BARIATRIC COACHING APPROACH TO OPTIMAL WEIGHT WELLBEING AFTER WEIGHT LOSS SURGERY

by

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This dissertation is dedicated to all those individuals who have suffered or who are suffering from the chronic disease of obesity. In resounding support of their hopes and dreams for a better state of health and a better quality of life.

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In this dissertation, I explore the benefits of using a bariatric coaching approach with obese clients pre-, peri-, and post-surgical weight loss. The word bariatric comes from the Greek root, "baros″ meaning weight and ″iatric″ meaning some type of medical management of weight. (American Heritage Stedman's Medical Dictionary, n.d., 2015) Bariatric coaching is to acknowledge the specific impact that a client's weight has on every aspect of their being. It is professional life coaching and human development focused specifically on how a person's weight affects their mind, body and soul. The bariatric client's thinking, body image, social experience and support, their ability to change and internalize new life style thinking and behavior patterns, are affected by their body weight. Specifically, interventions related to bariatric surgical weight loss coupled with professional coaching, can improve and

inspire the internalization of long-term health behaviors that optimize the health and life of obese clients. Bariatric coaching can empower the individual through this specific life journey. This dissertation will explore how coaching skills can create and optimize long-term lifestyle changes and maintenance of healthy behaviors over a lifetime. It will also present bariatric coaching skills that are specific and effective in decreasing the immediate challenge of weight recidivism in 30% of bariatric clients (de Gara, 2014).

I hope to demonstrate how a bariatric coaching approach leads to internalization of healthy values and beliefs that move the individual to optimal long term lifestyle behavior change in the obese client. The faulty and self-sabotaging lifestyle beliefs and behaviors of the obese client challenge the professional coach. This manuscript will show the professional coach, other health-care providers and the multidisciplinary team, how to assist the obese client to become aware of his/her self-limiting ideas. The obese client must fully participate in the formulation of new beliefs, behaviors, and actions that lead to optimal health and life wellbeing through the creation of health in harmony. Stapleton describes what it takes to maintain optimal weight loss after weight-loss surgery and that a great deal of change in thought patterns needs to occur over time (Stapleton, 2009).

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CHAPTER 1

PROBLEM FORMULATION

Introduction

The problem of obesity has become an epidemic that globally affects more than a billion adults and at least 300 million of them are clinically obese. Clinically obese is someone with a BMI of 30. (See BMI table located in the appendix.) Current obesity levels range from below 5% in China, Japan, and certain African nations, to over 75% in urban Samoa. But even in relatively low-prevalence countries like China, rates are almost 20% in some cities (World Health Organization, 2000). This chronic disease of obesity is a financial and social burden to the global community resulting in disability and many chronic metabolic diseases. It can often coexist in developing countries with under-nutrition; obesity is a complex condition with many serious social, psychological, and physiological dimensions, affecting all ages and socioeconomic groups. Obesity and overweight pose a major risk for metabolic and chronic diseases, including type 2 diabetes, cardiovascular disease, hypertension, stroke, and certain forms of cancer, sleep apnea, degenerative disc, and joint disease. The long-term health consequences range from increased risk of premature death to serious chronic conditions that reduce the overall quality of life. Of special concern is the increasing incidence of child obesity. Childhood obesity is already epidemic in some areas and on the rise in others. An estimated 22 million children under 5 are estimated to be overweight worldwide. According to the US Surgeon General, in the

United States the number of overweight children has doubled and the number of overweight adolescents has trebled since 1980. The prevalence of obese children aged 6 to 11 years has more than doubled since the 1960s. Obesity prevalence in youths aged 12–17 has increased dramatically from 5% to 13% in boys and from 5% to 9% in girls between 1966–70 and 1988–91 in the United States. The problem is global and increasingly extends into the developing world; for example, in Thailand the prevalence of obesity in 5 to 12 year old children rose from 12.2% to 15.6% in just two years (World Health Organization, 2000).

Obesity accounts for 2–6% of total health care costs in several developed countries; some estimates put the figure as high as 7%. The true costs are undoubtedly much greater, as not all obesity-related conditions are included in the calculations (World Health Organization, 2000). Here in the United States some of the key causes of obesity are reduced physical activity and increased consumption of energy-dense foods high in saturated fats and sugars, such as high fructose corn syrup. These factors have led to rising obesity rates that have doubled since 1980 in some areas of North America, the United Kingdom, Eastern Europe, the Middle East, the Pacific Islands, Australia, Asia, and China (World Health Organization, 2011; Chan, 2011). The obesity epidemic is not restricted to industrialized societies. This increase is often faster in developing countries than in the developed world (World Health Organization, 2000).

The continued rise of epidemic proportions can be seen quite clearly on the Centers for Disease Control website. (Centers for Disease Control and Prevention-Obesity, 2015) This epidemic reflects the profound changes in society and in

behavioral patterns of communities over recent decades. While genetics are important in determining a person's susceptibility to weight gain, energy balance is determined by calorie intake and physical activity. Thus, societal changes and worldwide nutrition changes are driving the obesity epidemic. Economic growth, modernization, urbanization, and globalization of food markets are just some of the forces thought to underlie the epidemic.

When incomes rise and populations become more urban, diets become diminished in complex carbohydrates and give way to more varied diets with a higher proportion of fats, saturated fats, and refined sugars. Additionally, large shifts toward more sedentary and less physically demanding work have been observed worldwide (World Health Organization, 2000). Around the world we are seeing a cultural movement toward less physical activity and the increasing use of automated transport, technology in the home, and more passive leisure pursuits. In the health-care arena and in society we have treated obesity, as opposed to coaching the obese client toward a weight of optimal health well-being.

Overweight and obesity lead to adverse metabolic effects on blood pressure, cholesterol, triglycerides, and insulin resistance. Some confusion of the consequences of obesity arises because researchers have used different BMI numbers as cut-offs to define obesity, and because the presence of many medical conditions involved in the development of obesity may confuse the effects of obesity itself.

The debilitating health problems associated with obesity include respiratory difficulties, chronic musculoskeletal problems, skin problems, and infertility. The more life-threatening problems fall into four main areas: cardiovascular disease

problems; conditions associated with insulin resistance such as type 2 diabetes; certain types of cancers, especially the hormonally related and large-bowel cancers; and gallbladder disease.

The likelihood of developing Type 2 diabetes and hypertension rises steeply with increasing body fatness. Confined to older adults for most of the 20th century, this disease now affects obese children even before puberty. Approximately 85% of people with diabetes are type 2, and of these, 90% are obese or overweight. And this is increasingly becoming a developing world problem. I n 1995 the emerging market economies had the highest number of diabetics. If current trends continue, India and the Middle Eastern crescent will have taken over by 2025. Large increases in diabetes will also be observed in China, Latin America and the Caribbean, and the rest of Asia (World Health Organization, 2000). Raised BMI also increases the risks of cancer of the breast, colon, prostate, endometrial, kidney, and gallbladder. Chronic overweight and obesity contribute significantly to osteoarthritis, a major cause of disability in adults. Although obesity should be considered a disease in its own right, it is also one of the key risk factors for other chronic diseases, together with smoking, high blood pressure, and high blood cholesterol. In the analyses carried out for World Health Report 2002, approximately 58% of diabetes and 21% of ischemic heart disease and 8–42% of certain cancers globally were attributable to a BMI above 21 kg/m2. Weight-loss surgery is now an option to most individuals who are at least 80 pounds over recommended weights by the National Institute of Health in 2001. Most insurance companies cover weight-loss surgery, yet only 1% of those eligible have

considered this option. Many of these individuals continue to increase their weight yearly, developing new chronic diseases and suffering a decreased level of health.

How do we as professional coaches win the hearts of the obese client so that we can assist them in discovering their own best thinking and lifestyle to optimize their life wellbeing? (National Task Force on the Prevention and Treatment of Obesity, 2002).

After significant weight loss through surgery an individual may lose from 80–200 pounds or essentially the size of a "person," this state often leads to a transformational process in mind, body, and spirit. This transformation can lead to continued success or weight regain, called *recidivism* (de Gara, 2014). In about 20–30% of the population of individuals who have weight-loss surgery we see weight regain of 20–50 pounds. Those individuals who lose weight with diet and exercise alone have 95% weight recidivism. Many of these people tend to feel shame and guilt, or "a failure" and often are lost to health care follow up. In the past we have used didactic education and teaching methods to assist individuals with weight loss. We use learning styles and give information hoping the clients or patients will change their behavior. This is often a short-term solution because underlying beliefs, habits have not been questioned or changed, and when a designated time frame is over the client reverts back to their old comfortable habits based on old values and beliefs. This is a key area where the Bariatric Life Coach can assist the obese or bariatric client to look at underlying values and beliefs to change them so that new healthy values and beliefs can internalize long-term healthy lifestyle choices. In some cases there is a mechanical problem with the surgery due to enlarged stoma, stretched pouch, or a slipped band.

The medical community's definition of weight-loss success after surgery is 50% maintained loss of excess weight for 5 years. If you have 100 pounds to lose and you lose 50 pounds you are considered successful in the medical community. Many co-morbid medical conditions are resolved with 50% weight loss. However, for most clients, if they are 100 pounds over ideal weight, they do not feel personally successful if they only lose 50 pounds. Bariatric Professionals see significant recidivism at 2 years post-op Roux-en-y bypass surgery, the gold standard of weight-loss surgery procedures. Another surgery that is gaining in popularity over the past 4 years is called the Vertical Gastrectomy. These surgeries along with the Lap-band are illustrated in the appendices. This is another key opportunity for Bariatric Life Coaches to assist these clients in optimizing their health and life. Perhaps this weight re-gain is due to magical thinking relying on surgical intervention to do all of the work rather than internalizing new healthy lifestyle behaviors. For the bariatric coach, weight loss surgery is a powerful tool, not a cure for obesity.

Background of the Study

According to Merriam-Webster.com, the word *treating* comes from *treat*, which means to care for or deal with medically or surgically, treat a disease. (Merriam-Webster's, 2009) Treating obesity generally relates to chemicals in the form of drugs, medical in the form of treatments, weight-loss surgery or other related surgeries.

This dissertation will evaluate the effectiveness of the traditional approach to weight-loss education after bariatric surgery vs. bariatric coaching for continued and sustained weight loss. The traditional approach of treating is considered a uniformed prepackage didactic approach, defined as giving new and pertinent information

regarding strategies for weight loss with no regard for client values, beliefs, or habits to deal with this new bariatric weight-loss tool called surgery. This strategy works for many people for a limited amount of time. The didactic approach and information comes from our national bariatric society called the American Society of Metabolic and Bariatric Surgeons, with over 4,000 members in the United States and a strong international presence as well. Evidenced-based didactic information is shared at conferences frequently each year as well as many online and long-standing resources for general healthy adult weight. Bariatric life coaching is health coaching specifically for those individuals dealing with excess weight. It is a combination of life, personal, health, and business coaching. Bariatric coaching assists obese clients to discover their vision or expected outcomes related to optimizing their own health in harmony. Health in harmony is a state of health that might be considered the optimal way of living and a life of wellbeing for any given individual. There are unique coaching skills needed to coach the obese client in discovering their values, beliefs, and behaviors and how they are influenced by their body weight. Bariatric life coaching will assist the bariatric client in dealing with the amazing life transitions that may result from losing 50 to 100 pounds (Appel, 2011).

