake and increasing calorie expenditure to maintain a healthy weight (Fullarton 1979; Nestle and Jacobson 2000).

The United States Department of Agriculture's dietary guidelines from 1980 to 1995 encourage Americans to eat a variety of foods, avoid too much fat, avoid too much sugar and sodium, and maintain a healthy weight through a balance food intake with physical activity (U.S. Department of Agriculture 2000). In 2000, the USDA guidelines were changed to aim for a healthy weight, be physically active, use the food pyramid as a guide, choose low fat, moderate sugar, and less salt (U.S. Department of Agriculture 2000). Although the wording changed slightly, the basic message from the USDA has remained the same for over 20 years; individuals should implement better eating and better exercise habits.

The U.S. Public Health Service (PHS) developed specific health objectives to reduce health risks with obesity prevention methods implemented in successive 10-year plans, which stress nutritional education and fitness programs (U.S. Department of Health and Human Services 1980; 1983; 1990). However, the prevalence of being overweight continues to rise, the number of people who diet and exercise to lose weight continues to decline, and fewer primary-care physicians counsel patients for overweight and obesity risks and behaviors (Allison, Zannolli, and Narayan 1999). When it comes to physical activity, more than 60% of adults in the United States do not get enough exercise and

more than 25% of adults are not active at all (Ault 1998). As a result of increasing health risks and overweight prevalence, Healthy People 2010, the third PHS 10-year plan, continues to focus on the benefits of exercise, but has added new objectives in the nutrition guidelines (U S. Department of Health and Human Services 2000). Although the new objectives tout increasing healthy weights (BMI 19 through 25), increasing nutritional education, and increasing weight reduction services, there is little information on how to implement these objectives, other than through public effort and sensible choices (U. S. Department of Health and Human Services 2000). Although the diet and exercise solution has not reduced the prevalence of overweight individuals, acceptance of the plan is widespread. Research studies continue to recommend similar preventative measures for development of weight management and weight reduction programs through an increasing focus on balancing energy intake with physical activity (Grundy 1998; Mokdad et al. 1999; Serdula et al. 1999; Wolf and Colditz 1998). I argue that the solution must be multifaceted in order to meet the challenge of such a complex problem.

Despite decades of government guidelines and dietary advice from heart disease and diabetes research centers, people in the United States continue to become overweight at increasingly higher rates (Flegal et al. 1998; Mokdad et al. 1999; Serdula et al. 1999). This is due in part to the generalized nature of the guidelines, which makes them difficult to implement. (A sample examination and treatment plan appears in Appendix F.) The guidelines also have little effect because people have heard the same thing over and over so many times that they no longer impact behavior at the time food and exercise choices are made (Nestle and Jacobson 2000; Weil 2000). The traditional eat less and exercise more solution to being overweight with the single focus of changing the behavior of

individuals, is inadequate and does not include other aspects that influence excess weight (Nestle and Jacobson 2000). The participants I interviewed spoke of the influence of other people, time constraints, and personal preferences as additional aspects to weight related issues.

Environmental. It is not just the amount of food eaten coupled with a lack of exercise that accounts for the number of overweight persons in the United States. The combination of busy lifestyles, large urban areas, and an abundance of fast food restaurants all conveniently located enhance environmental changes and cultural norms. The compounding effects of variables found in U.S. society contribute to the increase in obesity and are vital to an environmental solution (Koplan and Dietz 1999; Nestle and Jacobson 2000; Stunkard 1979 and 1980).

The way in which individuals respond to problems that surround good health is usually in agreement with their culture, norms and values (Cockerham 1998). This holds true for the difficulties that overweight individuals encounter when making choices about food and exercise in their own environment. Some of the advice overweight individuals hear is to consume less food, control portion size, or eat small meals. However, the norm in U.S. society is away from earlier diets high in grains and vegetables and toward increased portions, triple cheeseburgers, super-sized fries, 72-ounce soft drinks and all-you-can-eat buffets (Dortch 1997; Elmer-Dewitt 1995; Fumento and Soriano 1997). One reason behind the altered food consumption norm is that people regard huge portions as a good value (Dortch 1997). The result has been an eating culture, where eating is a sign of personal, societal, and family well being (Dortch 1997). The conflict between dietary

advice to consume fewer calories and the cultural norm of large portions is one of the many environmental barriers to a solution for weight control.

The post industrial era in the United States gave way to employment with little exercise opportunities, busy, fast-paced lives, and entertainment technology that only requires the push of a remote control or click of a computer mouse (Ehrenreich 1995; Grundy 1998). Along with labor saving devices came an environmental shift in housing construction and organization. Many neighborhoods discourage physical exercise because they are constructed without sidewalks, have no accessible outside areas, lack walking distance destinations, or are too dangerous to permit outside activity (Nestle and Jacobson 2000). The postindustrial era also saw changes to food sources, which must be considered as components to an environmental solution.

People in the United States spend approximately half of their food budget and consume about one-third of their daily calories outside the home often in sources such as the 170,000 fast-food restaurants or three million soft drink vending machines (U.S. Bureau of the Census 1997; Lin, Frazao, and Guthrie 1999; Vending Times 1998). Changes to the food environment that are considerations for a weight solution include the type of food available. For example, prepackaged, processed, convenient, and usually high fat, is the type of food found in grocery stores and restaurants that comprise the eating norm for most people living in the United States (Elmer-Dewitt 1995; Shell 1996). When one is tired, in a hurry and hungry the appeal of convenience foods is high. The type of food available, the relative ease to obtain it, and the value it represents make the choice of what to eat a simple decision.

Another difficulty is that the studies that do suggest environmental changes as solution variables rarely discuss implementation procedures (English 1991; Flegal et al. 1998; Harris et al. 1990; Kuczmarski et al. 1994; Grundy 1998; Serdula et al. 1999). Perhaps the most comprehensive exception is a NIH (1977) report that reviewed social and environmental influences on the solution to obesity (Stunkard 1979). The report included health education, benefits for health coverage, and actions to advance dietary improvements on a federal, community and private sector level. The recommendations were expensive, did not prioritize implementation, and did not specify the source of funding; therefore, the report was ignored along with the valuable information necessary to formulate a solution (Stunkard 1980; Nestle and Jacobson 2000).

The goals set forth by Healthy People 2010 indirectly address environmental concerns in their objective to achieve a 60 percent proportion of adults who are at a healthy weight (Department of Health and Human Services 2000). Examples of their suggestions include dispensing nutritional education that includes public education about how to achieve and maintain a healthy weight. Educational material would include policy and program planners that are able to aid in fostering healthful diets and physical activity patterns by providing leadership at the national, state and community levels. One form of leadership would involve supermarkets, restaurants and carry-out operations improving accessibility to nutrition information and education that will help consumers make better choices (Department of Health and Human Services 2000). However, the same barriers apply to the solutions of Healthy People 2010 that apply to the goals of the NIH in 1979. There is no funding plan, no guidance about implementation, and little chance of achieving the 2010 objectives without relying on improving nutrition and increasing physical fitness

(Nestle and Jacobson 2000). The solution to being overweight by increasing education on health issues and becoming aware of environmental changes that alter eating habits places the responsibility of reducing the number of persons that are overweight directly on the individual. Nevertheless, awareness of individual responsibility for their lifestyle choices and health problems continues to be a campaign of health care providers and the mass media (Crawford 1984).

The individual. The strategy for effective weight control focuses on individual awareness, self-control and understanding (Grundy 1988). "The public health goal of prevention is to expand each person's inherent ability to learn and exert self-control" (Grundy 1998:568S). The answer is not medical, but is up to the individual to display a range of self-control and change personal behaviors that affects health (Crawford 1984). As mentioned, self-control coupled with teaching good nutrition, exercise routines, and weight loss techniques has resulted in unsuccessful attempts to control weight gain over the past three decades (Elmer-Dewitt 1995). Some experts recently argued that obesity is neither a matter of simple willpower nor merely a risk factor, but a disease that can be prevented with medical treatment (Ault 1998; Koplan and Dietz 1999). As stated above, I argue that an exclusive medical focus will conceal the interaction of multiple factors involved in weight issues and treatment solutions.

With the pressure on individuals to seek remedies to the conditions of being overweight, many turn to diet aids or programs to lose weight, many of which are not medically approved (Serdula et al. 1999; Smith 1995). In the effort to lose weight, prevent weight gain, or maintain weight loss, consumers spend an estimated $33 billion per year (Federal Trade Commission 1999; Shape Up America 1998). Diet centers, group

and individual programs, weight loss books and magazines, over-the-counter and prescription drugs and professionals that specialize in weight loss bring in about $8 billion per year (Smith 1995).

The 1997 Federal Trade Commission concluded that consumers are not receiving the needed information about costs, duration, risks, staff credentials, and outcomes for the amount of weight lost or maintained from weight loss products and programs (Federal Trade Commission 1999). In addition, the commission cited an estimated annual five billion-dollar market for fraudulent weight loss products and services (Federal Trade Commission 1999). The prevailing attitude of physicians and health care professionals only exacerbates this serious problem for the individual.

People who are not suffering from a chronic disease and whose only reason for a visit to the doctor is being overweight are usually not involved in any type of aggressive weight treatment until after the onset of a related disease (Galuska et al. 1999). Despite being in the position to impact the health of many Americans, physicians and health care professionals do not actively participate in combating weight for many patients (Galuska et al. 1999; Wee et al. 1999). The persons most likely to be advised to lose weight by health care professionals are people who are female, middle aged, have higher levels of education, live in the northeast, report poorer perceived health, are extremely obese, and have diabetes mellitus (Galuska et al. 1999). The rate of physician counseling regarding exercise is low nationally, with failure to counsel younger, disease free adults and those from lower socioeconomic groups almost non-existent (Wee et al. 1999). Even when doctors recognize the dangers and deaths attributable to overweight conditions, their procedure is to bring awareness of the risk, but leave eating behavior and exercise habits

to the individual (Galuska et al. 1999; Wee et al. 1999). Currently, there is an estimated 58% of patients who are obese, that do not receive advice to lose weight by a physician or health care provider (Galuska et al. 1999). Although studies are limited, recommendations made to physicians and health care providers stress areas of change. "To increase counseling, perceived barriers such as lack of reimbursement, limited time during office visits, physicians' lack of training in counseling, or physicians' low confidence in their ability to counsel or to change the behaviors of their patients need to be addressed" (Galuska et al. 1999:1578). More individuals will attempt weight loss after receiving medical advice and weight reduction may result from even brief information sessions in a professional setting (Galuska et al. 1999).

Many of the solutions available are recommendations, comments and suggestions for procedures that focus on individual responsibility for reductions in weight and fat consumption, along with increases in physical exercise. "Every diet-and-exercise program is pitched as a one-size-fits-all remedy"(Vogel 1999:99). The practice is to group overweight individuals together and treat them as though they all have the same weight problems and will respond to treatment in the same manner (Vogel 1999). Therefore, these solutions result in temporary weight loss at best. Individuals continue to make unhealthy choices, despite the "evidence that large waist circumference and high body mass index are important indictors of physical difficulties with basic activities of daily living"(Han et al. 1998:1820). For the majority of persons, not only is the weight subsequently regained, but also increased. Many individuals resign themselves to a live of obesity, stopping all attempts to incorporate healthy living alternatives (Dortch 1997; Han et al 1998).

Public interest in health issues increased in the 1980's, however participation faded in the 1990's, despite a high awareness about the importance of lifestyle choices and health (Goldstein 1992). Awareness of unhealthy lifestyle behaviors and doctors' instructions to reduce health risks by losing weight does not mean overweight individuals will make changes. People pay little attention to their doctor's advice, do not take health problems seriously, and refuse to make changes to their lifestyle (Blaxter and Cyster 1984; Cockerham 1998). Individuals usually do not fully participate in efforts at all around health and instead turn to quick fixes and solutions that are costly, with few healthy benefits (Federal Trade Commission 1999). When faced with the responsibility of altering behavior, even when that behavior is life threatening, some individuals do not change a preferred lifestyle (Blaxter and Cyster 1984). Individuals become caught up in social customs and the pressure to maintain lifestyles is greater than the pressure to comply with medical advice (Blaxter and Cyster 1984). I extrapolate on the Blaxter and Cyster (1984) findings and argue that individuals become caught up in the pressure from outside influences, that pressure is greater than the pressure to comply with eating less and exercising more. For example, effect of other family members and lack of time pressure overweight individuals to turn to high calorie convenience foods found at the local drive-up window instead of cooking low calorie meals at home.

Because many of the reasons and motivations for lifestyle choices are unknown, "overweight is increasing in U.S. adults and continues to be a public health dilemma for which no efficacious, practical, and long-lasting preventive or therapeutic solution has yet been identified" (Kuczmarski et al. 1994: 211). Although there is no "cure" for being overweight, there is an abundance of solutions and suggestions to combat the problem.

The causes, theories, and solutions seem to be redundant at times, however, one angle to solving the increasing prevalence and the ensuing problem of being overweight has not been addressed. The choices made on a daily basis that are a result of the effect of others, time constraints, and personal preference, all of which have an influence on overweight individuals, are not a part of previous literature.

The factors that influence choices surrounding the multiple issues of excess weight combined with the inadequate solutions available for weight control are in need of further exploration from varied perspectives. Research concerning the prevalence of being overweight that bases its findings on quantitative data alone reach conclusions that are incomplete. The individuals I interviewed address influences to food and exercise choices, along with how they function, given the interwoven difficulties of being overweight.

CHAPTER III

METHOD

Procedure

The research method in this study included a combination of personal in-depth interviews and written correspondence using e-mail or postal response. Eleven in-depth interviews that ranged from 20 to 30 minutes in length along with five written responses comprise the study. I did not offer to pay any monetary compensation for participation in the interview sessions. A statement given to participants assured their privacy, explained rights, and provided contact information for questions. Each interview began with five structured questions, followed by unstructured questions as needed. (See Appendix G for the participants' information and confidentiality statement, Appendix H for structured and unstructured interview questions, and Appendix I for the background and demographic questions.)

I chose in-depth interviews in order to explore in detail weight control struggles and the effect of real life circumstances that occur in a natural everyday environment. Answers to structured questions collected via e-mail and regular mail provided additional information from interested persons. This aspect of data collection allowed for personal input combined with a degree of anonymity.

Initial contact of prospective participants occurred at a non-profit support group for weight control. I interviewed interested participants at a time and location scheduled for

their convenience. I also used snowball sampling; participants were asked to tell friends they thought would be interested in joining the study. These interviews were recorded on audio tape.

The same five structured questions, background information questions, and privacy statements as used in the personal interviews were e-mailed in a survey format as well as given to participants who responded in writing. I collected responses from three interview surveys via e-mail. These three participants joined the study through snowball sampling, and requested the use of e-mail rather than an in-depth interview.

I received two responses in the form of written correspondence. These two individuals requested copies of the five structured questions, along with the demographic information and privacy statements, to take home and fill out responses in writing, at their convenience. Both communicated a desire to participate in the study, but expressed reluctance at the suggestion of a tape recorder or were not comfortable with e-mail. An announcement made at a non-profit support group for weight control recruited both of these participants.

I transcribed the audio taped interviews into text to facilitate data analysis. The e-mail interview surveys were printed, so all data would be in the same format. I compared and contrasted the raw data from the participants to identify trends and discover influences leading to their decisions and choices. This type of thematic analysis is adapted from Hutchinson (1988) and from Miles and Huberman (1984).

Next, I arranged the data by organizing categories and patterns to focus on emerging themes found in participant responses. The grouping of data into segments follows the

second stage in the process of identification in thematic analysis (Hutchinson 1988; Miles and Huberman 1984).

Additional analysis of the themes in each category focused on the choices and decisions discussed by participants. I wanted to know whether or not they played a role or had an effect on participants' weight issues. The themes were narrowed down by each step in the analysis process and were assigned names to serve as a framework. (See Appendix J for thematic analysis information, emerging patterns, and influences.)

Participants

Demographic Characteristics. The demographic characteristics and health background of the participants in this study are components of the circumstances that become part of the explanation, the reasoning behind the choices. References to marital status, body mass index, and health concerns of the participants are discussed in the analysis.

I interviewed 16 participants in the study, 12 females and 4 males. One individual is in the 18-30 age group, seven are in the 31-45 group, seven are in the 46-60 category, and one is over 60 years of age. Four of the participants are single and 12 are married. Of the single participants, three are males and one is female. Said differently, one male is married and 11 of the females are married. One participant is African American, one is Filipino, two are Hispanic and 12 are Caucasian. The four males in the study are Caucasian. Three of the individuals are high school graduates, six have some college, a trade school or associates degree, five hold bachelor degrees, and two people have master's degrees.

I did not include demographic questions referencing social economic status. However, using the level of education as a guide along with appearances, mannerisms, occupations, and setting of the interviews, participants gave the impression of being middle class.

Health Background. Previous research suggests that many people are not educated sufficiently about health risks associated with being overweight, which increases risks and the prevalence of overweight individuals (Ault 1998; Grundy 1998; Kuczmarski et al. 1994; Mokdad et al. 1999; Serdula et al. 1999). To the contrary, the individuals in this study appeared very informed about health risks, healthy eating habits, and the need for exercise. All 16 of the participants stated that they were aware of the health risks associated with being overweight. They obtained the information on health risks either from their health care provider or through reading and research on the subject of health and being overweight. At the same time, the majority of participants in this study also admitted that knowing what to do and actually doing it are quite different.

Participants' body mass index scores ranged from 22 through 45, where 25.0 and above is considered overweight and 30.0 and above is considered obese. Two individuals ranked 25.0 or below, three scored 29.9 or below, and eleven individuals' indices are 30.0 or greater. Using government BMI weight categories, two participants are normal weight, three are overweight, seven are obese, and four are extremely obese (Bray and Gray 1988; Calle et al. 1999). I did not combine BMI figures with other supplemental measurements, relying on one source of information to determine weight categories instead. Many overweight individuals are sensitive to revealing weight information, therefore BMI scores appeared less intrusive.

The majority of people interviewed (69%) had a positive experience with a doctor when inquiring about weight and health risks. These participants said their doctors were concerned, and gave helpful information and answers to their questions. These same participants also stated that either they, or an immediate family member, were on a restrictive diet or medication as the result of heart problems, diabetes, or high blood pressure.

Five individuals stated that they had a negative experience with a doctor when inquiring about weight issues. The negative experiences varied, including confusion about what is defined as being overweight, lack of direction in how to begin losing weight, or no clear guidance for where to obtain assistance with understanding associated health risks. The physicians either ignored their questions or offered no information about risk prevention. In answer to participants' questions concerning excess weight and weight loss, doctors suggested programs, such as Weight Watchers or Jenny Craig. The complaints about non-responsive doctors and health care providers in the area of overweight health risk issues are among changes suggested by previous researchers (Galuska et al. 1999; Grundy 1998; Mokdad et al. 1999; Must et al. 1999; Serdula et al. 1999; Wee et al. 1999).

At the time of the interviews, 12 participants were in a program to either lose or maintain their weight; however, three of them discontinued their programs before the study was completed. Of the remaining four people interviewed, two had participated in weight loss programs in the past and two had never been in any type of weight loss program.

Nine individuals said that they are not physically active, five considered themselves physically active, and two stated that they are slightly physically active. Participants' level of activity in relation to body mass index did not reveal overestimation; that is, no one's physical activity was reported at a higher level than expected.

Health background and current physical condition comprise one component of the social issues encountered by overweight individuals. Efforts to control or maintain weight revolve around decisions and choices. Because I focus on the influential factors that individuals encounter in the decision making process, a combination of theories provides a comprehensive understanding of the issues behind the choices.

Analytical Framework

The approach taken in this study concerning life choices that in turn impact an individual's weight differs from past frameworks. The purpose of the study was not to determine the best way to lose or maintain weight. Instead, the reasons or influences that explain choices made in everyday situations are the focus. Sometimes motives enable individuals to make sense of their lives, but do not support efforts to control weight. The social problems encountered by overweight individuals and the theories that explain weight conditions and associated behaviors center on decisions and choices. The analytical framework I have chosen considers the life choices individuals make concerning their weight, including how they make sense of those choices. Although some of the definitions found in the analytical framework are discussed in the introduction, they are reintroduced here as they are applied in the analysis.

Life Choices and Weight. Social expectations, health risks, and the food choices available are some of the influences people consider when making decisions about their

health and weight. Efforts to explain influences on a person's behavior can also include a search for the motivation behind the act. However, it is a mistake to try to explain an act by linking it to underlying motivations (Hewitt 1997). "Since the motivational underpinnings of most human acts are more complex than they appear on the surface...few acts can be explained by a single motivation" (Hewitt 1997:97). Therefore, to explain how and why individuals make some choices over others I draw on Charon's (1998) depiction of Weber and Mills. Charon notes that motives are verbalized explanations of behavior that serve to explain, rationalize, or condemn one's own behavior or the acts of others (Charon 1998). People act based on the meanings they attach to their impulses to act, and in turn, some meanings are more prominent than others (Hewitt 1997). Not only is the meaning important, but *how* the person explains *why* they behave as they do is crucial to understanding their view of reality (Hewitt 1997). A motive, what people say about their behavior, becomes a part of social interaction and gives the individual an opportunity to express reasons and explanations of conduct (Hewitt 1997). The in-depth interviews used in this study provide the participants, through social interaction, a way to discuss and explain their eating and exercise behaviors and choices.

Aligning actions are also a verbalized part of social interaction that can bring an individual's conduct into alignment with norms and values deemed culturally appropriate (Stokes and Hewitt 1976). The retrospective or prospective nature of aligning actions are an important dimension because aligning actions are often used in the context of defending behavior or when searching for social support of behavior (Hewitt 1997; Hunter 1984). Being overweight, including the behaviors or choices that contribute to it,

is not viewed by most people as culturally appropriate (Grundy 1998; U.S. Department of Health and Human Services 1999). Alignment brings those actions into a more socially acceptable light (Stokes and Hewitt 1976). The form of aligning actions most employed by the participants in this study is accounts.