Goal setting and Goal Getting as described by Cook (Back on Track, 2005) are integral parts of the process of coaching. Cowen describes the coaching field as, someone who works with a professional coach, is the practice of supporting an individual, referred to as a coachee or client, through the process of achieving a specific personal or professional result. The structure and methodologies of coaching are numerous but are predominantly facilitating in style. That is to say the coach

mainly asks questions and challenges the coachee (Cowen, 2010). The life coaching field is different from the therapeutic and counseling fields of discipline. It can be defined as a mentor or skilled individual who assists people with decision making, goal setting, and reaching those goals, as well as dealing with problems stated by the person being coached (Merriam-Webster's, 2015c).

Life coaching is a practice with the aim of assisting clients to determine and achieve personal goals. Life coaches use multiple methods that will help clients with the process of setting and reaching goals. Coaching is not targeted at psychological illness and coaches are neither therapists nor consultants. Life coaching has its roots in executive coaching, which itself drew on techniques developed in management consulting and leadership training. Life coaching also draws inspiration from disciplines including sociology, psychology, career counseling, mentoring, and other types of counseling. Coaches may apply mentoring, values assessment, behavior modification, behavior modeling, goal setting or goal getting (Cook, 2005) and other techniques in assisting their clients.

Life coaching focuses on effecting change in a client's current and future behavior. Life coaching does not delve into diagnosing mental illness or dysfunction.

According to a survey of coaching clients, the coach may serve as a reflective listener and a cheerleader or inspirer or motivator; these were the top roles selected for a coach. Clients are looking for a coach to provide a mirror for feedback. There are a variety of approaches within the coaching methodology. Life coaching is performed with individuals and groups, in person, over the phone, and online.

The facilitative approach to coaching in sport was pioneered by Timothy Gallwey (1970); before this time sports' coaching was and often remains solely a skills-based learning experience from a master in the sport. Other contexts for coaching include executive coaching, life-coaching, emotional intelligence coaching, and wealth coaching.

Today, coaching is widespread. For example, Newcastle College registered 15,000 students on its Performance Coaching Diploma Course from launch and within its first 4 years. (How To Do : A more succinct definition positions coaching as follows Managing is, 2013) The United Kingdom's Chartered Institute of Personnel Management reports that 51% of companies "sample of 500" "consider coaching as a key part of learning development" and "crucial to their strategy," with 90% reporting that they "use coaching." (How To Do : A more succinct definition positions coaching as follows Managing is, 2013) The basic skills of coaching are often developed in managers within organizations specifically to improve their managing and leadership abilities, rather than to apply in formal one-to-one coaching sessions. These skills can also be applied within team meetings and are then akin to the more traditional skills of group facilitation.

Personal coaching is a relationship that is designed and defined in a relationship agreement between a client and a coach. It is based on the client's expressed interests, goals, and objectives. The coach brings to the relationship a set of coaching skills or competencies (International Coach Federation, 2013). A professional coach may use inquiry, reflection, requests, and discussion to help clients identify personal and/or business and/or relationship goals, develop strategies,

relationships, and action plans intended to achieve those goals. A coach provides a place for clients to be held accountable to themselves by monitoring the clients' progress toward implementation of their action plans. Together they evolve and modify the plan to best suit the client's needs and environmental relationships. Coaches often act as human mirrors for clients by sharing outside and unbiased perspectives. Coaches may teach specific insights and skills to empower the client toward their goals. Clients are responsible for their own achievements and success. The client takes action, and the coach may assist, but never leads or does more than the client. Therefore, a coach cannot and does not promise that a client will take any specific action or attain specific goals.

Professional coaching is not counseling, therapy, or consulting these different skill sets and approaches to change may be adjunct skills and professions. Counseling is defined as to give counsel or give advice. An expert would give advice on a particular subject. Counseling is the act of exchanging opinions and ideas (Merriam-Webster's, 2015b); consultation is giving expert opinion (Merriam-Webster's, 2015a). Therapy is defined as the treatment of disease or disorders, as by some remedial, rehabilitating, or curative process: speech therapy or a curative power or quality or psychotherapy (Merriam-Webster's, 2015e). Consulting is defined as employed or involved in giving professional advice to the public or to those practicing the profession such as medicine, business, and personal. The body of positive psychology research, however, indicates that a coaching orientation is an effective and valid perspective. It is our belief that positive psychology theory and research will provide the scientific legs upon which the field of coaching can firmly stand (Kauffman, 2013).

Health coaching preparation and models can be seen all over this country. In the United States there is no official accreditation or national board certification for profession coaches. Duke University began offering an Integrated Health Coach Certificate Program in 2008. In the world of health and wellness, the health coach has an emerging new role to optimize a client's or patient's health and wellness. Health coaching is becoming recognized as a new way to help individuals manage their illnesses and conditions. It is especially valuable to those of a chronic nature. In both sports and health, a coach is a person who observes, gives objective feedback, teaches, helps to develop a plan of action and hold another responsible for their actions and commitments. The coach will use special techniques, personal experience, expertise, and encouragement to assist the coached individual in bringing about his/her behavioral changes. Duke University is one of the first in this country to recognize the health benefits of health coaching as defined below. Duke University's Program for Integrative Health Coaching is defined as follows:

A health coach promotes a thorough understanding of the the integrative health care model. They develop effective integrative health coaching skills for use with individuals and groups. The health coach enhances participants skills sets, knowledge, and professional marketability. Health coaches create dynamic partnerships with people who wish to adopt lifestyle changes that will help them reach their short and long term goals for satisfying and healthful lives. They help people clarify their health goals and implement and sustain behaviors, lifestyles, and attitudes that are conducive to optimal health. They guide people in their personal care and health maintenance

activities and assist people in reducing negative impact made on their lives by chronic conditions such as cardiovascular disease, cancer, and diabetes. (Duke Health, 2008) Developing and learning new ways of thinking and doing things related to optimal health, is a life-long journey. This journey is diverse and uniques to individuals based on their life experience and their desire to change. Prochaska and his co-authors describe creating lasting change as a process in which he uses the change model. The first use of this model in the psychological arena was seen in a linear fashion, they now describe it as a spiral model of stages that an individual goes through when creating change. This model consists of six basic steps: Precontemplation, contemplation, preparation, action, maintenance, and termination. (Prochaska, 2010) This model can be applied to any area of chronic disease where lifestyle change can improve outcomes or where change is wanted.

This researcher was not able to locate much information on Bariatric Coaching in the research literature. My colleagues and I have been using the coaching skill set with our Bariatric clients and patients for over 10 years and have begun to see an increased internalization of healthy lifestyle behaviors (C. Cook, J. Hall, and S. Lassetter, personal communication, January 30, 2003) An internet search did elicit many bariatric or weight-loss surgery coach training programs with varied requirements.

Statement of the Problem

The problem with health or bariatric coaching is that it has not been a well-defined or well-utilized and the preparation for health coaches is not consistent; the field of coaching has guidelines but is not licensed and oversight is not consistent (International Coaching Federation, 1995). Life coaching is the umbrella over health coaching and more specifically bariatric or weight-loss surgery coaching. Its awareness is well known in the general public and is just becoming legitimized in many university settings under the program area of health coaching. Some universities call it positive psychology or motivational interviewing and others call it health coaching. Many people have websites calling themselves bariatric coaches and offering training, but their training is not all the same and it seems extremely diverse. However, some universities like International University of Professional Studies are offering PhDs in Life Coaching, this will assist in defining its value as well as setting the standard of education to health care professionals. Using coaching in the health care setting has been done for the past 5 to 10 years. The coaching techniques have not been well defined or studied; the evidence is still at a phenomenological level. There is a critical need for more research in the area of health/wellness coaches, and more specifically bariatric coaches, to address chronic diseases in the area of weight loss to optimize a client's physical, mental, and spiritual life. There is also a need to define what education and preparation is needed to provide this critical service to those suffering from excess weight and weight recidivism so that individuals can maximize their optimal weight goals. Weight recidivism and non-optimal weight loss, after bariatric surgery is has many causes. How we approach it with the client or patient is

as critical as why it occurs. According to de Gara (2014) and Karmali et al. (2013) the causes can range from inappropriate patient selection to technical/anatomic or mechanical causes related to the original surgery. They reported their experience by establishing a dedicated weight recidivism and re-visional bariatric surgery clinic, in contrast to the majority of practices of bariatric surgeons who focus on primary bariatric surgeries (de Gara, 2014). Weight recidivism and sub-optimal weight loss post-bariatric surgery has significant societal, economic, and medical negative consequences. According to Karmali et al (2013) there is very limited understanding of how to predict which bariatric surgical patients are more likely to experience weight regain and suboptimal weight loss following surgery. It is also difficult to know how to appropriately treat patients or clients who have experienced these phenomena (Karmali et al., 2013).

Purpose of the Study

This dissertation is written for professional coaches, other professionals, and para-professionals who work with obese clients who want to see their clients or patients achieve optimal long-term health goals. It is for those clients or patients who are seeking to obtain optimal health through a plan, program, weight-loss surgery, or clients who would like to obtain optimal weight with other interventions. Professional coaches can learn to assist their clients and or patients to optimize and internalize their long-term health outcomes by assisting the client in creating their own optimal health through the utilization of coaching skills. This dissertation is targeted for professional life coaches, relationship coaches, health and wellness coaches, psychologists,

physicians, nutritionists, nurses, social workers, support group leaders, and integrative health support staff.

The purpose of this dissertation is to assist the professional coach and other health care providers in using a bariatric coaching approach with tools and a skill set in partnership with the obese client, and to assist the coach in optimizing the obese client's weight wellbeing. The Mayo Clinic states that people who regain weight after surgery are consuming too many high-calorie foods and beverages and do not get enough exercise. They may be grazing. Perhaps these people believe the surgery will do all of the work. According to the Mayo Clinic those people who are successful avoid high-sugar, high-fat foods, which provide many calories but few nutrients; they exercise regularly; take recommended vitamins and mineral supplements; attend regular follow-up appointments with their health care provider (Zeratsky, 2012). Lloyd Stegeman, MD, states that the key to prevention of weight regain is education and follow-up before and after weight-loss surgery (Stegeman, 2015). Clients/patients need to be taught how to use their surgery to optimize their success. I have observed over the past 10 years that implementing coaching skills allows weight-loss clients to internalize these new behaviors to suit their own lives, optimizing their own long-term outcomes. Dr. Stegeman also states that one of the most important things a program can do is create an environment in the clinic where the person feels comfortable coming, when they are doing well and when they are struggling (Stegeman, 2015). A coaching intervention can then be taken before significant weight regain. Arthur Frank, MD, Director of George Washington University Weight Management program,

states that they have found once people have lost weight and kept it off for 2 years they tend to maintain their weight (Sacks, 2009).

This dissertation contributes to the field of coaching and obesity as a foundational and conceptual tool-based approach. This tool can be used by the coach with their obese client to discover and rediscover new possibilities for their health and life. This concept of bariatric coaching can be used by the coach with the obese client to assess new possibilities in progressive moments in time.