The accounts (verbal explanations) of the actions, decisions, and choices analyzed in this study explores the use of this technique by the participants. The opportunity for explanation can result from a direct request, an implication, or from the individual's perception of the situation (Hewitt 1997). Two types of accounts, justifications and excuses, accomplish the task of qualifying the behavior and the responsibility for that behavior (Scott and Lyman 1968). Conversely, when using a justification to explain socially unacceptable conduct, responsibility for the act or behavior is accepted, but any disparaging quality is denied (Hunter 1984; Scott and Lyman 1968). When using an excuse to explain conduct in question, the act or behavior is acknowledged as wrong or undesirable; however, responsibility is denied and the blame belongs to someone or something else (Hunter 1984; Scott and Lyman 1968). Because the prevailing solution to being overweight places the responsibility for excess weight on the individual, their behavior is often viewed as unacceptable. Many overweight individuals face taking responsibility and offering explanations, for their behavior and choices concerning food and exercise, that seem to conflict with norms and values of a society that values thinness. The theory of accounts enables overweight individuals to bring their actions in line with acceptable norms and values.

Norms, values, and roles in society help shape how individuals appear and behave while carrying out their perception of reality (Johnson 1997). An individual's perceptions

and decisions regarding life choices leads to behavior and lifestyle adaptations that lay out a path or pattern that is easy to follow (Fritz 1984).

I use the behavior adaptation of the path of least resistance as a means to analyze life choices and perceptions about weight in this study. The principle is that energy always moves along the path of least resistance and the easiest, although not necessarily easy, choice is to go along that path (Fritz 1984; Johnson 1997). Each individual struggling with issues that surround being overweight focuses on a way to meet their own personal needs when making "health" choices. Healthy choices are not always made because "personal solutions arise primarily from a sense of our own personal needs, and focusing our attention on this is a path of least resistance"(Johnson 1997: 29). As stated above, the easy choice is to move along such a path (Fritz 1984; Johnson 1997).

Decisions and choices, at times, are the normal consequences of the path of least resistance set in place within a society or culture (Johnson 1977). At other times, a variety of underlying factors contributes to choices and behaviors. These factors include the priorities and circumstances unique to each individual as well as those they have in common with others.

Today, society in the United States often consists of people working in sedentary occupations, living fast paced lives, who have easy access to quick meals that include large portions and high calorie counts. Furthermore, doctors are not taking an active part in explaining the risks associated with being overweight or working closely with patients (Galuska et al. 1999). The cultural norm in the United States is for doctors to put the responsibility of weight loss on the individual without consideration of how influences in life often encourages failure instead of success. This in turn creates the opportunity for

many overweight people to justify their choices. After numerous unsuccessful attempts to lose weight and then repeatedly gain it back, many dieters use frustration and stress as a reason to give up on losing weight. Overweight individuals that are stereotyped as responsible for their excess weight, but view themselves as powerless to lose weight offer justifications as a way to give themselves credibility and social acceptability (Charon 1998; Hewitt 1997; Johnson 1977; Scott and Lyman 1968).

Cultural norms and values combined with individual behaviors and choices contribute to numerous paths of least resistance (Johnson 1977). For overweight individuals, the path of least resistance unfolds with the selection of easy, quick choices for food and the avoidance of exercise because of numerous time constraints. Ironically, the path of least resistance can include choices that contradict a healthy lifestyle, yet conform to certain values of society. For example, when choices are made in accordance with the ease and availability of popular high calorie foods and increased portions sized meals, individuals are following norms, values, *and* a path of least resistance.

Throughout the data analysis, I explore the various techniques of explanation used by the participants as they strive to make sense of their life choices concerning weight. I analyze the motives underlying their choices and the aligning actions of accounts--justifications and excuses--that took place while participants explained their behavior during the interviews. The justifications and excuses used by the participants help to have their behavior viewed as socially acceptable.

CHAPTER IV

DATA ANALYSIS

The analysis of these data and any conclusions drawn from the interviews apply only to those who participated in this study. Any comparisons to previous research are made with the understanding of this limitation. Reference is made only to participants in this study, not to all individuals who are in weight loss programs, who have weight-associated health risks, or who are overweight. However, this does not imply that insights gleaned from this exploratory study are limited in their scope.

When participants discussed decisions made during an average day concerning food and exercise choices, many of their statements indicate that *effect of others*, *time constraints*, and *personal preferences* were the most important influences. (Influence categories and the percentage of influence appears in Appendix K.) As individuals discussed their choices, they incorporated these influences into the process of aligning actions. Accounts, one type of aligning action, helped the participants understand their choices, reduced conflicts over their choices, and brought some assurance that their perceptions made sense. Previous research has associated the use of accounts with criminal and deviant behaviors, providing alternatives for removing negative consequences (Hewitt 1997; Scully and Marolla 1994; Scott and Lyman 1968; Sykes and Matza 1957. Previous research also suggested further examination of the role of accounts

toward a positive or negative effect toward weight loss efforts and in conjunction with the implications for treatment of weight related problems (English 1991).

The process of aligning actions explored in this study does not imply a lack of effort, determination or will power by the participants, only their explanation of *how* one course of action is chosen over another. As the participants gave accounts of their actions, justifications and excuses surfaced. The analysis that follows gives insight into choices and the decision-making process, which in turn are explained with two types of accounts, justifications and excuses. As the participants move along their chosen path of least resistance, providing a justification or an excuse is a way to make taking that path acceptable. Behavior that appears to be contrary to norms and values is also explained by participants during the process of giving an account. A primary justification or excuse behind choices for food, exercise, and management of daily routines is the effect of others.

Effect of Others

Relationships with others, whether family members, friends, co-workers or health care professionals, influence choices about what foods to eat, exercise possibilities, and pending commitments in daily routines. The effect of others can bring different levels of pressure to the process of making choices. Pleasing a family member reflects behavior that is voluntary, but with a small amount of pressure. On the other hand, complying with someone's wishes seems to have the connotation of following orders. During the interviews 62.5% of the participants indicated that other people had an effect on their choices. The following participants discussed how others affect their struggle with being overweight.

Rosa, who is *overweight* and has had health problems from childhood, talked about how the decision to eat out was influenced by her husband.

> I usually go out with my husband; he usually goes for the heavy restaurant type stuff. He doesn't like what would be a salad bar, something like that. So just to keep the peace, I have to pick from there.

Compliance with the circumstances of her husband's food preferences complicates Rosa's health issues. Her path of least resistance is to comply with her husband's preference. In order to explain why she is not eating a more healthy diet, Rosa gave an account of the reasons behind the choice to defer to her husband. Not only does her husband become the motive that makes her behavior appear more sensible, but keeping the peace is a justification for why her conduct should not be viewed as inappropriate. In this sense, the peacekeeping justification aligns Rosa's choice to place her husband's preference over her health into a favorable light. She justified her behavior by *appealing to loyalties*--her feelings for her husband. The successful use of the peacekeeping justification is also a way for Rosa to maintain her "agreeable" identity instead of being viewed as a troublemaker.

Has Rosa sabotaged her health by using her husband's preferences as a justification for unhealthy food choices? Clearly, Rosa's path of least resistance is not a healthy one. She related that her husband also did the grocery shopping and bought what he liked. Rosa stated:

> When I worked I had more choices because I was around eating places. But now since I am at home I'm kinda limited to what I have in the refrigerator. But I do try to have healthy foods, in the refrigerator. Even if it takes forceful methods (laughs) to the person that goes grocery shopping.

Rosa lets others (her husband) affect her food choices up to a point. She continued to justify her limited choices of healthy food, the neutralization technique is again *appeal to loyalties*. With regard to her husband's shopping choices, Rosa takes quasi control of the type of food available with her verbalization about "forceful methods." In this way, she is able to assert the positive value in her behavior and her limited choices are justified (Scott and Lyman 1968). Another participant also has the effect of others as well as health issues to consider.

Julia, who is *obese*, worries about having a silent heart attack like a friend of hers did. She offered an account that explained her obesity and then justified her eating behavior with other people, her husband and her co-workers.

> I grew up until 40, a 'skinny'. I never believed that I was actually overweight. I know I am because the mirror and the scale say so, but in my head I'm still slim . . . My husband cooks and I am under his influence for dinner . . . [I] try to make my breakfast and lunch every day. My problem comes when I get to work and the doughnuts and sweet rolls appear.

Julia began her account with an explanation that brought in her past as a very 'skinny' girl. She further explained her circumstance with her husband's cooking as an excuse, *scapegoating,* for what she sees in the mirror. Julia shifted back to herself, relating the positive aspects of the meals she prepares (breakfast and lunch). She uses the same type of excuse, *scapegoating,* for not maintaining proper eating habits when her co-workers bring in sweets. Julia uses a combination of positive behaviors and excuses to neutralize situations where her actions result in high calorie food choices, which oppose weight loss. By using excuses, she relieves herself of the responsibility because she blames others for her food choices. However, by eating her husband's cooking and enjoying doughnuts and sweet rolls, Julia follows a path of least resistance at home and at work.

Julia added the effects of another person when speaking about her options for exercise when she said the following:

> Guilt feelings about leaving my husband all day with the care of my aged father keeps me from staying away from the house to take part in after work classes [exercise].

Julia's father becomes the motive for not being able to exercise regularly. She is able to justify her behavior of not attending exercise classes because of guilt feelings about being away from the house. Julia is *appealing to loyalties* to her husband and her father. Like Rosa, the others in Julia's life exert effects that ultimately become justifications for her exercise choices.

The influence of personal considerations for other people also provides a path of least resistance for Julia. There is little resistance in the path of behavior she has chosen, because Julia uses the effects of others as excuses or justifications for any inappropriate behavior on her part. Do these excuses and justifications support a health benefit for Julia? By relieving her guilt and supporting her relationship with her family, her interest is served by the relief of stress. However, Julia continues to be overweight, which is not a health benefit. The effects of others are not always in the form of pressure from family or friends. Karl, another participant, discusses the effect of his doctor's response concerning his excess weight.

Karl is *obese*, has high blood pressure, and takes medication. When asked if anything influenced his decision to exercise, he became quite agitated as he related:

> I'm the one who has to bring that issue up. They just indicate that you need to exercise and that's about it. They may send you to a nutritionist, but that's nothing rigid . . . they just tell you, hey, you need to eat less. There's no penalty . . . other than personal penalty as far as health goes. They keep telling you, well you need to lose, you need to lose weight.

> The doctor never goes far enough back into my chart . . . to see what other is happening, other than if you're on blood pressure medication.

Karl excuses his not exercising and continuing to be obese by blaming the doctor for what he perceives as a lack of restrictions and monitoring. He sought and received health information from a medical professional, but regards the advice as ineffective. Karl acknowledges his obesity, but then by using the doctor's lack of follow-up as an excuse, relieves himself of the responsibility for his obese condition. Karl also excuses his not eating less because the effects of seeing a nutritionist are not "rigid" requirements in his perception. The use of excuses allows Karl to make sense of his continued unhealthy behavior by using the doctor and the nutritionist as *scapegoats.* Not all of the participants who asked their doctors about weight issues questioned the recommendations of their physician.

Dianne states that she has healthy numbers for blood pressure and heart rate although she falls in the *overweight* category. She also does not consider herself at risk for any associated risks from weight. Her doctor's approach of regarding her blood pressure and heart rate as good (textbook numbers) affects her choices in reference to her weight.

> He thought it would be good if I would lose some weight . . . because of my back, he thinks it would be better. But, all of my, I have textbook numbers. So he doesn't mess with me. He tells me he doesn't mess with me, just because of that (laughter).

Dianne's doctor suggests weight loss, but she justifies not losing weight because her doctor does not push the issue. Her actions are permissible and correct by *appealing to loyalties* of her doctor's judgement. Dianne owes an allegiance to her doctor because of his medical expertise and she trusts his evaluation of her "textbook numbers." Dianne's decision not to lose weight and her justification of that choice are both influenced by her

doctor. Dianne overlooks her doctor's initial concern about back problems; she focuses instead on not being "messed" with. Dianne justifies being overweight and having back difficulties with her doctor's confirmation of a healthy blood pressure and heart rate. The effect of her doctor not putting pressure on her to lose weight is, for Dianne, an explanation for her actions of not losing weight. Another participant expresses a similar situation with similar effects.

Emily is *extremely obese,* with diabetes and high blood sugar. Emily said she has discussed both health and weight issues with her doctor. She gave the following account of what her doctor suggested, in addition to exercise:

> She's quite blunt, "Emily, you've got too much weight on you. You've got to get it off and you do that by eating less." She talks about it, but she doesn't recommend a certain thing. Her deal is eat less.

Despite her health problems, Emily does not regard the advice of her doctor to eat less as a medical recommendation. Instead, Emily *appeals to loyalties* and her interpretation of the doctor's advice as a justification for not losing weight. Like Dianne, Emily's loyalty and trust are in the medical profession to take command if necessary. When her doctor does not take charge, Emily perceives her continued weight gain as permissible. Because Emily has several pertinent health issues but is not controlling her weight, others can view this behavior as inappropriate. Emily neutralizes the situation by justifying her behavior; her doctor did not recommend "a certain thing", eating less was only "talk." Emily, Dianne, and Karl are all influenced by their doctors' perceived passivity to health issues and being overweight by taking less stringent actions against their excess weight.

Doctors are aware of the risks attributable to overweight conditions and have brought it to the attention of the three previous participants. However, talking to patients about

eating less and exercising more without any responsibility for follow through procedures by the doctor is not active participation in controlling health risks. The difference between doctors' orders and doctors' advice affects the perception of seriousness in situations for overweight individuals. Consequently, overweight individuals with health risks many times either excuse or justify their unhealthy behavior, despite the warning of their physician regarding weight.

Another important influence for people faced with decisions about health issues is the lack of time they have because of work, school, and family schedules. When circumstances demand more time than is available, choices must be made about who or what receives attention.

Time Constraints

Long hours, busy schedules, and little free time are time constraints indicated by over 69% of the participants as having an effect on making food and exercise choices and decisions. Fast-paced lives are part of the environment for most people living in the United States. However, overweight individuals refer to time constraints as one of the problems encountered in their efforts to control their weight. The next participants' work schedule is an influence for his not being physically active.

Max is the youngest participant (18-30) and the person with the highest BMI (45). He is *extremely obese* and his probability for associated health risks is extremely high. Max makes sense of his daily routine and explains why he does not participate in physical activities, despite having a gym club membership.

> Work schedule. I work right in the middle of the day, so it's like, I get home, I want to go to sleep. I wake up, I gotta go to work, ya know…It doesn't fit into my day.

Max was quick with an answer and an excuse. Earlier in the interview, he had talked about going to the gym as being an effective means for weight loss. However, Max's knowledge of health risks associated with being overweight brought his conduct of not going to the gym into question. The aligning action of explaining the time constraints of his work schedule and using it as an excuse for inactivity blames the work schedule instead of himself.

When Max discussed his health risks, he stated that his doctor did tell him about the risk of heart attack and high blood pressure due to obesity. The advice given by his doctor about individual responsibility for weight reduction and healthy behaviors is similar to that of previous participants. Max related:

> Just watch what you eat, not eat out as much. Try something like Jenny Craig or Weight Watchers, ya know. But something like that really wouldn't fit into my schedule.

Max interjects time restraints as an excuse for not following his doctor's recommendations. Unlike the other three participants, Max does not refer to the advice as being too lenient, but instead focuses on his work schedule and no available time to follow the recommendations. Max not only excuses his continued eating out, but his non-participation in a weight loss group by faulting his time schedule.

Like Max, Karl also has a conflict with his work schedule and exercise. He stated:

> I go to work early. I usually start my work by 6:00 or 6:30. So by the time I get home in the afternoon its been a long day. I am very exhausted, basically mentally. But, by the time you come home and eat something and it gets late, so I'm exhausted physically. Time. If I would get off at 2:30 then I would probably have that extra two hours to walk or go somewhere and do some exercises and get back in the time frame.

Karl gives an account of his day in order to make sense of his inactive behavior, justifying why others should not view it as wrong. He uses a *sad tale* of rising early,

being exhausted, and not having enough time to justify his lack of exercise. Karl adds a further aligning action with the use of "probably" when referring to possibility of exercising if his work schedule would change. Both Karl and Max find inactivity a path of least resistance and use time constraints that surround work schedules as excuses and justifications for their behavior. Their type of account has both positive and negative effects for Karl and Max. Accounting for their lack of exercise by using busy schedules, the behavior in question takes on a positive slant and is not viewed as wrong. However, at the same time, when responsibility for their lack of exercise is removed from Karl and Max, it inhibits their attempt to reduce the health risks of being overweight, a decidedly negative effect.

The time constraints of a busy work schedule are also cited by Donna, an *obese* young professional, as a factor in her choices of foods and exercise.

> Working long hours prohibits me from cooking as healthy as I should. I also do not seem to be able to find the time to exercise as often as I should to maintain a more healthy weight.

Donna appears to have the necessary knowledge about what constitutes health conscious cooking and exercise by her references to them as "healthy." However, to excuse not following through with what Donna considers healthy behaviors she blames the time constraints of her work schedule, thereby shifting the responsibility "to maintain a more healthy weight" away from herself.

On follow-up questions, Donna said "work, speed, and convenience" were the three most important decision considerations when making her choices. The influence of time constraints has an adverse effect on healthy behavior for Donna. However, the lack of

time becomes a *scapegoat* to explain unhealthy choices that would otherwise call her actions into question.

Like Donna, Rebecca is a professional who is *obese.* She also finds her work schedule does not promote a healthy routine. Rebecca determines what type of food she will eat by how hectic her schedule is for that day.

> Depending on my schedule is what I eat. I eat more ready to eat foods than foods from scratch, especially for lunch. Things that might get in the way of doing activities is a busy schedule and the heat during the day. I might find it quicker and easier to pick something up at the fast food place than to cook.

Rebecca uses the time constraints of her work schedule as a justification for not cooking and for picking up fast food. Rebecca's form of justification is to assert the positive value of eating ready to eat foods (quicker and easier) and not doing exercises (dangerous heat) before her actions become questioned by others. If Rebecca's behavior of inactivity takes on an "unhealthy" definition by others, a busy schedule or hot weather is in place as a justification to claim that her actions are permissible under these circumstances. She also does not directly admit that her behavior will be unacceptable given her weight issues, because she precedes her intended actions with "might" in order to make them seem contemplative.

Emily also said time constraints influence her choices concerning what to eat and where to eat it. A part-time student, working wife, and a mother whose children demand much of her time, Emily talks about her family:

> Right now my daughter has a doctor's appointment at least once a week. And coming back from that we just automatically, on the drive back, stop at McDonalds and go through the drive-in. Because it will be comin' up on 6:00, their bedtime is eight, I get up at 4:30 in the morning. So, ya know, I just can't face, at that point (laughs), and I'll get the small hamburger and try to resist the fries (laughs again).

Emily mentioned her health problems initially in the interview, but surrounds her food choices and going through a drive-in with the justification of a *sad tale*. The time constraints due to family circumstances with her daughter, her children's bedtime, and her early wake-up become the sad tale intended to justify her eating choices. Emily used laughter in several places during her account, usually where her behavior was in direct opposition to her health issues. Her use of laughter, making light of the situation, is an example of how conduct that appears to disregard her health, is made less important and becomes a strategy to avoid giving a further account. Emily appears to be aligning her actions so her conduct is in line with social norms, but also so that her conception of herself is consistent with social norms and values (Hewitt 1997; Stokes and Hewitt 1976). Additional factors considered by individuals when making choices that ultimately reflect on their actions are the influences of personal preferences.

Personal Preferences

In analyzing these data I am defining preference as a greater liking, giving of priority or advantage, and a preferring or being preferred when referencing a taste or flavor, an appealing activity or style of living. For example, some participants like meat better than vegetables, going to the movies better than going for a walk, and eating fast-food better than cooking.

Personal likes and dislikes are a strong influence when making choices, changing a behavior, or altering a lifestyle. Restricting previous behaviors, adding new behaviors, or non-compliance with doctor's guidance can result when it means changing a preferred lifestyle (Blaxter and Cyster 1984; Cockerham 1998). Personal preferences are what almost 75% of the participants said influenced their choices and aided them in reaching a

decision concerning the type and amount of food to eat and whether or not to be physically active.

Victoria is one of the participants who cited personal preferences as an influence in making food choices. She is *overweight* with high blood pressure. Victoria discussed her weight problems and preferences in conjunction with her husband's hypoglycemia and the need for sugars in their house.

> Ya know, I'm not going to do without it. If I crave it, I'm gonna have it. But I'm just gonna have to have it in a smaller, ya know, more controlled piece of cake or pie or whatever it may be. I always have sweets in the house, mainly because of my husband. I have to cut down on it, but I won't deprive myself completely of it either.

Victoria's preference is not to deprive herself of the flavors and tastes in food she craves. As she discussed her tastes and preferences, she justified her decision to eat what she likes in several different ways. Victoria begins her account with a *self-fulfillment* justification to have what she craves. She references "smaller" and "controlled" as a way to align her non-denial of sweets with her high blood pressure. Victoria also excused her questionable behavior by making her husband the *scapegoat* and the "main" reason for having sweets in the house. Victoria partakes of "controlled" sweets, but excuses her responsibility for such behavior as she proceeds along her path of least resistance.

Karl also has flavor and taste preferences and does not want to deprive himself of what he likes. His account at first appears to have several personal preferences that center on not feeling deprived. He stated:

> Sometimes the money is a factor. You feel like you want to get the most out of the money that you pay. So therefore, sometimes we have an all you can eat buffet to make up for that difference. The variety of my taste, basically I'm more of a meat eater than a vegetable. I've been on diets before, so I've been on salads. So I just don't feel justifiable to have a

> *salad* for dinner. It doesn't fill me up. So I just go out and eat (pause) usually what I don't fix at home.

Karl's motives are good value, variety, and satisfaction. Karl has a number of personal preferences and a number of justifications as well. He wants to eat what he likes to satisfy his tastes; therefore, he uses a *self-fulfillment* justification to explain his preferences. Karl justifies "all you can eat" buffets, because you get the most for the money. He justifies not dieting with his experience of salads not filling him up. Finally, he justifies his decision to eat out, because there are things he does not cook at home. Karl is taking responsibility for his personal preferences as he protects himself from the view of unacceptable behavior for an overweight individual. Karl is able to align the problematic actions that result from his preferences by using justifications.