This skill set of bariatric coaching will be demonstrated with several weight-loss support groups, Back on Track classes, and individual coaching from volunteer clients in the Santa Clara Valley of California. Their ages range from 30–65 and the ratio of female to male is 80/20%. Almost all have had weight-loss surgery of various types. Several coaching tools are used along with a set of bariatric coaching skills and a back-on-track guide that was modified with a coaching approach after years as primarily a didactic course (Cook, 2005).

Research Questions

In relationship to the bariatric patient or client, what is the difference in the level of involvement, commitment, and health improvement when a person participates in a coaching approach versus the more traditional didactic approach? Will there be a significant difference in the long-term outcomes related to overall health? What preparation does the bariatric coach need to be effective? What are the most effective tools that may assist the bariatric coach create focus for the client to measure or describe a client's change in thinking related to optimal weight and weight loss? The importance of this dissertation is in using a bariatric coaching approach with

preparation and tools along with obesity surgical treatment can maximize positive long-term health and life outcomes for the obese client. The biggest challenge facing a significant number of people in the bariatric community is maintaining healthy lifestyle behaviors over the long term and preventing weight regain. This process requires many changes in client thinking. Beck describes many of those changes in thinking related to, what it means to have hunger tolerance, changing ones definition of full, dealing with self-sabotaging thoughts, poor me syndrome, and recognizing thinking errors (Beck, 2015). Becks is a licensed psychologist and an expert in cognitive behavior therapy, the techniques for changing a person's thinking are helpful.

The Importance of the Study

The importance is to determine the degree of improvement in short- and long-term health outcomes when the coaching approach is used with bariatric surgery clients. The significance of using a focused coaching tool to assist the client in making a health plan with the bariatric coach will improve weight loss and maintenance. The significance of the bariatric coaching approach is the preparation of facilitators of support groups and with individuals who work closely with the bariatric patient or client. This coaching skill set should improve short- and long-term weight loss and health outcomes. The relevant literature will be presented that supports the need for an internalization of a post-surgical healthy lifestyle intervention plan. It will include the coaching research in related medical conditions such as coronary heart disease, diabetes, cancer, and other chronic disease conditions. This work contributes to coaching: A framework of coaching skills that are specific to the obese and bariatric

client to obtain optimal weight wellness. Many professional coaches, MD's, nurses, psychologists, counselors, social workers and para-professionals, as well as groups and individual dealing with the disease of obesity, will see improved weight and health outcomes. This observational study of coaching skills will demonstrate, that if it is used by professionals and paraprofessionals to assist a client or patient in empowering themselves toward a better life through internalizing optimal health behaviors and therefore improved health outcomes.

This study will also demonstrate the need for a structure training program for the coaches and the need for reliable tools to assist clients or patients to focus in various areas of their health plans. This study is just one tip of an iceberg in the field of bariatric and health coaching, to assist in determining what tools or set of skills lead to the best outcomes for all. It is exciting to see the many diverse tools and techniques that are coming into favor. There are very few tools specific to obesity and weight loss after bariatric surgery and this study is an attempt to evaluate several to determine their effectiveness in client attitude toward weight.

Laurie Beebe, RD, states weight-loss counseling does not create change but does cause immense frustration for the clients and the dieticians. When they use more of a coaching approach, listening more than talking, clients become more engaged in the process and more invested in developing a plan and setting health goals they can achieve. This approach does require a new skill set that is developed over time. To learn what motivates different individuals is a unique skill. One may define coaching as being fully present to establish relationship and create a sense of trust and to support accountability.

Coaching is client centered and gets the client involved in the process to optimize their own weight outcomes. Most of us do not like being told what to do. Assisting the clients to choose their own paths is much more empowering (Beebe, 2013). According to Miriam Hospital (2012), hospital researchers with the weight-control and diabetes center state that health coaches have increased in popularity recently; however, the empirical results that can be measured are extremely limited. The health-coach model is providing ongoing support, accountability, and a team approach with the client or patient at the center. Many professionals, as well as others, may use these coaching skills, such as, nurses, dietitians, social workers, psychologists, doctors, and peers, along with individuals who are facing or have faced a similar health challenge successfully. (Leahey, 2013) Kaiser hospital in Fremont, California is using a video health coaching series to support their surgical weight-loss patients. The topics included getting physical, the SMART eating plan, and stressing less (Kaiser Permanente, 2007). This shows how many health and bariatric coaching approaches there are with little empirical evidence to show the long-term effectiveness for sustained weight loss and maintenance after surgery. They are all searching for the most effective and economical approach and skill set that will improve weight-related health outcomes.

The Limitations of the Study

The limitations are that very little formal or informal coaching has been done in the area of bariatrics, and very little could be found in the literature. I believe the health coaching intervention could be applied to the bariatric or obese clients to improve long-term health and lifestyle outcomes. The scope of this work will be limited to coaching used in health-care settings for the chronic disease of obesity and several tools that have been developed and used in bariatric coaching support groups and with individuals. The relevant literature will be presented that supports the need for an internalization of a healthy lifestyle intervention plan. The biggest limitation is lack of a standardized tool and the difficulty in measuring outcomes with a control group.

The limitations of the study are that, very few tools specific to bariatric surgery were found. This significance of surgery may add an additional challenge of magical thinking related to the surgery doing all of the work, and when it does not it is perceived as another sign of failure. There is a fair body of literature on health coaching for other disease processes. The subjects who participated were volunteers who joined a Back on Track courses or attended weight loss surgery support groups regularly of one on one coaching for weight loss after surgery. All subjects were all interested in losing more weight and discovering what thinking, behaviors or habits had caused weight regain. These participants were already motivated and seeking help by attending support group and attending Back on Track classes. All of the subjects are primarily from the Santa Clara Valley in California. The Back on Track participants are from all over the nation, however the same bias occurs in that they

sought out this course. Another limitation is in the use of the Bariatric Circle of Life tool, it is similar to many other Life Balance circles that have been reliable and have been validated. The bariatric-specific tool has not been validated.

Definitions for Understanding

Bariatric surgery (weight-loss surgery) – includes a variety of procedures performed on people who are obese. Weight loss is achieved by reducing the size of the stomach with an implanted medical device (gastric banding) or through removal of a portion of the stomach (sleeve gastrectomy or biliopancreatic diversion with duodenal switch) or by resection and re-routing the small intestines to a small stomach pouch (gastric bypass surgery). Long-term studies show the procedures cause significant long-term loss of weight, recovery from diabetes, improvement in cardiovascular risk factors, and a reduction in mortality to 23% from 40%. (National Institute of Health, 2014).

Bariatric Coaching – provides a support and educational structure that reinforces the importance of personal values, integrity, fulfillment, and life balance in achieving and maintaining over-all health specifically related to weight (Appel, 2011).

Body Mass Index (BMI) – the standard measure of body fat. BMI is calculated based on an individual's weight relative to that person's height and measured by multiplying the individual's weight in pounds by 703 and then dividing that number by the individual's height in inches squared (Centers for Disease Control, 2014).

Co-morbidity – two or more diseases or conditions existing together (Valderas, 2009).

Gastric Banding – an obesity surgery option that is designed to limit the amount of food the stomach can hold by sectioning it off with the placement of a band near its upper end. The band creates a small pouch, which delays the emptying of food from the pouch and causes a feeling of fullness (Rodgers, 2015).

Gastric Bypass surgery or Roux-en-y bypass surgery – a surgical procedure that combines the creation of small stomach pouches to restrict food intake and the construction of bypasses of the duodenum to prevent food absorption (ASMBS, 2014).

Ghrelin (hunger hormone) – this hormone is reduced with bariatric surgery except the banding procedures (Mandal, 2014).

Grazing – To eat snacks throughout the day in place of full meals.

High-density lipoprotein (HDL) – a lipoprotein of blood plasma that is composed of a high proportion of protein with little triglyceride and cholesterol. It is associated with decreased probability of developing atherosclerosis (also referred to as alpha-lipoprotein, "good" cholesterol) (Conason, 2014).

Health/Wellness Coaching – provides a support and educational structure that reinforces the importance of personal values, integrity, fulfillment, and life balance in achieving and maintaining over-all health, often related to a chronic health disease (Appel, 2011).

Intention – an act or instance of determining mentally upon some action or result (Grant, 2012).

Integrity adherence to moral and ethical principles; soundness of moral character; honesty, the state of being whole, entire, or undiminished (Dean, 2005).

Life Coaching an advisor who helps people make decisions, set and reach goals, or deal with problems (Merriam Webster's, 2015c).

Life Purposes to define why you are here on the planet. Who is it that you are moved to be and what is it that you are moved to create? (Grewal, 2014).

Low-carbohydrate – or low-carb; common designation of food containing less than average carbohydrates (Appel, 2011).

Metabolic syndrome – a disorder characterized by a cluster of health problems including obesity, high blood pressure, abnormal lipid levels, and high blood sugar (Wubben, 2006).

Metabolism – as it relates to the obese person, to how glucose and lipid metabolism act differently with increased abdominal fat. In metabolism, some substances are broken down to yield energy for vital processes while other substances, necessary for life, are synthesized (Fujioka, 2004).

Motivational Interviewing – The motivational interview is defined as a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence (Lussier, 2007).

Morbid obesity – a BMI (body mass index) of 35–40 (Vorvick, 2014).

NASH – Nonalcoholic steatohepatitis is a common, often "silent" liver disease. It resembles alcoholic liver disease, but occurs in people who drink little or no alcohol. The major feature in NASH is fat in the liver, along with inflammation and damage.

Normal Weight – ideal weight per height measurements; a classification of BMI (body mass index) between 18.5 and 24.9 (Greenberger, 2012).

Sedentary – having low activity/exercise levels.

Stretched Pouch – refers not to the pouch itself in the gastric bypass, but to the stomal opening; there is no restriction of food to the small intestine.

Stroke – A sudden loss of brain function caused by a blockage or rupture of a blood vessel to the brain (Merriam Webster's, 2015d).

Vertical Sleeve Gastrectomy – A vertical sleeve gastrectomy or simply sleeve gastrectomy is a purely restrictive bariatric surgery. Restrictive bariatric surgery, and specifically vertical sleeve gastrectomy, aims to reduce the overall size of the stomach (ASMBS, 2014).

Visionettes – refers to a simpler form of life vision or purpose (Lassetter, 2004).

Waist Circumference – measurement of distance around the waist, which physicians may use to assess a patient's abdominal fat (an obesity evaluation tool) (Centers for Disease Control, 2012).

CHAPTER 2

LITERATURE REVIEW

There is a great deal of information on the topic of cognitive behavior modification and the weight-loss-surgery patient or client. A newer diagnostic term called binge eating disorder or BED, without vomiting can be found in a subset of obese patients prior to weight-loss surgery. Beck had developed cognitive behavior therapy was initially developed to treat depression and stress. Apple describes how Becks work has been modified for use with patients who compulsively overeat or binge; this also relates to as many of those who have developed obesity (Apple, 2006). When professionals are working with obese individuals the goal of cognitive behavior therapy is to offer interventions to deal with negative thoughts that lead to choices and behaviors that sustain obesity. Another challenge with behavior modification is that the individual using these strategies to deal with feelings of the client or the patient needs to be educated and a licensed therapist. This modality is very expensive. Some individual visits and some group visits with a therapist and patient may be covered by insurance. The majority of professionals who work with this population are not therapists. Lahaise (2012) describes bariatric surgery as being one of the most effective treatments for obesity; with the lowest rate of recidivism or weight re-gain (Lahaise, 2012). These patients or clients may need a partner to assist them with adapting to the changes needed for long-term healthy weight behaviors, once the honeymoon phase has ended. Lahaise also talks about attendance at support group meetings being associated with higher percent decrease in the basal metabolic index or

BMI (Lahaise, 2012). One notable after-care program discussed by Lahaise was done at Sanford Center of Excellence Bariatric Program in Fargo, North Dakota. It consisted of 12 1-hour group sessions using a cognitive behavioral model. A licensed psychologist or dietitian led the groups each week. This treatment option is expensive, whether being paid for by insurance, the individual, or the institution. A similar program is in use at Stanford BMI Center of Excellence by the EnteroMedics company in the RECHARGE research study can be seen in the behvior modification lessons. These lessons talk about changing thinking pattterns, asking questions, and setting goals. These monthly and bi-monthly lessons are 15 minutes long for the 5-year duration of the study. There are also lessons for monthly support groups. These lessons in most cases are delivered by a licensed individual, however, a non-licensed person can also review these individual and group lessons with subject participation (EnteroMedics, 2010). Samelson talks about willingness and willfulnesss as significant behavior traits that can define success or failure with long-term weight wellness. She defines willingness as accepting what is true about your body and then doing whats is effective for your body and your lifestyle (Samelson, 2011). When people do not change their eating behaviors that were used prior to surgery, this would be called willfulness. Samelson describes willfulness as the polar opposite of willingness (Samelson, 2011). Samelson'a approach is the most user friendly, it is geared toward the individual having surgery. You do not have to be a licensed person to utilize this approach. It can be used by the professional working with weight-loss surgery people or the individuals themselves. Her background is in education and that may explain the ease of approach. Samelson also addressed many concepts like mindful eating, body

image, inadequate weight loss, weight regain, self-limiting beliefs, and goal setting in a workbook approach, so the clients can ask themselves questions related to each concept. A challenge may be that out of 200 pages in Samelson's book only 40 or so are geared toward the post-op experience; this is the majority of time for each individual and may need more intense focus for long-term success. There are numerous books by weight-loss surgery patients who have been successful with weight loss. Their approaches seem to be primarily antedotal and didactic. The main premise being: If you do what I say then you will be succssful with weight loss. Many of the books are based on their surgeons' recommendations, show minimal citations, and seems to have very little background research. There are a few resources out there that are based on changing thinking patterns that prevent long-term success. Hottinger (2011) talks about five steps to long-term weight loss and then breaks them down to barriers and self-coaching tools or skills. Hottinger talks about seven barriers to weight loss. He describes them as follows: weight fixation, all or nothing thinking, feelings of unworthiness, resisting responsibility, the willpower myth, tuning out, and selective accountability. Hottinger also describes positive self-coaching skills or tools, such as expecting greatness, regaining your balance, creating successful environments, being unstoppable and awakening your intuition. Simon's book (2012) titled *The Emotional Eaters Repair Manual* set off a red flag. It implies that emotional eaters are broken, perhaps they have found food as a coping device . Lifestyle coaching focuses on moving individuals forward, not repariing the past; learning from past choices and deciding to try a different path going forward. Simon describes some helpful skills, principles, and practices if you can get past the title of the book. The skills are very

similar to other references from professional coaching and psychology. The first section of Simon's work focuses on changing thoughts and goal setting (Simon, 2012).

Coaching and Health Care

Coaching in the area of chronic health conditions has become very popular in the past few years. Areas such as diabetes, arthritis, chronic obstructive lung disease, cardiac rehabilitation, spinal injury, brain injury programs many of which involve some type of coaching approach (Linder H. M., 2003). The research in the specific area of obesity and coaching was difficult to locate, much of the available literature was not research based. The terms health coaching, motivational interviewing, and lifestyle coaching are becoming more commonplace. Health coaching has been highlighted in several different areas. Edelman described a study called A Multidimensional Integrative Medicine Intervention to Improve Cardiovascular Risk, and how this study was to determine if the strategy of personalized health planning, which includes the patient or client as the center of the plan, would reduce 10-year cardiac risk (Edelman, 2006). This researcher put Health Coaching into Google and it returned 41 million entries. Many of these were for physical training. This indicates a need to promote health in many specialty areas of chronic disease, such as cardio vascular, hypertension, diabetes management, chronic obstruction pulmonary disease, and obesity. People who have expertise and experience in all sorts of areas are becoming life coaches. Coaching can complement the coaches' current area of expertise and improve their own quality of life, as well as helping the person being coached. Ben Butler said the life-coach training the college provided, almost mirrored the type of coaching one would offer to a client in the capacity of a lifestyle coach

(Jodi, 2005). A specific positive psychology framework suggests that a language of strength and vision, a forward-looking model, as opposed to focusing on weakness and pain, needed to be dealt with before moving forward it the firm foundation upon which the coaching work rests. Coaches with a positive psychology orientation also develop a different internal decision tree when selecting what material to follow, what to let pass by, and what cause-effect sequences to focus on.

Coaching used in analysis and general coaching psychology offer a baseline for positive psychology. All of these areas require an advanced degree. Grant describes the comments that experts came up with regarding the emerging field of coaching psychology and commercial coaching as an industry. The key areas the experts defined, according to Grant, were the potential for health promotion, organizational development, and social change. Grant describes these experts as having viewed the psychological coaching outcome literature and described finding a total of 69 outcome studies between 1980 and July 2007: 23 case studies, 34 within-subject studies, and 12 between-subject studies. Grant reports that only eight randomized controlled studies have been conducted. What this may suggest, according to Grant, is that coaching psychology is still in the very early stages of development. Coaching psychology as described by Grant can be seen as an emerging or pro-scientific psychological discipline. Grant says for the growth of coaching psychology to continue it will need to be separated from the personal development industry, while at the same time being involved in the greater coaching industry (Grant, 2007). This researcher is not clear how Grant proposes to keep these two areas separated.

"Integrative healthcare is defined here as prospective, relationship based, patient-centered, comprehensive, and holistic healthcare that focuses on patients' priorities for well-being, as well as preventing, managing, rehabilitating, and palliating diseases and injuries" (Deng, 2010).

Defining Health Coaching

The definition of health coaching can be described as multidimensional. Coaching psychology is for enhancing wellbeing and performance in personal life and work domains with normal, non-clinical populations, underpinned by models of coaching grounded in established adult learning or psychological approaches (Palmer, 2003). The general concepts that can be seen in all types of coaching are enhancing wellbeing, learning, facilitation, educational instruction, development of skills, and improving performance or outcomes in some particular area. Coaching also is very goal and solution oriented in order to achieve the desired state of being. In health coaching the coach takes a facilitative role. The coach assists the coaching client to achieve that person's goals by facilitating the learning process. The coach may help to educate the coaching client on specific health-related topics, such as bariatrics, cardiac rehabilitation, diabetes, or other chronic diseases, by the promotion of healthy behavior and achievement of health-related goals (Palmer, 2003). In a study by Spence and Grant for improving life style well being showed that peer coaches versus professional coaches showed that:

> The present randomized controlled study compared peer with professional life coaching over a 10-week period with 63 participants. Results indicated that, compared to peer coaching clients and controls, coaching clients of

> professional coaches were more engaged in the coaching process, had greater goal commitment and progression, and greater well-being in terms of environmental mastery; other facets of well-being did not change. The results suggest that the presence of a supportive person may be a necessary but insufficient condition for enhancing goal striving and highlight the importance of expertise in coaching (Spence & Grant, 2007, p.185).

Other similar terms, like bariatric coaching, usually refer to Life Coaches with specific focus on bariatric patients to assist in positive post-operative outcomes. The Adelaide Bariatric Program in Australia offers a 6-week course for patients. It is not clear what training the coaches have had (Adelaide Bariatric Centre, 2015). There are many bariatric patients who are certified life coaches or have become certified after surgery, as they discovered the many opportunities and challenges of significant weight loss (Ginette, 2014). Another website called the Bariatric Life Coach Association is actually one person (Bariatric Life Coach Association , 2008). There is little to no information on the preparation for these women to become certified life coaches. The International Coaching Federation (ICF) has specific guidelines and coaching ethics that are defined (International Coaching Federation, 1995). Another term often used by many psychologists is motivational interviewing. This can be defined as: "a form of collaborative conversation for strengthening a person's own motivation and commitment to change" (Motivational Interviewing, 2013). This form of coaching or counseling is client-centered and the focus in on change itself. The design is to promote and increase an individual's motivation to change to achieve a particular goal in a climate of compassion and acceptance. The training for motivational interviewing

is also extremely varied with no code of ethics of its own Motivational Interviewing, 2013).

The GRACE program describes a study with a geriatric population in which the subject is involved in the plan of care. This action supports a bigger commitment with the individual to follow the plan. It is not simply something the professional says is best but a team approach which is inherently more successful due to patient or client involvement

Steven Counsell, professor of medicine at Indiana University and a scientist at the Center for Aging Research, designed the Geriatric Resources for Assessment and Care of Elders (GRACE) program, first implemented at Wishard Health Services in Indianapolis. The GRACE program uses a team approach, combining transitional and primary care via home visits and engaging patients in a care plan individualized to their needs. Community Health Network in Indianapolis established an e-business department, led by vice president Dan Rench. Rench and his team sought to capitalize on the proliferating use of hand-held devices to help patients better comply with medication use" (Wetzel, 2011).

"We all thrive when the patient or client is involved and engaged in new health behaviors. Health outcomes can be improved and in the case of bariatric clients fewer complications and readmissions for dehydration or other potential problems" (Wetzel, 2011). The US Department of Health and Human Services has made family and patient or client involvement a priority. In March of 2011 Secretary Kathleen Sebelius released the National Strategy for Quality Improvement in Health Care. The strategy, mandated by the Affordable Care Act, defines three broad aims and six

national priorities, including "Ensuring that each person and family are engaged partners in their care. The pressure to reduce avoidable readmissions underscores the need to engage patients better" (Wetzel, 2011, p. 20). The research, as well as common sense, supports the view that engagement of the individuls, as well as support for people in their plan for health and wellness, will improve outcomes. This study supports this assumption based on the reduced rates of readmission to hospitals for the bariatric patient.

"Over the past year, the transition coach program has had more than 850 patients referred and has had success in preventing readmissions" (Wetzel, 2011, p. 21). Ochsenrider says, "Additionally we identified opportunities for improvement across the continuum of care. We're listening and learning more about the patient's needs and implementing interventions accordingly" (Wetzel, 2011, p 21). Due to the positive outcomes of a health-coaching pilot for its employees with diabetes, Advocate Health Care, an integrated health-care system based in Oak Brook, Illinois, now offers health coaching to its patients, employees, spouses, and employer groups as part of its comprehensive wellness solution (Advocate Health Care, 2012).