Like Karl, Michael also justifies his preferences and behavior. Michael is an *obese* young man, but does not consider himself at risk because his weight has not changed in over ten years. Although Michael has not discussed weight issues with a doctor, he has a family history of high blood pressure and heart attacks. When asked about considerations when making food choices, he replied:

> To try and watch how much pop I drink . . . I've tried and, of course, I'm not crazy about diet pop, I like the real thing. So I gotta have that Mountain Dew in the morning for break. So I've tried to limit myself as to how much of that I drink. So I had one tonight for supper and I had one this afternoon for break and I had one this morning. So I didn't watch it that much, but most of the time I try and keep myself to only one a day.

Michael uses a *self-fulfillment* justification for his taste preference for "real" pop (Mountain Dew) consumption at break. Although he does not view his taste preference as wrong, Michael does take responsibility for drinking too much pop. He interjects another justification into the interaction with his use of "tried to limit" so his actions, in that

respect, have a more positive aspect. When his self-limitations fall short, "I didn't watch it that much," he justifies his actions in the same sentence with "most of the time I try." Michael's *sad tale* justification explains his behavior and his preference; he is trying to limit his consumption. Another participant discusses her personal preferences and food choices.

Leia, who is in the *obese* category, has personal preferences that influence her choices of what type of food is consumed when she is not working. Leia stated:

> Once a week my husband and I have a day off and we get away and eat out . . . splurge a little bit. Ya know, every time I want to bite into a third piece of cheeseburger (laughs), I know I have to get on that scale . . . ya know, be accountable to myself. I know after I either have done something or I shouldn't have done something, it just eats at me, ya know. I just wanna not be harsh on myself, but forgive myself and just, the next time, ya know [do better].

Leia likes to splurge and enjoy her day off by eating out and having cheeseburgers. She realizes that this behavior is not going to reflect positively when she weighs in at her weight reduction meeting. Therefore, Leia justifies splurging with a *sad tale* that includes forgiving herself for high calorie choices. A *sad tale* explains enjoying cheeseburgers, being harsh on herself, and forgiving herself in anticipation of the next time. Leia accepts the responsibility that the scale will reflect her personal preferences, but her dismal state justifies the behavior. Preferences are not always centered around specific tastes or types of food.

Personal preferences may also include whatever the individual is focused on at a particular point in time, relevant to the circumstances in their lives (Blaxter and Cyster 1984). Jill is *extremely obese* with numerous health problems and is under a doctor's care for weight loss. When asked what influenced her food choices, Jill replied, "My health

and time." However, when asked what influenced the choices in her routine on an average day she said,

> Schooling always comes first, before exercising or eating lighter or eating whatever. And then second was working . . . and then family comes in there.

Jill's schooling is relevant to her at this time and takes priority before anything else, despite the risks to her health. The preference for school takes precedence over instructions from her doctor to exercise. Although she has exercise opportunities, Jill uses school priorities as an excuse. For example, I asked if she walked around the school campus or parked in places to facilitate walking. Jill replied, "No, (laughs) as close to the bus stop as you can possibly get" (more laughter). Although she was laughing as she explained her desire for convenience to classes, Jill seemed distressed when prioritizing her "schooling" and her actions in that environment (parking close) when asked about health issues. She employs excuses, which are an attempt to gain social approval of school centered behaviors that appear unacceptable.

Jill further excuses placing her school preference above her health as she explains her eating patterns during school by saying:

> Eating for me has always been, it's not a choice, it's a matter of what my brain tells me is necessity. Sometimes it's not logical (laughs a lot). For me, sometimes the necessity for me is to grab a candy bar as I'm running to where ever is next, or a soft drink or whatever. It's a matter of whatever is available as I'm going between here and there . . . usually zoom through a fast food . . .

During her account of an average day, Jill excused her unhealthy eating at school with a *biological drive* when she said, "eating's not a choice . . . my brain tells me...." Jill does not want to change her preferred lifestyle of going to school or the eating habits that

result. Therefore, she excuses herself from responsibility for disregarding her doctor's recommendations and frames her behavior as a necessity of *biological drives.*

A focus for another participant is to have fun while making decisions based on personal preferences. Although during his interview Max discussed not having enough time to exercise, when asked about leisure activities he had this to say:

> We mainly just go to the movies or we go to the mall, mmm, a movie's more fun (laughs). Usually we're just like, well, let's like go ahead and go here and try this, or this, or that . . .Yeah, it's personal preference, yeah.

When asked what influenced his choice, he said, "I don't know I just do it. I mean it's instinct, I guess, you know." His answer excused his preference for a fun activity instead of exercise by using "instinct" as a *biological drive* for his decision. For Max, his choice to have fun is also a path of least resistance that appears to be a "natural" choice.

What seems natural is not always a path in the direction of healthy decisions and reducing the condition of being overweight. However, *biological drive* excuses bring a measure of positive value to choices, paths, and provides a way to make sense of the way life choice and weight issues are interconnected. The participants also strive to make sense of additional influences that are not as prominent, but are a part of the struggle with being overweight.

Additional Influences

Additional influences discussed by other participants were personal health problems or a family history of health problems, being on a budget, and deciding what kind of weight loss or weight maintenance plan would be best for them. Ruby, who corresponded in writing, has many additional influences that affect her choices and decisions.

Ruby, who is *extremely obese,* gave a different influence for each choice she encountered. She seemed to be at odds with why she kept gaining weight. When asked about influences on decisions about where to eat and what to eat, she simply wrote: "husband, children, and money." Her reluctance to discuss details may result from the sensitive nature of being overweight and as a reason for her written response.

A question about physical activity was answered with a *sad tale* justification, "I don't exercise on a regular basis, too tired." When asked if she had any considerations that influenced her decisions as she went about her daily routine, her short answers were: "Stress at work, anger if things aren't going the way I want, and not enough leisure time." Again, Ruby relies on a *sad tale* justification by relating the dismal influences on her life choices. She offered no further insight into the circumstances that influence her decisions and life choices. Throughout the use of a justification, Ruby is trying to make sense of her weight and the difficulties associated with a variety of influences on the life choices she makes. She appeared reluctant to disclose details, leaving the impression that she was protective of her weight and the problems that influence her decisions.

On the other hand, leisure time versus weight maintenance is not justified by Dianne. She talked about choices concerning leisure activities:

> We go and do things because it's fun! Yeah, we don't think oh, we're gonna go over her and do this because it's good for our heart, no! (laughter). We're gonna go pick up the grandkids and go to the movies or what ever.

Dianne and her husband have weight and health issues; they also have grandchildren that are part of their lives and therefore have an effect on choices. Dianne takes a realistic approach to the influence of health and having a good time with the family. Karl talks

about the realities of his working environment and the effects on his ability to exercise. He says:

> This facility I work at does not have anything available [to take a shower]. Therefore, I don't have the capability to do that [walk during lunch]. And again, with the short time frame of a lunch period and me sitting behind a desk all day. Basically, keeps the physical activity fairly minimum.

The influences in Karl's life are an example of interconnected issues having an effect on weight. His working conditions offer no means of exercise and compounding Karl's weight problems is the fact that he sits all day. Karl could be viewed as using his work environment as a *scapegoat* for inactivity. However, because the influences are inter-related, the impact of one over the other cannot be separated. Therefore, the use of an excuse is questionable under these circumstances.

Max also sits during most of his workday. However, his daily influences affect him differently as he makes food choices. Max talks about his day:

> How I feel. How the days been going. If I feel I want to cook or not. Cause if I really don't feel like going home and cooking a meal and sitting down. I'd just rather go [out] and eat and get it over with.

The circumstances of the day, whatever they may be, have additional influences on Max's eating habits. The influence of a bad day take priority over the prospect of cooking, despite the possible health risks associated with eating out. Max is influenced to eat out. His choice may have compromised his health, but at the time, that was less important than getting through the day. Max does not excuse or justify his choice, the norm in U. S. society views this as acceptable behavior. The decision to eat out is made daily in the United States by both normal and overweight individuals because the cost is not prohibitive and there are varieties of restaurants conveniently located.

Rosa also solves influences in life with convenience foods. She says:

> If I think that going the healthy route is gonna take longer, I'll just do something quick. Have take-out, something like that.

The influences of having these conveniences are not excused or justified by Rosa, they are a part of life in the United States. However, the positive and negative aspects of their influence are debatable; take out options and fast food restaurants remain a related circumstance to food choice that impact weight maintenance. Although the answer of a quick meal is an easy remedy, not all of the circumstances encountered by overweight individuals are simple. A number of problems and difficulties that influence choices and decisions for overweight individuals are life threatening. Leia is one of these individuals.

Leia's history of family health problems and her resulting fear is an additional influence for her when making choices about her own health and weight. Leia's family history was difficult for her to put into words. Her account:

> And umm, my siblings on the female side, ya know. I'm not saying I'm slim, but, umm there's a weight factor. And umm, my mom, ya know, got a weight factor too and so, umm. So she also had cancer, breast cancer, ya know. Cause I've always been taught where they say it can be passed down or I'm likely to get it down in the future. We don't know where it's comin' from . . . but, ya know, it's a conscious *fear*. Hopefully it doesn't happen to me. But if it does, ya know.

Leia is not just struggling with her weight and health issues; she is struggling with how to make sense of the fear that concerns her weight. Because specialists have established a link between obesity and developing cancers, including breast cancer (Fumento and Soriano 1997) this risk is a source of fear for her. Leia excuses her not being slim by using a fatalistic force component of *biological drives*, "we don't know where it's comin' from."

To further alleviate her fear, Leia continues along the same line, to excuse her admission that sometimes her behavior is in conflict with her health fears. Her account continued:

> Cause I just wanted to have somethin'. . . I'm paying for it now . . . I just try to correct that moment, ya know. Even the healthiest person can just wake up one day and ya know. One out of three people . . . is gonna have cancer in the future or sometime. Ya know, so it's just a question mark.

Leia admits her actions are not always in the best interest of her health, "I'm paying for it now," but is trying to make corrections. She continues to use *biological drives* as an excuse to have what she wants, because even healthy people get cancer. Again, a fatalistic force excuses her responsibility for unhealthy eating behavior and diminishes her fear, since "it's just a question mark." However, fear affects people differently, which in turn brings additional influences to the perspectives about life choices and weight.

Many weight loss programs involve fear, frustration, and little success (Dortch 1997). The fear and frustration involved in weight loss and weight maintenance are additional influences that impact choices. Dianne talked about the fear and frustration of joining weight loss programs. She had this to say about the experience:

> I could go to their program, I could do their thing, I could lose the weight. And within a year, (laughter) guess *what!* I gained it all back . . . every time I went, I lost it. But when I would gain it back, I would gain back *more.* It didn't, it wasn't like go lose twenty pounds, put back on twenty pounds. It was like go lose twenty pounds, put back on twenty-five. Then go lose twenty pounds again and then go back and maybe the next time you might gain thirty. And that's how, and that got frightening for me. And then I read some different things about the yo-yo effect, and I decided I wasn't gonna do that any more.