> When the health coaching program was piloted with patients with diabetes in 2006, participants reduced their LDL cholesterol by an average of 10 points and their hemoglobin A1c by one point. The health coaching program now targets patients with diabetes, asthma, and/or cardiac disease but doesn't turn away anyone who wants to participate, says Jennifer Sponholtz, CHES, wellness coordinator. Sponholtz, who works in the Advocate Medical Group division supervises and trains Advocate Health Care's lifestyle coaches, all of

> whom work from their homes and counsel their clients by telephone. In the first year that Advocate added a weight-loss component to the program, participants reduced their body mass index (BMI) by an average of 0.8 in the first year. Studies show that for every one-point drop in the BMI, the company saves $202 per employee per year. (Advocate Health Care, 2012)

Lifestyle coaches work closely with case managers and disease managers to provide whatever assistance, information, or support patients need. Sponholtz says: In this program at Advocate the lifestyle coaches include health educators, nurses, dieticians, and exercise physiologists. (Advocate Health Care, 2012)

Preparation for Health Coaching

The coaches for the Advocate Medical Group have at least a bachelor's degree in a health-care field and some of them have master's degrees. They all go through intensive training to become lifestyle coaches. This training teaches them how to effectively engage individuals who are resistant to change. Some of the training techniques include not offering healthy living ideas but assisting them in improving their health by helping them come up with their own goals. The coach guides or assists the patients or clients in coming up with things they are willing to do to have a healthier life. Assisting them to the “a-ha” moment by discovering what is important to them. This idea is one the individual is far more likely to act on. Motivational interviewing is a critical part of the coach training, which helps them identify the clients' readiness to change. The Advocate program also found that a combination of intrinsic development training and motivational interviewing created a balanced approach. This approach assisted in coaching success when working with individuals,

says Sponholtzs (Advocate Health Care, 2012). AREA Health Management provided telephone web-based coaching to overwieght participants. This team consisted of dietitians, exercise physiologist, psychologists, and nurses, who provided ongoing support by phone to help people eat in a more healthy way. The coaches assisted the clients in creating a 6-month action plan, the coach provided encouragement, support, and motivation (Ellis, 2009). The biggest challenge with health coaching is the variety of education and preparation to become a health coach. It is a not a regulated industry. Wetzel (2011) states that health coaching is emerging rapidly as a way of approaching the individual by partnering and assisting them to enhance self-management health and wellness strategies to prevent exacerbations of chronic illness and supporting the healthy lifestyle change they desire.

> Medicare is now pilot testing this approach for patients with congestive heart failure and diabetes. With acute care hospitalization an outcome of great interest to us all, health coaching is an exciting technique worthy of consideration by home health providers. (Wetzel, 2011, p. 22)

Veenu Aulakh, MPH, Senior Program Officer for Chronic Disease Care for the California HealthCare Foundation says for chronic-care management to work successfully on behavior, or habit, their needs to be a change on the part of the individual or patient. The old model of the expert provider telling the patient or person what to do has not been effective (California HealthCare Foundation, 2008). Coaching is a collaborative approach to educate and facilitate change, to teach skills that people are ready for and that increase their confidence in their ability to change is crucial. Many who practice health coaching applaud this method as a great way to help

individuals achieve optimal wellness, to facilitate the learning process, and to engage them in health-seeking behaviors. Another question to ask is does health coaching have implications for home health clinicians who manage patients with chronic and comorbid conditions? Health coaching is the practice of health education and health promotion within a coaching context to enhance the well-being of individuals and to facilitate the achievement of their health-related goals. Health coaching effectively motivates behavior change through a structured, supportive partnership between the participant and the coach. The coach helps the participant to clarify goals and provides insight into goal achievement through inquiry, collaboration, and personal discovery. Health coaching also is sometimes referred to as "motivational interviewing" (Wetzel, 2011).

The Roots of Health Coaching

The roots of health coaching or motivational interviewing began with psychologists treating addicted persons. Psychologists who developed the process described it as a client-centered counseling style for eliciting behavior change by helping clients explore and resolve ambivalence. In the early 1990s, the National Institute on Alcohol Abuse and Alcoholism conducted the research project, MATCH, which compared three treatments for alcoholism: (1) cognitive behavioral therapy, (2) a 12-step approach such as that used by Alcoholics Anonymous, and (3) motivational enhancement therapy, a technique aimed at improving readiness and willingness to change drinking habits (Miller, 1996). The MATCH project showed that all three treatments were equally effective, but that motivational interviewing took less time and cost less. This finding prompted an increased interest in this method. Since then,

other research has focused on health coaching and motivational interviewing as methods that have helped patients achieve health behavior change in other populations, especially those with chronic conditions such as diabetes, obesity, renal failure, and heart disease (Miller, 1996).

The Patient as the Center in Bariatric and Health Coaching

Effective chronic illness care requires two things: first, an active involved patient and caregiver, and second, a health-care team that centers on the patient and caregiver. It is estimated that 95% to 99% of chronic illness care is provided by the person who has the illness. This makes sense. After all, it is the patient and many times his or her caregiver who make the decisions about the patient's health on a day-to-day basis. Providing care in the patient's place of residence affords the home health provider opportunities that other providers do not have. Patients typically feel safer and more secure in their own homes. This provides an environment with an excellent opportunity for developing trusting and caring relationships with patients and caregivers. This also sets the stage for determining what is important to the patient, what the patient wants to accomplish the most relative to the disease or condition he or she has, and how active the patient is in caring for self. Making the patient the center of our efforts puts the patient's needs, concerns, and goals at the center of how we address them, how we respond to them, and how we focus our efforts (California HealthCare Foundation, 2008).

Helping Patients/Clients and Caregivers Set Goals

Funnell (2015), a certified diabetic educator for the University of Michigan Health System at Ann Arbor, explains that the process of setting “self-management”

goals with the patient involves essentially two steps, as follows. Start at the problem. Funnell recommends that health-care professionals start with a comment such as, “Tell me what bothers you most.” “Tell me what is hardest for you.” “Tell me what you're most distressed about.” “Tell me what you most want to change.” This helps the clinician get to the core of what is most important to the patient or caregiver and provides the best place to start making progress toward behavior change. This method has been in practice since 2007 and has experienced better outcomes in diabetic self-care management when the individual is setting the goals. Lab values can help validate the need for behavior change. For example, for hypertension, taking blood pressure readings and documenting them in a diary or on a calendar is an important self-management task. However, discovering why the patient is noncompliant with making entries in the diary is basically more important. If the patient or client has problems with this task for any reason and does not take the blood pressure the readings are unknown, and cannot guide care (Funnell, 2015). The next step is to develop a collaborative goal. Funnell advises that we not try and solve the problem or issue for the patient, and that we not say “It will be okay.” Rather, we should validate the patient's feelings and his or her capacity to deal with the problem. We should continue asking questions that help lead the patient to his or her own solution. She suggests that the patient be asked, “What do you think would work?” “What have you tried in the past?” “What would you like to try?” (Funnell, 2015).

Strategies and Techniques

Huffman states that health teaching has been the foundation of home health care since its inception. The traditional approach of just do what I suggest, teach,

review, and then review again if needed, and then confirm understanding of the given information has not proven to be successful in the long term. No one thought to ask the patients or clients what they most want to achieve related to their medical conditions (Huffman, 2007). Miller developed one very interesting strategy is the acronym called the OARS technique, like oars in the water moving a person forward. This technique is a classic motivational interview technique considered a skill set in health coaching. O is for open-ended questions; A if for affirmation of the person's strengths; R is for reflective listening; and S is for summary. Many health-care experts want to share their advice, but the client or patient may not be ready to hear it. Affirming the patient's strengths validates the internal and external resources upon which the patient can draw going forward. This helps the patient feel a confidence that goals can indeed be met. Reflective listening demonstrates that your purpose is to be "interested," not "interesting." Carefully listen for underlying concerns that may come from the patient or the caregiver. Delve deeper as the patient allows or is ready. Summary allows the clinician to reiterate the main points shared by the patient and to verbalize an interest in the patient's concerns (Miller, 1996). Huffman suggests that a more productive interaction with the patient than simply giving health-care facts would be to elicit what the patient identifies as the problem, provide appropriate information, and elicit the patient's reaction to the information. This technique is very similar to OARS in that the patient's identification of the problem comes first, followed by the giving of health information relative to his or her concerns. Finally, the health-care professional listens to the patient and observes his or her response. The focus, like OARS, is "all about the patient" (Huffman, 2007, p. 398). Growing evidence continues to show that as much

as 90% of the management of a chronic disease must come directly from the patient. In response, CHCF has produced a video featuring coaching techniques for providers to effectively educate and motivate patients to take charge of their health. Just telling patients what to do does not work. Healthy behavior change requires making an agreement between the caregiver and the patient and developing an action plan. The video "Coaching Patients for Successful Self-Management," includes two topics: using the action planning process to support healthy behavior change and ensuring patients are taking their medications appropriately. In both cases, patients are coached on the skills they need to become active participants in their own care. Coaching can be done by clinicians or other provider team members (California HealthCare Foundation, 2008).

Studies on Health Coaching For Weight Loss

Health coaching is a new approach for the home-health industry that holds great promise. Because health teaching is a cornerstone of the care we provide, patient self-management could be enhanced through the use of health coaching. Using this approach in the patient's place of residence may be the key to enhancing outcomes such as reduced exacerbations, emergent care use, and acute care hospitalization, all of which will improve our care quality while reducing the overall cost of health care. Merrill did a study on employee weight management through health coaching done at Brigham Young University. This study evaluated the effectiveness of an interactive health coaching intervention at lowering weight (Merrill, 2010). Another study by Seaverson, Grossmeier, and Anderson showed that Interactive health coaching via telephone significantly lowered BMI among participants through 3, 6, and 12 months

of follow-up. It had pre/post quasi-experimental design comparing weight loss and related behaviors between program completers and non-completers (Seaverson EL, 2011) Seaverson concluded that those participants who lost weight, increased physical activity; and learned new eating behaviors and nutrition practices benefited greatly from the telephone-based health coaching, and this approach can have a positive impact on the health of obese or overweight worksite participants.

Another interesting study done for weight loss was the Empower Research Study-Year one, individual coaching toward optimal weight loss was a double-blind study for a surgical weight loss intervention with a health and behavioral coaching component. Subjects were implanted with a Vagal Stimulating Device for Weight Loss developed by EnteroMedics and performed at Stanford University Hospital and clinics. All subjects received individual health coaching as part of the study design. All subjects underwent laparoscopic surgery for implant of this device. All subjects BMI's were 40 and above. All of the subjects were screened by Dr. John Morton's tool for potential compliance with stated protocols (Lundberg, 2005).

Bariatric/Health Coaching Tools

One tool for chronic health problems used in the primary care clinic health coaching program that was designed for clients or patients is called The Action Plan. It gives the clients choices of areas they would like to work on. The areas included taking medications, something bothering them, better food choices, reducing stress, and cutting down on smoking (University of California at San Francisco, 2013). A tool that has demonstrated some validity is the Patient Activation Tool, which has a score called the PAM and this score has predictive value. Studies have shown that higher

PAM scores indicate that these individuals are most likely to be compliant with healthy behaviors and long-term outcomes. It is used by at least 50 organizations, including government agencies, Medicaid, physicians' offices, and state government in Oregon. It has been translated into 16 languages (Chase, 2011). Another tool is the Five Factor Wellness that states it is an evidence-based tool. This tool assesses motivation or allows focus for clients or patients in the areas of coping, creative, physical, essential and social (Myers, 2014). The Wellness Inventory is a well-known tool created by Dr. John Travis MD, MPH in 1975 that has been well validated since then. It asks the clients to rate 12 areas of their lives. Those areas include self-responsibility and love, breathing, sensing, eating, moving, feeling, thinking, play and working, communication, intimacy, finding meaning, and transcendence (Wellpeople, 2011).