Dianne is not providing an excuse or justification for discontinuing weight loss efforts. Rather, the fear and frustration she has experienced in weight loss programs influenced her decision. The negative influence of weight loss programs and the other influences that

Dianne discussed all affect her life choices concerning weight issues. She is not alone in her negative experience with efforts to lose weight. Emily talked about her life long efforts at weight reduction:

> Since I was 13 (laughs). The ones when I was a teenager, I would usually lose weight and keep it off for awhile. But when I got into my twenties it would be, it yo-yoed. And it's done that ever since.

Emily, like Dianne does not offer an excuse or justification; she presented a history of her efforts. For someone who has been struggling with weight reduction since the age of 13, the interwoven influences of the weight loss experience cannot be removed from the decision making process when making life choices. The pattern of failure with weight loss programs has also been a life long struggle with Jill.

Jill has also experienced her share of weight reduction failures. She discussed the number of doctors and their weight loss techniques. Jill said:

> Every doctor I've see, all my life (laughs). First thing they mention (laughs). I've gone to lots of doctors, some have offered, aah, (deep breath) pills. I've had two doctors, actually, that have actually offered medicine to help me with it. Most of them suggest weight programs. Ya know, like Weight Watcher's or like that. Weight Watcher's is good for some people, it's great for some people. But for me, it has never worked (deep breath and long sigh).

Jill offers no excuse for why the doctors' suggestions and methods have never worked. The accounts she offered previously, in the section on Personal Preferences, were filled with excuses and justifications, providing a measure of credibility and acceptance that extend to her failed weight loss attempts. The additional influence of frustration and little success is expressed by Jill verbally, "but for me, it has never worked," and nonverbally with a sigh and deep breath. Jill, Emily and Dianne are examples of the individuals with multifaceted issues surrounding their failed attempts to

keep from gaining weight. They are among a growing majority that find the one-size-fits-all solution does not work for all. Meanwhile, despite the latest estimates that 61% of U.S. adults are either overweight or obese (National Center for Health Statistics 2000), overweight behaviors are still considered inappropriate or deviant and diet-and-exercise programs remain the cure.

Gaining back weight that has been lost is not uncommon; as much as two thirds of weight lost is regained within one year and almost all weight lost is regained in five years (Dortch 1997; National Institutes of Health 1992). Nevertheless, some individuals are successfully maintaining their weight. We will see that they too have fears, which incorporate additional influences to the process of making life choices.

Betty is one of a very small percentage that is able to maintain weight loss over an extended period. She began her account by explaining how she changed the influences in her life to support weight loss. However, her fear of gaining back weight surfaces, and is a priority behind her choices.

The oldest person in the study (over 60), Betty, also has the lowest BMI (22), with her weight in the *normal* range. Betty is in a program to maintain her weight after having reached her goal. She talked about what influenced her in making a choice among the many available weight loss programs.

> I had tried Weight Watchers, but I found it to be very expensive, which I probably could have afforded. But I didn't find any warmth, any help, just kinda cold. So I quit. Then I met these ladies that were going to this TOPS club. They were having so much fun and talking about the fun they had. I had no friends [in Denver], I didn't know anyone. But in going there [TOPS] . . . I could start losing the weight I had gained.

The combination of warmth and fun led to comfortable circumstances that worked to Betty's advantage and provided a path of least resistance toward losing weight rather than

toward gaining it. She also developed preferences about her food choices and places to eat that now support her desire to stay healthy. In turn, these positive factors provide her with additional influences that lead toward a path of least resistance for continued weight maintenance. Betty gives this account:

> Well, on my mind is constantly low fat...and I probably think about food almost all day long. We like to go out and eat...we tried out lots of restaurants, and we found this one restaurant, IHOP. It's where I could order . . . I like that and they will serve you pretty much what you ask for. And a lot of restaurants don't have eggbeaters. Because if your not going to enjoy what your eating, then your going to end up looking for food all the day long that's gonna satisfy you.

Betty has a host of eating guidelines that revolve around weight maintenance. She wants a certain type of food, served specifically, and she wants to enjoy what she eats. As Betty's account reveals, keeping herself focused not only satisfies her needs; it provides a path of least resistance for her conscientious health choices. Focus and influential guidelines are appropriate and do not require an explanation. However, her fear of weight gain leads her to constantly think about food. Betty justifies having food on her mind all day as acceptable conduct, because she will feel better. Her facial expression and body language revealed her discomfort as she says:

> I didn't feel good at that weight . . . I used to not walk or do anything and I would get real depressed . . . I do it because I know I'm gonna feel better. I am pretty healthy for my age. I'm not obsessed, but I do think about it.

For Betty, being physically healthy and minimizing her fear with a sense of *self-fulfillment* because her weight is controlled, justifies conduct others may perceive as obsessive and therefore improper. Some researchers consider a constant need to monitor food consumption as a sign of excessive pressure to remain thin or as a sign of compulsive behavior (Averett and Korenman 1996; Dortch 1997).

Fear of weight gain is not an influence for Richard, because his decisive lifestyle for weight management is maintaining a supportive, healthy atmosphere. Richard is on the line between normal weight and being overweight. He says he is using information and techniques he has tested to help maintain the weight he lost by "having my body systems fairly well managed . . . so I feel good physically." Richard has positive weight management techniques that influence his lifestyle, therefore he does not fear regaining weight. In the course of several follow-up questions about decisions for his daily and leisure routines, Richard talked about exercise choices:

> I guess whether it would be fun for me and or the family . . . and what we enjoy is being active. If that was a decision that was made, it was made so long ago that it's such an automatic thing . . . we both enjoy being active. We enjoy being outside, the kids are following in that, it's just what we do. That's just our lifestyle. Just active.

Richard makes it clear that he and his family lead an active life that has become a path of least resistance not only for Richard, but also for his entire family. Unlike Betty, who views exercise as fear oriented weight control, Richard's response is "I do it because I love it and the health consequences are a natural fallout." Betty and Richard are both former overweight individuals who explain their behavior to maintain a healthy weight differently. Betty must justify the influences on her behavior while Richard regards his decisions as "automatic" and not in need of justification. Richard is an example of healthy weight maintenance, but he is also an exception. The continued rise in the prevalence of being overweight underscores the lack of healthy weight maintenance.

Healthy weight maintenance combined with the influence of everyday routines is sometimes at odds. The result is choices and decisions that do not support a decisive health conscious lifestyle, such as Richard's. The additional influences from ordinary

circumstances of daily living are interwoven into food and exercise decisions and choices. Emily has not found an answer to the influence of daily routines and implementing an exercise routine. She relates:

> My husband comes home and he's tired also, so it's kinda hard to carve out [time to exercise]. I've already carved out the time to go to school. So it's kinda hard, you kinda have to carve this time out of time that doesn't influence anybody and that wouldn't be cuttin' into my sleep. I haven't quite figured that one out yet.

Emily is aware that exercise will help in weight reduction, however with the influence of school and getting enough rest, she has not found a solution that accommodates the many aspects of her life. Emily is not excusing or justifying her behavior; she is attempting to understand it. Like the other participants in this study, she is addressing the health risks associated with being overweight, is influenced by the interconnected issues, and is trying to make sense of the multifaceted effects woven into everyday life.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

The decisions and resulting behaviors of overweight individuals are often not socially acceptable, despite the norms and values of society that encourage those very behaviors. Excess weight is not only socially unacceptable, economically it is a burden, and it is dangerously unhealthy, even deadly (Allison et al. 1999; Averett and Korenman 1996; English 1991; Mokdad et al. 1999; Must et al. 1999; Nestle and Jacobson 2000; Wolf and Colditz 1998). Physicians and health care providers often ignore obese and overweight patients, leaving them at the mercy of the one-size-fits-all governmental weight reduction guidelines or the expense and failure of the commercial diet industry (Galuska et al 1999; Federal Trade Commission 1999; Nestle and Jacobson 2000; U.S. Department of Health and Human Services 1999; Smith 1995). The life choices made by individuals in the face of a variety of inadequate solutions have resulted in a rising prevalence of being overweight to epidemic levels.

The choices made by the participants in this study often follow the path of least resistance resulting from the effect of other people, time constraints, personal preferences and a variety of additional influences. The aligning actions comprised of justifications and excuses, not only aid in receiving social approval of their behavior, but bring some measure of positive value to their choices and their paths. Therefore, with aligning

actions, life choices made by participants, even the negative ones, make sense in their perception of reality.

Making sense of daily reality is an important part of the ability to function in society. It is also an important foundation for the answer to why the prevalence of being overweight continues to increase. The success or failure to curb the increase in the prevalence of being overweight relies on the ability of individuals to comply with decades of recommendations to "eat less and exercise more." Caloric balance hinges on how that guideline fits into the everyday lives of overweight individuals and intertwines with the norms and values of society. The result has been a failure, in part, because the recommendation is insufficient; it does not consider people's lives. There is a need to consider the effects of others, time constraints, and additional influences in addition to "calories in and calories out."

There are two latent effects of having an approach that does not address realistic influences in the lives of people who are overweight. One, it ignores the tendency to take the path of least resistance resulting from the influences discussed; and two, it discounts the need for people to make sense of their choices through the use of accounts. Being thin is valued in the United States. Yet, individuals often encounter failure and frustration in their quest to achieve thinness. The importance of being thin is replaced with other goals and preferences, excuses and justifications provide a functioning mechanism and a way to make sense of it all.

Being overweight is clearly outside the norms and values of U.S. society. However, this society does value what contributes to overweight conditions, such as wanting the most for the money, eating out to save time, regarding giant sized portions as a good

value, advocating relaxation as the absence of exercise, and accepting a sedentary lifestyle. Overweight individuals, as well as many individuals of normal weight, are following a path of least resistance by accepting the present norms and values, even though such behavior is a health risk.

The responsibility to prevent being overweight is focused on the individual, not society. I am not arguing that people who are overweight are not at all responsible for that situation. I am arguing however that ignoring the context in which eating and exercise choices are made is a limited approach if the goal is to understand and curb the increasing prevalence of being overweight. This study suggests that pressure and influences outside of individuals exacerbate the problem. Future studies should investigate outside pressures and additional influences further.

Individuals lead fast paced lives working in sedentary conditions and often resort to easy, fast foods when they are mentally and physically exhausted in order to maintain their daily obligations. Therefore, to advocate the caloric balance recommendation (calories in versus calories out) when it does not consider other variables is to ignore a considerable part of the problem related to overweight issues. I agree with previous conclusions that the success of compliance with medical restrictions, changing behavior, and accepting the potential seriousness of the situation is largely dependent on social factors and life's influences (Blaxter and Cyster 1984; Cockerham 1998). I also agree with previous research that points to environmental and societal factors as crucial elements of weight control (Grundy 1998; Mokdad et al. 1999; Nestle and Jacobson 2000; Serdula et al. 1999). However, most of these studies conclude with recommendations that ultimately bring the responsibility back to the individual, without

addressing the societal factors that they point out. The focus therefore reverts to food and exercise choices, falling short of an adequate solution that is inclusive of all of the factors involved.