CHAPTER 3

RESEARCH METHODS

The research approaches that have been used in previous research consist of quantitative, interventional, and randomized control groups to determine one particular teaching or informational intervention. In some cases these interventions came with a medical intervention as well. Below are several examples.

There have been numerous research designs used for health and or bariatric coaching of people who are planning weight-loss surgery or who have had surgery. One common design seen in more recent years according to the NIH is to offer additional in-person health coaching to primary care patients. This study compared two interventions: One was in-person support and the other was remote. Using the randomized control trial model the researchers found that:

> Obese adults who received weight loss coaching via phone, web, and email contact, as well as support from their primary care providers often lost a significant amount of weight—5 percent or more of their starting body weight—and kept it off for two years, reports a research team funded by the National Institutes of Health. (Appel, 2011)

A second study funded by the NIH was a study led by Thomas A. Wadden, PhD, of the University of Pennsylvania. That study found that 25 lifestyle counseling sessions combined with the option to use weight-loss medication or meal replacements (such as liquid shakes or meal bars) helped about one-third of obese participants lose a significant amount of weight and keep it off for 2 years (Wadden, 2011). This was a

randomly controlled trial with the one intervention of the 25 lifestyle session given by a medical assistant. Another very prominent study was the "Weight loss maintenance (WLM) trial, which compared three different strategies for maintaining weight among 1,685 overweight or obese adults with high blood pressure or high cholesterol or both. Of those, 1,032 lost an average of 18.7 pounds during an initial six-month weight loss intervention involving 20 weekly group-counseling sessions which emphasized a heart-healthy dietary pattern and 3 hours per week of physical activity. They were then randomly assigned to one of three strategies for weight-loss maintenance: monthly personal counseling on diet and physical activity, a web-based intervention with the same advice, and self-direction, where participants received minimal further intervention from study staff. Personal counseling sessions were brief and mainly by telephone. At the end of the study, participants receiving personal counseling retained an average weight loss of 9.2 pounds, compared to an average of 7.3 pounds for those using the web-based intervention and 6.4 pounds for those in the self-directed group. Most people in the study regained at least some of the weight they initially lost. However, both the personal counseling and the web-based program modestly alleviated weight regain for up to 2 years, with the personal counseling ultimately proving to be the most beneficial by the end of the study." (Svetkey, 2008, p.1139-40)

After reviewing dozens of studies funded by the NIH and related organizations funding qualitative studies I realized how expensive it is to provide ongoing coaching for internalization of new ways of thinking that would then influence new lifestyle choices. I considered using existing tools to measure the transformation and progress I was observing and clients were sharing. I realized that there is no question that health or bariatric coaching improves long-term weight loss. The problem is preparation of the health coaches and cost of providing this service. I found a recent study in the health coaching literature that states:

> Our study suggests health coaches may not only yield impressive weight loss outcomes, but that lay – or peer – health coaching may be particularly promising as a cost-effective obesity treatment strategy. Although these findings are only preliminary, it's encouraging that lay health coaches successfully supplemented a less intensive, lower cost behavioral intervention and that their weight losses were actually comparable to those produced by professional coaches - something that could be critical in this changing health care landscape. (Leahey, 2012, p. 1002)

Below is more detailed information on the study design:

> In this randomized controlled pilot study, 44 participants took part in a group behavioral weight loss program that met for 12 times over the course of 24 weeks – half the amount of sessions of a traditional treatment plan. Groups met weekly for the first six weeks, biweekly for the following six weeks and monthly thereafter. Miriam researchers randomly assigned individuals to work with one of three different types of health coaches: a professional (behavioral

> weight loss interventionist), peer (a fellow group member) or mentor (a successful weight loser). During the weeks where there were no group meetings, participants emailed their weekly weight, calorie and physical activity information to their coach and received feedback. All coaches were trained on appropriate coaching strategies and feedback delivery. While all three groups yielded clinically significant weight losses, participants guided by professional and peer coaches had the most success, losing more than 9 percent of their body weight on average, compared to just under 6 percent in the mentor group. At least half of the participants in the professional and peer coaching groups achieved a 10 percent weight loss, which research has shown can reduce the risk of a wide range of illnesses linked to obesity, including heart disease and diabetes. Only 17 percent of those in the mentor group accomplished this goal. (Leahey, 2012, p 1002)

Currently there is a Peer Coaching study at Stanford University in the weight-loss surgery or bariatric clinic that has a randomized control design. The study will not be complete for another year (Communication, 2014). This is the only study I was able to find for weight-loss surgery specifically.

Which Approaches Were Considered for this Dissertation?

All of the above approaches were considered, but this researcher found it difficult to quantify the amount of change in ways of thinking and then how that influences behavior and lifestyle choices related to obtaining optimal weight. There is no question that coaching improves outcomes for weight loss in the obese person.

Phenomenological Approach. I chose a phenomenological approach due to the nature of the observation of clients and patients over the course of 10 years. Cost and lack of funding were significant limitations as well. The information and research is very limited on the use of life coaching skills, specifically as a learned skill set or as a tool for optimal weight after bariatric surgery. I also noted over a 10-year period a very positive change in the success rate of weight loss and improved lifestyle behaviors of clients and patients in Back on Track courses, weight-loss surgery support groups, and individuals before and after weight-loss surgery, when using coaching skills and a specific coaching tool. The control group were those patients at a local hospital that had weight-loss surgery and attended the informational only support group run by the physician. Lester talks about how the phenomenological approach can assist the individual or group to identify or shine a light on specific ideas. When the phenomena can be defined by the participants in a particular situation or in this case the weight -loss surgery support groups. This researcher noted significant thought reshaping through the group coaching approach. It was also noted that significant ideas, concepts, new perception can be derived through discussion and participant observation according to Lester. "Phenomenology is concerned with the study of experience from the perspective of the individual, 'bracketing' taken-for-granted assumptions and usual ways of perceiving" (Lester, 1999, p. 1).

In health care or the management of chronic diseases like obesity and weight-loss surgery, one can see the application of this method of research. Creswell describes the main concepts of phenomenology: Take a significant experience and then look at the ways human beings make sense of it and then what meaning they will give to this

experience. Phenomenological research design is being used in many disciplines; it can be seen in nursing, health sciences, psychology, sociology, and education (Creswell, 2007).

This dissertation uses interpretative phenomenological analysis (PA) and discusses the particular contribution it can make to health/bariatric coaching. The discussion then focuses on one area in the weight-loss surgery field and the patient's concept of obesity as a chronic illness, what it takes to change thinking, to change behaviors, and then change actions to determine new outcomes. This dissertation will conclude with the use of two bariatric coaching tools used to assist the bariatric client/patient in focusing on one area of health promotion at a time based on where they are in any given point in time (Smith, 1996).

Aspers talked about how we should deliver descriptions or observations of the thinking states of our clients as well as attempting to understand the way clients think about weight. This dissertation takes an in-depth observation of how the obese person views themselves and how their weight affects every thought, action, and behavior in every aspect of their lives. The methodological problems that were overcome by using this approach can be described as the ability to observe the subtle and not so subtle changes in thinking patterns, willingness to change, and willingness to internalize new ways of thinking that would lead to new lifestyle behaviors (Aspers, 2004). The methodological problems that were not overcome by using this approach were the ability to measure the amount of change that coaching skills knowledge inspired and the use of the bariatric tools to focus on a particular area at a time.

Research Design

This research was done by two weight-loss surgery (WLS) patients: Dana Schroeder, an RN, Coordinator at a local hospital, and WLS Support Group Leader; and Sue Lassetter, a Support Group Leader with an MA in Education Counseling. They both had facilitated weight-loss-surgery support groups for 3–5 years using a didactic informational approach. These two individuals also taught between 5–10 small groups of 8–10 people in a Back on Track (Cook, 2005) course to weight-loss-surgery patients who had weight regain. In 2005 Sue became a Certified Life Coach and Dana became an Associate Certified Life Coach. These designations, education, and coaching hours are defined by the International Coaching Federation-ICF) (International Coach Federation, 2013). Dana and Sue were both certified by the Institute of Life Coach Training (ILCT) (Institue for Life Coach Training, 2013). Based on their new personal discoveries with the coaching experience, they began using the coaching skills in their support groups and Back on Track courses. They developed a 30-unit continuing education course for registered nurses and others to learn basic bariatric coaching skills.

The phenomenological control groups were all of those groups we had led and taught before our own transformations through life coaching skills knowledge and internalization. The experimental groups were all of the Support Groups since 2005 and Back on Track participants.

Groups. The groups were as follows: Phenomenological Group (R)

Coaching skills and Tool and Control Group (R) No tool or coaching skills.

In this study, each group was given an option of where or who to take the course with, specifically the Back on Track course developed by Colleen Cook (Cook, 2005). A. The phenomenological group facilitated by Sue and Dana then received the same information as the control group, with the addition of coaching skills design approach and bariatric specific tools for focus.

Significant differences between the two groups were noted by Cook (2005) and Hall (2005), as well as by the coaching group facilitators. The noticeable behaviors were an increased excitement, discovery of self, versus the control group that did not obtain and seem to internalize as much insight as the coached group. The group that was exposed to bariatric coaching skills was more likely to internalize new ways of thinking and then incorporating this into new lifestyle choices that supported their goal of weight wellbeing.

Research Questions

Several questions were asked, such as: Does the implementation of coaching skills into an established Back on Track curriculum and a bariatric support group structured curriculum increase the internalization of new weight wellbeing lifestyle thinking and behaviors? As a result of these new behaviors will weight loss and weight maintenance be achieved over the long term? Will the use of two bariatric specific tools assist the weight-loss surgery client/patient to focus on a particular area of health to move in a forward direction?

Subjects

The individuals who participated in the study were 90% women 10% men. All individuals had weight loss surgery and were attending bariatric support groups or attending Back on Track courses. The participants were between the ages of 45–65; all coaching skill participants lived in the San Jose, California area. The coaching groups were based in San Jose, California and Salt Lake City, Utah. All of the participants were at least 100 pounds or more over ideal weight when they had surgery. Some had reached their weight-loss goal and then had weight re-gain and were seeking answers. Most participants had lost at least 50 pounds of excess weight. Support Group attendance is about 30 people two times per month for 2 hours. The Back on Track courses were a total of 812 weeks for 2 hours with 8–10 students in a course. There were about 400 participants over the course of the years 2006–2012. There were 90 participants in the Bariatric Life Coach Skills courses from the years 2005–2013. This course consisted of 2 hours on the phone for 8 weeks with a total of 30 hours of bariatric coaching skills practicum. These participants had the same age demographics of the groups above. The participants were from all over the United States and Australia.

Instrumentation

The first tool developed was a Bariatric Life Coach Training Skills course. In all of the phone and in-person bariatric support groups and the Back on Track groups it was noted that the coaching approach assisted subjects in becoming more engaged in their own process of achieving optimal weight for health. The literature extensively supports the effectiveness of the coaching approach with chronic diseases and obesity

specifically. This researcher was unable to find any training tools specific to weight-loss surgery or bariatric professional or clients specifically. Unfortunately, there was no specific education or training for bariatric life coaches. The two support group facilitators, Sue Lassetter, MA, and Dana Schroeder, RN, ACC, who were both life coaches and who had many years of experience facilitating bariatric support groups, developed a 30-unit continuing education program to teach and experience basic coaching skills for use with the bariatric client or patient. This course was developed based on a combination of life coach training courses and the two facilitator's years of experience with this client population. Schroeder took her basic life coach training through The Institute for Life Coach Training with additional post-graduate courses through International University for Professional Studies. (Institute for Life Coach Training, 2015). Lassetter's life coach portfolio training and professional education is listed as follows.

> MA in Counseling and Guidance with an emphasis in Transpersonal relationship, she is a Certified Hypnotherapist through the Hypnotherapy Center with Marilyn Gordon, received her Certified Life Coach from the Institute for Life Coach Training (ILCT) and was a course instructor with this researcher. She also has post-grad courses and is certified as an Individual, Couples and Group Coach through the Relationship Coaching Institute (RCI), additional course works "Now What …?" Training with Laura Berman Fortgang, Coaches Training Institute (selected trainings), Coach U (selected trainings),
>
> "Business of Coaching" with Dorcas Kelly, "Wealthy thought Leaders" with

Andrea Lee, “Voices Dialogues” for Coaches, Ongoing course and offerings through ICF

Conventions and classes. Individual supervision work with Lynn Meinke, MS, RN, PCC, Process Therapy Institute, Masters practicum, with Carole and Don Hadlock and “Creative Visualization” with Lisa Nichols. This researcher and Lassetter have worked together facilitating and developed coaching curriculum for various weight loss surgery support groups since 2006 to the present.

Lassetter and Schroeder went on to teach for several terms to teach and facilitate this foundational life coach training course. The foundational life coach training standards are set up by the International Coach Federation and consist of the following; a minimum of “125 student contact hours, 80 percent of all training must be delivered in synchronous activities and focused in the ICF Core Competencies:

Compliance in operational standards, course lists, ICF Credentialed instructors, observers, mentors and performance evaluation reviewers, MCC credentialed Director of Training, Six (6) observed coaching sessions for each student, 10 hours of Mentor Coaching, Performance evaluation, Audit materials, Statements of agreement, compliance and limitations, duty to notify and payment agreements. (International Coach Federation, 2009)

ILCT was founded in 1998 by Dr. Patrick Williams, MCC, for counselors, psychologists, and social workers. The ILCT foundational coach training program was one of the first accredited by ICF and has trained over 3000 life coaches in a variety of

professions. This gives their course credibility, reliability, and validity. The Co-Active Coaching by Laura Whitworth was used extensively in the development of this course (Whitworth, 2007). Lassetter and Schroeder developed the Bariatric Life Coaching Skills Course and Workbook training in 2006 for support group facilitators of bariatric/weight-loss surgery support groups. They have had several hundred facilitators go through the training with very positive results. The outline is in Appendix B.

The Bariatric Coaching Life Purpose Wheel was developed based on the Life Balance Wheel (Coaching Mandala) designed by Dr. Patrick Williams, Institute for Life Coach Training (Williams, 2013). The Wheel of Life Exercise (Whitworth, 2007) template was also used in development of a bariatric specific tools. The Bariatric Coaching Life Purpose Wheel is also included in the Bariatric Life Coaching Course. There was no specific life coaching or balance wheel that dealt directly with weight or bariatric specific behaviors as the common theme. The third Back on Track group held in San Jose, piloted the Bariatric Life Purpose Wheel that was used in all subsequent groups, including bariatric coaching and bariatric support groups.

> The validity of the Wheel of Life tool developed by Laura Whitworth is the base for the artful practice of life and executive coaching. But first, what exactly is the wheel of life tool is to help make ill people better by finding clinically valid and empirically supported data? The ratio of balance of how much you zoom in on the positive or negative can determine the outcome. The famous wheel of life or pillars exercise is another case in point. (Whitworth, 2007)

The theory described by Dr. Seligman was instrumental in the new coaching focus and development of the bariatric tools.

> One model of applied positive psychology, Authentic Happiness Coaching (AHC), developed by the former president of the American Psychological Association and the father of positive psychology, Dr. Martin Seligman, will be described in detail. A process-coaching application of AHC with two clients follows. The heart of positive psychology, like coaching, lies in the practitioner's choice to shift attention away from pathology and pain and direct it toward a clear-eyed concentration on strength, vision, and dreams. Despite this intent, many coaches are still steeped in the culture of therapy and can find it difficult to transcend the medical model. (Williams, 2002)

See appendix A for the two tools that were used in all of the groups. It was developed for bariatric clients based on the life balance wheel as a life coaching foundation.

Data Collection Procedures

At the end of the course the participants were given the Bariatric Optimal Health Wellbeing tool to determine the areas they were most interested in focusing time and energy on. All but two of the 12 coaching courses were held on the phone with participants from all over the United States and Australia. The Bariatric Life Balance tool is in Appendix A For 14 weeks for 2 hours a week a new topic was discussed and coaching teachers demonstrated/ Then student demonstrated the coaching skills in turn after practice offline with a classmate on the phone. This researcher received numerous comments about the value of this coaching model with

weight-loss surgery people. Notable change in thinking and attitude of the course participants was noted.

This stimulated a movement toward using coaching skills in all of our bariatric support groups and Back On Track courses as well. The coaching method led to deeper discovery and behavior change for each individual optimal weight wellbeing. In the Back on Track course client comments on the end of class surveys were gathered and reviewed. In the bariatric coaching course the results were observed over the course of 8 weeks.

Data Analysis Procedures

We began all Back on Track and Bariatric Life Coaching Skills coaching courses with the client's vision or visionette—or smaller vison— for their health and life. We then asked them to share what they wanted for themselves with the group. This took place in phone classes and in-person classes. All members participated in the sharing of their visions for health. Many of the participants had never articulated what they wanted regarding their health in such a profound way. Many began by saying, "I want to lose 100 pounds." However, in creating a vision we request that the individual ask themselves what might they be doing if they were 100 pounds lighter? How would their life be different? How would their health look? What would their close relationships look like? The more emotionally grounded the vision was the greater the potential for new behaviors, beliefs, and possibility for personal discovery was noted. Without asking for a vision as in previous didactic groups there is very little opportunity for internalization of new ways of thinking and then creating new behaviors. At the end of Back on Track groups and the Bariatric Life Coaching Skills

groups we used the Optimal Health Wheel, this assisted the client to see what area of focus was most interesting to them or where they saw the greatest need for change. The surroundings for the classes for Back on Track were groups of 8–12 people in a classroom. The Bariatric Skills Training course was done on the phone with only the 6–12 participants and then additional time with smaller groups to practice coaching skills.

Many of the Bariatric Coaching Skills participants had never taken a course over the phone and some adjustment to focus was noted with individuals. It was important to keep all participants engaged by asking the open-ended questions and going around the virtual room for each participant to respond. This same technique was used in the in-person Back on Track groups. Often a 15–30 minute core of information or concept would be presented and then the round robin for each group member to respond. One major theme with this approach that was noted was complete engagement in the content and how they would apply it for themselves, which then led to new self-discoveries. This phenomenon was not seen in our previous non-coaching groups where there was little time for interaction or self-processing; it was a teacher student model. Many of the participants stated they were beginning to think about their weight differently, letting go of past views that may have been holding them back. The participants expressed hope for themselves and a resolve for their ability to create change in their own lives. As one participant shared a new insight many others would build off of that foundation for themselves. The group process with coaching took on a life of its own in the ongoing self-discoveries of the participants. These personal

discoveries led to personal choices for change which were more likely to be internalized by each individual and more sustainable.

CHAPTER 4

RESULTS

This chapter will demonstrate the depth of life change that is a consequence of releasing weight in the range from 80–100 pounds. Many of these individuals have carried around with them a life time of shame about their size and weight. The transformation with the coaching process is profound and appears to ingrain new and healthy behavior change for sustained positive health outcomes. Without the coaching process for long-term behavior change it appears the healthy behaviors become challenging over time and weight recidivism is seen in a fair percentage of weight-loss surgery people (Dykstra, 2014).

Subjects

The first three Back on Track courses were given in 2006 as written courses, without coaching skill incorporated, about 19 subjects total, all women, average age 40. The course ran for 2 hours once a week for 8 weeks. Approximately 50 subjects participated in the Back on Track course from 2007–2009 with coaching integrated into it. All of the subjects participating have had one of the three weight-loss surgeries, lap band, gastric bypass, or vertical sleeve. There were approximately 20% men and 80% women in these courses. The age range was from 30–70 years with the average age of about 45. The subjects were primarily residents of Santa Clara County. Introduction to Bariatric Coaching Skills was taught from 2007–2009 only on the phone. The subjects were located primarily in the United States, Canada, and one from Australia. The phone bariatric coaching courses consisted of 90% women, 10% men,

with an average age of 45. All subjects paid a fee for the Back on Track as well as the Bariatric Coaching Skill course. It was recommended that those who participated in the Bariatric Coaching Skills course be post-surgery by one year. There were about 150 participants over the 2-year period.

Research Questions

In relationship to the bariatric patient or client, the difference in the level of involvement, commitment, and health improvement when a person participates in a coaching approach was observed to be significantly more sustainable over time. The didactic approach gave clients information but no inspiration. It was observed that those individuals who experience coaching through Back on Track or Introduction to Bariatric Coaching Skills remained engaged in personal development past the second year and even longer. They continued to question their thinking, seek information, and then process that information for themselves. It was also observed that preparation in coaching skills made for more effective Support Group Leaders, who were able to engage their participants for extended periods of time over 1 year. It was recommended that subjects who took the introduction course to bariatric coaching and wanted to open their own business pursue a Life Coaching Foundational course accredited by the ICF. Having the Optimal Health Wheel for bariatric clients assisted them in focusing in one area based on their view of the need for growth or change. This dissertation asks the important question if using a bariatric coaching approach with preparation and tools along with obesity surgical treatment can and does maximize positive long-term health and life outcomes for the obese client. The biggest challenge facing a significant number of people in the bariatric community is

maintaining healthy lifestyle behaviors over the long term and preventing weight regain.

Results

Through an interview process of requesting a vision or a smaller hope to get vignette question, the respondents share profound ideas about their vision for their own lives. These interview responses are formulated through the Back on Track or the Bariatric Coaching Skills course to allow each individual to experience the ability to change their own thinking, change their behavior, and ultimately change their health and life in a positive way. It is a small sample of client participants in the coaching groups. Some of them gave permission to use a first and last name, some just a first name and others wanted to remain anonymous. I did not edit their responses for grammar. The responses are word-for-word each client's own response, with their spelling and punctuation.

Once our clients have envisioned one of their relationships being in a state of joy and authenticity which is equal to well-being they can begin to look at each relationship in their lives one by one. Relationships in balance create relationship well-being. The first coaching question was the following:

How has weight loss changed your relationships? Here are a few of my client's responses in the various coaching and bariatric coaching courses.