Although the prevalence of being overweight has continued to rise for decades, the recommendation for curbing the prevalence has remained unchanged. I agree that the basic tenet of calories in and calories out is a proven means of losing and maintaining weight. Nevertheless, because there are no workable guidelines in place by governmental agencies or obesity experts that adequately consider the multidimensional issues of being overweight, its prevalence will continue to rise.

I recommend that the latent effect of the influences from others, time constraints, personal preferences, and additional factors needs further research. A more sociological approach is preferred, one that examines the increasing prevalence of being overweight in its fullest context. Merely restricting and controlling behavior is not the answer to excess weight; a multifaceted problem requires a multifaceted answer. It is paramount that the approach does not categorize every obese and overweight individual the same, presenting a one-size-fits-all solution.

It is also important that physicians and health care providers become actively involved with overweight and obese patients in areas of education, prevention and intervention. In addition, I suggest that governmental agencies and health associations include implementation procedures in their preventative guidelines and treatment solutions. These procedures should center on individual, societal, and environmental elements that affect life choices, such as those uncovered in this study.

Finally, additional studies are needed that focus on issues of functioning in a society that both supports and condemns the conditions of excess weight. A multifaceted approach that considers the interwoven and complex issues associated with being overweight would begin to uncover the countervailing effects that have entrenched this problem for so many decades. Perhaps then we will see a decrease in the rising prevalence and unravel the problem of being overweight.

APPENDIX A

Table 1. Conversion of Height and Weight into Body Mass Index (BMI)

To use the table, find the appropriate height in the left-hand column. Move across the row to the appropriate weight. The number at the top of the column is the BMI for that height and weight.

BMI (kg/m^2)	19	20	21	22	23	24	25	26	27	28	29	30	35	40
Height (in.)	Weight (lb.)													
58	91	96	100	105	110	115	119	124	129	134	138	143	167	191
59	94	99	104	109	114	119	124	128	133	138	143	148	173	198
60	97	102	107	112	118	123	128	133	138	143	148	153	179	204
61	100	106	111	116	122	127	132	137	143	148	153	158	185	211
62	104	109	115	120	126	131	136	142	147	153	158	164	191	218
63	107	113	118	124	130	135	141	146	152	158	163	169	197	225
64	110	116	122	128	134	140	145	151	157	163	169	174	204	232
65	114	120	126	132	138	144	150	156	162	168	174	180	210	240
66	118	124	130	136	142	148	155	161	167	173	179	186	216	247
67	121	127	134	140	146	153	159	166	172	178	185	191	223	255
68	125	131	138	144	151	158	164	171	177	184	190	197	230	262
69	128	135	142	149	155	162	169	176	182	189	196	203	236	270
70	132	139	146	153	160	167	174	181	188	195	202	207	243	278
71	136	143	150	157	165	172	179	186	193	200	208	215	250	286
72	140	147	154	162	169	177	184	191	199	206	213	221	258	294
73	144	151	159	166	174	182	189	197	204	212	219	227	265	302
74	148	155	163	171	179	186	194	202	210	218	225	233	272	311
75	152	160	168	176	184	192	200	208	216	224	232	240	279	319
76	156	164	172	180	189	197	205	213	221	230	238	246	287	328

Body weight in pounds according to height and body mass index.

Adapted from Bray and Gray
Obesity, Part I, Pathogenesis, *Western Journal of Medicine* 1988:149
Retrieved from http://www.consumer.gov/weightloss/bmi.htm

APPENDIX B

Table 2. Standard Definitions of BMI Weight Range and Associated Disease Risk

Risk of Associated Disease According to BMI and Waist Size			
BMI		Waist less than or equal to 40 in. (men) or 35 in. (women)	Waist greater than 40 in. (men) or 35 in. (women)
18.5 or less	Underweight	--	N/A
18.5 - 24.9	Normal	--	N/A
25.0 - 29.9	Overweight	Increased	High
30.0 - 34.9	Obese	High	Very High
35.0 - 39.9	Obese	Very High	Very High
40 or greater	Extremely Obese	Extremely High	Extremely High

Adapted from Bray and Gray
Obesity, Part I, Pathogenesis, *Western Journal of Medicine* 1988:149
Retrieved from http://www.consumer.gov/weightloss/bmi.htm

APPENDIX C

Table 3. Obesity Prevalence in Adults and Mean Weight by Year, 1991 to 1998*

	1991	1992	1993	1994	1995	1996	1997	1998
Obese, %								
Total	12.0(0.18)	12.7(0.17)	13.6(0.17)	14.4(0.18)	15.3(0.20)	15.8(0.17)	16.4(0.16)	17.9(0.17)
Men	11.7(0.26)	12.3(0.24)	13.7(0.26)	14.6(0.28)	15.6(0.32)	15.5(0.25)	16.6(0.26)	17.7(0.25)
Women	12.2(0.24)	13.0(0.23)	13.5(0.22)	14.2(0.23)	14.9(0.24)	16.1(0.22)	16.3(0.22)	18.1(0.23)
Weight,kg								
Total	73.1(0.09)	73.6(0.08)	74.0(0.08)	74.5(0.09)	75.0(0.10)	75.2(0.08)	75.5(0.08)	76.2(0.08)
Men	81.5(0.12)	82.0(0.11)	82.4(0.11)	83.1(0.12)	83.5(0.15)	83.4(0.11)	83.8(0.11)	84.4(0.11)
Women	65.1(0.10)	65.7(0.09)	66.1(0.09)	66.4(0.09)	66.9(0.10)	67.4(0.09)	67.6(0.09)	68.4(0.09)

*Data were collected using the Behavioral Risk Factor Surveillance System, a cross-sectional random-digit telephone survey. Data in parentheses are SE.
Source: JAMA, October 27, 1999—Vol. 282, page 1520.

APPENDIX D

Table 4. Changes in Obesity Prevalence in Adults by Characteristics*

Characteristic	1991	1998	Difference	% Increase
Sex				
Men	11.7 (0.26)	17.7 (0.25)	6.0	51.5
Women	12.2 (0.24)	18.1 (0.23)	5.9	47.4
Age, years				
18-29	7.1 (0.29)	12.1 (0.34)	5.0	69.9
30-39	11.3 (0.34)	16.9 (0.35)	5.6	49.5
40-49	15.8 (0.48)	21.2 (0.41)	5.4	34.3
50-59	16.1 (0.58)	23.8 (0.51)	7.7	47.9
60-69	14.7 (0.52)	21.3 (0.53)	6.6	44.9
≥ 70	11.4 (0.53)	14.6 (0.42)	3.2	28.6
Race				
White	11.3 (0.18)	16.6 (0.18)	5.3	47.3
Black	19.3 (0.68)	26.9 (0.62)	7.6	39.2
Hispanic	11.6 (0.76)	20.8 (0.74)	9.2	80.0
Other	7.3 (0.88)	11.9 (0.87)	4.6	62.0
Education levels				
<High school	16.5 (0.48)	24.1 (0.56)	7.6	46.0
High school	13.3 (0.30)	19.4 (0.30)	6.1	46.1
Some college	10.6 (0.36)	17.8 (0.32)	7.2	67.5
≥ College	8.0 (0.30)	13.1 (0.27)	5.0	62.9
Smoking status				
Never	12.0 (0.24)	17.9 (0.24)	5.9	48.5
Ex-smoker	14.0 (0.37)	20.9 (0.36)	6.9	49.4
Current	9.9 (0.32)	14.8 (0.33)	4.9	50.3

*Data are presented as mean (SE) percentage unless otherwise indicated.
Source: JAMA, October 27. 1999—Vol. 282, page 1520.

APPENDIX E

Table 5. Estimated Number of Deaths Attributable to Obesity in the United States in 1991*

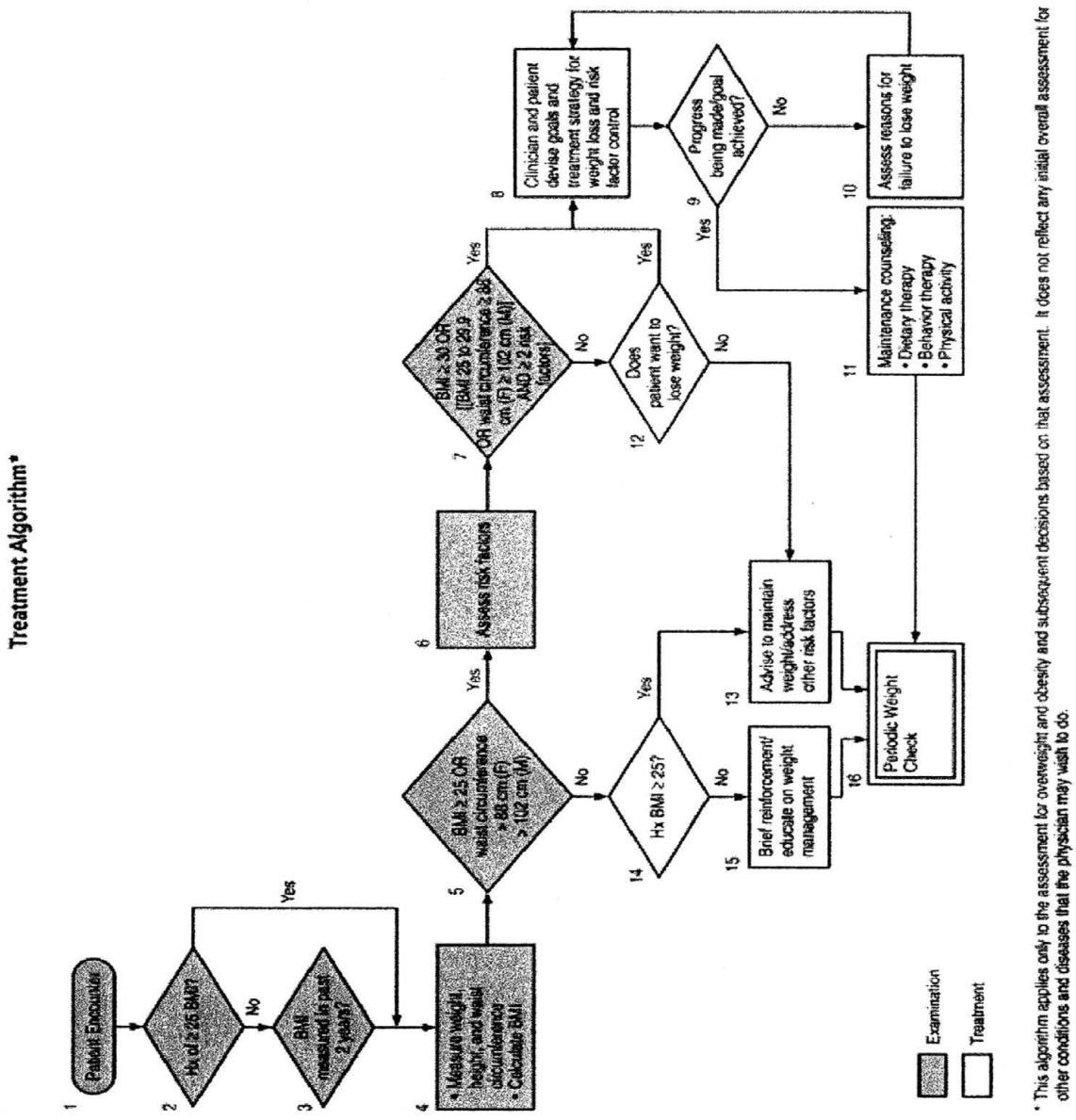
BMI, Kg/m2	**Alameda County Health Study**	**Framingham Heart Study**	**Tecumseh Community Health Study**	**Amer. Cancer Society Prev. Study**	**Nurses' Health Study**	**NHANES I Epidem. Follow-up**
	Based on	Data From	All Subjects	In Each	Data Set	
25 to <26	-1913	-5297	27029	3018	-11082	-4830
26 to <27	-15833	15269	-14132	9394	-5005	16277
27 to <28	21046	4703	14365	10160	11100	-3830
28 to <29	21965	7976	-6588	13228	19783	38561
29 to <30	16912	32065	-4618	17122	25804	5263
30-35	82357	147380	113602	90472	123784	88163
>35	216619	123297	117759	100867	122384	96507
Total	**341153**	**352393**	**247417**	**244261**	**286768**	**236111**
Based on	Data From	Nonsmoking	Or Never	Smoking	Subjects	
25 to <26	-6904	12719	25723	6460	0	-16642
26 to <27	-14543	10380	19464	12102	8071	-10293
27 to <28	24326	17286	-19083	12819	22993	-4913
28 to <29	6121	29509	-17857	15896	31249	14635
29 to <30	10498	47610	26621	16394	39826	20356
30-35	146729	119602	154377	92635	165392	145494
>35	217183	119354	73588	106235	108635	159593
Total	**383410**	**356460**	**262833**	**262541**	**376166**	**308230**

*Negative values for a body mass index (BMI) category occur when the estimated hazard ratio in that category is less than 1.0. Were such values statistically different (none were), this would imply that these BMI levels were "protective" relative to a BMI of 23 to 25 kg/m2. Alternately, these values may represent random fluctuations owing to sampling variation.

Source: JAMA, October 27, 1999—Vol. 282 page 1534.

APPENDIX F

Illustration 1. Sample Examination and Treatment Plan



Adapted from Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults
National Institutes of Health Pub. 98-4083.
Retrieved from http://www.nhibi.nih.gov/guidelines/obesity/sum_clin.htm

APPENDIX G

Research Participants' Information and Confidentiality Sheet

You have been asked to participate in a study that is part of a thesis project entitled:

THE RISING PREVALENCE OF BEING OVERWEIGHT:

LIFE CHOICES, INADEQUATE OPTIONS

- You may obtain answers to pertinent questions about this study by telephoning:

  Carol D. Bronn 512-440-8048 E-mail cdj3@flash.net Thesis Author
  Dr. Barbara Trepagnier 512-245-8054 - Office 512-245-2113 - Department

- Participation in this study is voluntary; you may withdraw your consent to participate at any time.

- You have the right to a description of the nature and purpose of this study.

- You have the right to be given an opportunity to ask questions concerning the study, the procedures involved, and confidentiality steps taken.

- You have the right to be given the opportunity to consent or not to consent to participation in the study without any element of force, fraud, deceit, duress, coercion, or undue influence on your decision.

- Your confidentiality will be respected and your identity will not be revealed to anyone other than the author or the advising chairperson, as listed above.

- Any reference to your responses and answers will be done in a manner to protect your identity and confidentiality.

APPENDIX H

Life Choice Interview Questions

Introduction: During any given day each of us makes choices and decisions about what foods we eat and where we eat. Choices and decisions are also made about how we believe food and exercise effect our health. The following questions are interested in what all is taken into consideration when these choices and decisions are made. The results of why we end up choosing some types of foods and types of physical exercise over others and how all of this effects weight and health is my goal.

1. Are you currently participating in a program to lose or maintain your weight?
   a. If so, why are you in the program?
      Have you participated in any weight loss or weight control program in the past?
      If so, what were the results?
   b. If not, do you do anything special on your own to lose or maintain your weight?
      If so, has it had a positive effect?
   c. (Follow-up questions, as needed, per circumstances.)

2. On an average day, what are the three most important things that influence the decision of where you eat and what you eat?
   a. Do you usually use ready to eat foods or cook from scratch?
   b. (Follow-up questions, as needed, per circumstances.)

3. Would you call yourself a physically active person?
   a. If so, what activities do you do? What enables you to stay active or might get in the way of doing activities?
   b. If not, what influences that decision?
   c. (Follow-up questions, as needed, per circumstances.)

4. Have you discussed the subject of being overweight with your doctor?
   a. If so, did the doctor offer any helpful information?
   b. Has your doctor ever told you about the health risks associated with being overweight?
   c. (Follow-up questions, as needed, per circumstances.)

5. As you proceed through your daily activities (daily routines), what are some of the choices concerning work, family, or leisure that call for a decision on your part and in the long run have an effect on your weight?
   a. What are some of the things that you take into consideration that usually helps make these choices?
   b. (follow-up questions, as needed, per circumstances.)

APPENDIX I

Background and Demographic Information

a. Name:

b. Birth Place:

c. Place you live now:

d. Ethnic Background:

e. Male ( ) Female ( )

f. Age Group (18-30)____ (31-45)____ (46-60)____ (over 60)____

g. Education:

h. Occupation:

i. Religious Background:

j. Marital Status:

k. Body Mass Index (BMI)____

APPENDIX J

Table 6. Thematic Analysis: Information, Emerging Patterns, and Influences

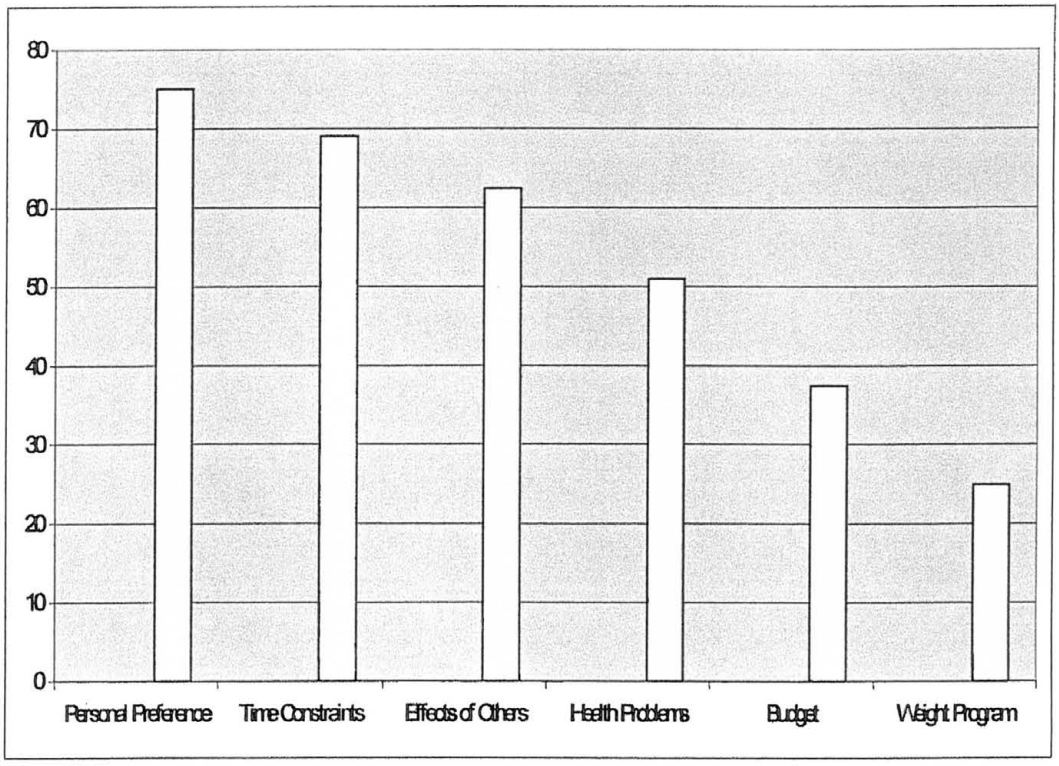
	Donna	Anna	Ruby	Rebecca	Julia	Karl	Rosa	Leia
Sex	F	F	F	F	F	M	F	F
Age	31-45	46-60	46-60	31-35	46-60	46-60	46-60	31-45
Education	BA	HS	HS	BA	AS	HS +	BA +	HS, trade
Marital	M	M	M	M	M	S	M	M
Racial Eth	C	C	C	C	AA	C	H	Fil
BMI	35	24	40	35	33	35	28	30
In Progrm	N	Y	Y	Y	Y	Y	Y	Y
Factors	work	appear.	spouse	time	spouse	work	availability	budget
food	speed	health	children	work	diet	time	taste	available
food	conven.	daughter	budget	schedule	mind set	budget	spouse	work
Phy Active	N	Y	N	medium	N	N	N	medium
Dis w/Doc	Y	N	Y	Y	N	Y	Y	Y
Know Risk	Y	Y	Y	Y	Y	Y	Y	Y
Doc Visit	P	P	P	N	P	N	P	N
Influences	long hrs	lifestyle	stress/wrk	work	health	conven.	nutrition	spouse
daily	no time	activity	anger	time	others	time	cost	health
daily	no exercis	cook scrat	no time	long hrs.	work	taste	others	worry/fear
daily	preference	preference	no leisure	easy	preference	preference	preference	mind set

	Michael	Max	Betty	Emily	Richard	Victoria	Dianne	Jill
Sex	M	M	F	F	M	F	F	F
Age	31-45	18-30	over 60	31-45	31-45	46-60	46-60	31-45
Education	BA	HS,trade	HS, trade	BA +	MA	HS	HS +	BA
Marital	S	S	M	M	M	M	M	S
Racial Eth	C	C	C	C	C	H	C	C
BMI	33	45	22	40	26	29	31	42
In Progrm	N	N	Y	Y	Y	Y	N	Y
Factors	time	mind set	diet	health	health	time	spouse	others
food	work	preference	preference	easy	preference	work	health	budget
food	available	budget	taste	time	spouse	spouse	preference	diet
Phy Active	Y	N	Y	N	Y	Y	N	N
Dis w/Doc	N	Y	Y	Y	N	N	Y	Y
Know Risk	Y	Y	Y	Y	Y	Y	Y	Y
Doc Visit	P	N	P	P	P	N	P	P
Influences	limitations	preference	mind set	fatigue	family	health	health	school
daily	satisfying	others	health	time	satisfying	mind set	spouse	no time
daily	long hrs.	fatigue	active	family	preference	work	diet	preference
daily	preference	satisfying	satisfying	preference	active	fatigue	satisfying	health

In Progm= In weight loss program
Factors (food)= Impacts where and what eaten
Doc Visit= Positive/negative outcome
Influences (daily)= Impacts food and exercises choices
Phy Active= Physically active
Dis w/Doc= Discuss weight with doctor
Know Risk= Aware of health risks

APPENDIX K

Illustration 2. Influence Categories and Percentages



Personal Preference	75.0 %	Health Problems	50.0 %
Time Constraints	69.0 %	Budget	37.5 %
Effect of Others	62.5 %	Weight Program	25.0 %

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