A. My biggest change was the one with my very best friend. We were friends for 18 years. I had my surgery on Nov 14th, 2003. I had RNY. At first she was so supportive and encouraged me all the way. She as well is overweight. She first was not interested in the surgery says it's the easy way out. Now she wants the

surgery but is going through some run around. I found the thinner I got the less she was around. Now I speak with her very rarely. I am so sad by this ending of a great friendship… I will send some positive ones as well but thought this is the one that hurts me so much and happens to a lot of us women.

Linda

B. Regarding Transforming Relationships my story is one of being honest with people. For many years I simply joked and laughed about my weight and everyone I worked with or was friends with joked and laughed good naturedly with me. When I decided to finally have Bariatric Surgery I decided to be very, very open and let everyone know how irritating it is to ask for an extension belt of plane over, and over, and over again. I told them how because the seats were so tight that my seat back would automatically go back because my leg pushed the dammed button. I told them how I loved gardening but could not bend over or kneel down to do it. I made it very clear WHY I could not do something they asked me to do and what I was doing about it and when. I stopped joking and laughing about my weight and showed instead the pain and frustration of doing simple things others take for granted. I told my fellow employees the embarrassment of having the company takes out TWO tickets on an airliner just to hold me. I stayed jovial but not about being fat but about not having these frustrations any longer. I told my neighbors, my grocery store, my fellow employees and my relatives and friends. I made them all share in my happiness that I was finally going to do something positive about my weight.Then, as I gradually lost weight prior to surgery I took their compliments and put them

into perspective and how this was strictly the start BEFORE the surgery. I also read everything about the surgery and became so well versed in the procedure that I could tell people how various methods differed and why I made the choice I made of the Lap Band.

C. People changed their relationship with me and I with them. I was no longer the big fat heavy man… I was the guy that was about to make a lifestyle change. What I found is that people were totally supportive and even interested. Almost everyone had battled weight…even if only ten pounds…and they were happy to see someone doing something about it.

Client Stories. Barry

It's been 5 months since my gastric bypass surgery. I had the Roux-en-Y bypass on November 29, 2005 and I've lost 76 lbs so far. I'm feeling good although it's been an uphill battle part of the way. I'm 62 years old and I guess the older body takes a little more time to adjust to the new way of eating after surgery. I still have difficulty eating meats and some other foods but I haven't given up the fight. Just when I think my body is comfortable with a new food, I am reminded that I had stoma-reducing surgery and I just can't eat like I did before. I usually vomit and actually, that's a good thing! I know my bypass is still working. I even worry when I haven't thrown up in a couple of weeks!

Anonymous

2. My relationship with my husband has changed somewhat. My husband use to act jealous of me when I was a heavy person but now, strangely enough, he's not! We don't bicker like we did in the pre-op days. He is so supportive of my decision to have

gastric bypass surgery. He's there for me when I weigh in or buy new clothes and he's there for me when I'm not feeling well. He reminds me to take my protein, vitamins, and to drink water. I know that he's as happy as I am to have me in better shape both medically and physically. My adult children are very supportive of me too. My son had lap band surgery and my daughter-in-law had gastric Roux-en-Y bypass surgery about a year ago. It was they who inspired me to pursue a healthier life for myself. My other children encourage me every day on my journey to a better me.

3. My relationship with my best friend remains close. I didn't tell her about my surgery until about a month ago and when I did tell her, she was 'proud' of me. She just can't say enough kind words to me about my new look.

4. I haven't told my relatives about my surgery yet because they live so far away and have no idea how much weight I've lost. My Mom and one of my brothers will most likely be critical. The other two brothers will be okay with it but for now, "I'll wait and see". I have never regretted my decision to have gastric bypass surgery. I sleep like a baby at night, no more cholesterol medication, no more acid reflux, my knees and feet don't hurt like they did before my surgery, and best of all no more incontinence. I'm not afraid to be seen in public, I don't mind having my picture taken, I can shop in 'regular-size' clothing stores, and I don't hate mirrors. I just plain don't feel invisible anymore!

Happy to be alive – Susan

Sample Bariatric Client Vignette's Introduction to Coaching Skills Vignettes

Maryn-My Health. I see myself free of medical conditions that have held me back in the past - free of high blood pressure, sleep apnea, pre-diabetic, irregular menstrual cycles, low energy, sedentary lifestyle. I envision myself filled with energy, being able to physically do what I want (ie: bungee jumping, zip lining, bike riding, taking long hikes, etc.) I see a beautiful, sexy body that fits into a single-digit size!

My Career / Bariatric Coaching

I see myself as a successful Bariatric Coach and support group leader. I have an abundance of clients with whom I work with on a regular basis to support them in achieving their health and WLS goals. I work in partnership with a few bariatric surgeons to help support their WLS patients as they move through their WLS journey. I facilitate support groups and empower numerous people throughout their WLS journey. This success will allow me to resign from my corporate job and focus on my Bariatric Coaching career full time while raising our children.

My Family

I see my life filled with joy being married to Jill and raising our family. We will have 1-2 children and it will be so amazing! My marriage to Jill is such a blessing – filled with love, passion, communication, fun, laughter, honestly, vulnerability, caring, support for each other, balance, and commitment. Out of our love, we are creating our family with at least one child. The amazing miracle of life happens through us as we grow our family. Our child will know a home filled with love, compassion, joy, and laughter.

Cassandra If Life Were Perfect 3/14/11

If Life Were Perfect: Vignette 1

My husband and my 15 year old son (his step-son) would love each other, enjoy each other's company, respect each other, and want to spend time together.

When life is perfect, my husband and 15 year old son love each other and we can't wait to have our next family activities together. There would be so much less tension and stress in the house. We are a very happy family who enjoys each other's company more than anything else. We eat family meals at the dinner table at home several nights a week and on weekends. I'm busy in the kitchen chopping vegetables, opening cartons of chicken broth and filling the frying pan and several other pots & pans with delicious, healthy meals that everyone enjoys. I smell the luscious odor of the different dishes when I open the pots to see if they are done. It smells wonderful, and I see that people are beginning to hover around the kitchen asking how long before it's done. I feel the smoothness of the plates and serving bowls as I take them to the dining room table, and I see that glasses of tea or water with ice are already there. I can hear the serving utensils clacking against the serving bowls as I watch everyone get their desired helpings of food. As we begin to eat, I hear laughter and good-natured joking from everyone at the table. Everyone is giving their tales of their day, and everyone else is listening intently. As each one finishes their meal, they are talking about how good it was and how they are stuffed. I see smiles on everyone's faces, and there are clean plates all around. I am very content and satisfied with my family and the life we have created together.

If Life Were Perfect: Vignette 2

When life is perfect, I am about 150 lbs and fit my clothes like a model. When life is perfect, I am about 150 lbs and fit my clothes like a model. I taste the satisfaction that only the confidence of looking great can give. As I get dressed I gently trace my oblique muscles across my perfect waistline. I hear complements all the time about how fantastic I look in my clothes and people are always complementing me on my sophisticated sense of style. I see myself in the mirror with flawless hair and makeup, and a body to kill for. I wear expensive perfumes and smile when I get a whiff of the aroma. I am very happy with my body and my shape and I see that I knowledge that I have the body that I always wanted to have. I am ecstatic that I made the decision to WLS 11 years ago in the midst of my darkest moments ever.

If Life Were Perfect: Vignette 3

When life is perfect I am attending a multiday spiritual workshop studying with Neale Donald Walsh.

When life is perfect I am attending a multiday spiritual workshop studying with Neale Donald Walsh. Upon arrival at the venue, I hold his hands and pray with him. We chat about my trip and how happy he is to meet me. I am giddy with delight. I feel an incredible sense of excitement and anticipation. In the registration area I smell scented candles given off a lightly sweet aroma as I complete the paperwork and pick up my materials and badge. As Neale begins to speak, I can barely contain myself. I almost can't believe that it's really happening! I'm finally here! I hear the words and principles of Conversation with God that so impacted me in 2004 that it changed the direction of my life. Neale has invited other speakers that also enhance my experience

of the materials. I see the other students sitting at tables within the small intimate venue. They are simultaneously furiously writing notes and basking in the aura of the event. During the meal breaks I taste new regional foods of Oregon at local restaurants and fantastic vegetarian meals served at the event. It is one of the pinnacle experiences of my life. I cannot stop smiling.

Corbin, B. / Vignettes / Spring 2011

Vignettes of Barbara

1.) I am holding my first Success Habits class in a meeting room of Geisinger Medical Center, the local hospital where I had my bariatric surgery 4 years ago. The room looks bright and cheery, with posters and signs I put up earlier, and a table displaying S.H. products, games, and some giveaway items. There is also a refreshment table, and rows of chairs set up. As clients enter, I greet them with a warm smile and a handshake, thank them for coming, and provide them with an introductory handout about this class and myself (showing my before and after pictures) letting them know I'm "one of them" & I understand their journey. Its winter and I've prepared some sugar free hot chocolate and mulled cider for refreshments, which smell (+ taste) warm, comforting and inviting for the clients. They help themselves to drinks, and I hear their initial greeting conversations as they cautiously mingle at the refreshment table, with the warm drinks serving as "ice-breakers" for this 1st meeting.

I see the hour unfold successfully, as the clients and I interact with each other through the presentation of the S.H. materials and games. I sense their nervousness lessening as they become engaged in the lesson and conversations, and I see their demeanor shifting from skeptical to cautiously hopeful, which invigorates me as I

invite them to join me for the next class. As I say my goodbyes and begin packing up my materials, I am smiling, feeling relieved and happy that it went well, and I'm already thinking about how to present the next class!

2.) Its August and I'm in Puerto Rico with my best friend Wanda, visiting her family there. When I was there with her 4 years ago, I was only 8 weeks post-op from my bariatric surgery, so I was still obese and could only eat very limited types + amounts of foods. It was also hard for me to do activities like hiking and snorkeling then. This time I am 135 lbs., full of energy, and ready to enjoy the full experience of exploring the activities and foods that Puerto Rico has to offer. As Wanda and I hike through the rain forest, I marvel at the colors in the myriad of plants, trees and birds that surround me, while I listen to the dripping of water droplets from palm leaves overhead and the almost raucous sound of tropical birds and the ever-present "coqui" – the tiny native tree frog of Puerto Rico. The play of light and shadow through the canopy of leaves above create beautiful scenes worthy of painting. I feel my leg muscles working and flexing as we ascend the rain forest trail, and the sweat trickling down my neck; I relish my ability to undertake (and enjoy!) this climb. I'm also enjoying rediscovering Puerto Rico this time, especially after rediscovering my physical + emotional self that had been lost, buried underneath obesity and self-loathing for so many years. The rainforest feels alive, timeless, spiritual and free… and so do I as I breathe in its essence.

3.) I'm sitting in a chair at the tattoo parlor, marveling that I had the courage to come here – and wondering if I'll have enough to actually get the tattoo without "chickening out"! My heart is pounding and my palms are sweating from nervousness,

but it's also exhilarating to be here – marking a sort of "rite of passage" celebrating my long journey from obesity to healthiness, of both body and mind. I've chosen this particular, permanent mark as a symbol to remind me of the journey and to celebrate how far I've come. The artist assembles his colors and needles, in preparation for creating the small, delicate, blue butterfly on the back of my right shoulder. I close my eyes as he begins, feeling a slight stinging sensation as the needles apply the color to create my butterfly in flight. I imagine I am the blue butterfly, free from my cocoon at last, flying effortlessly in the sunlight among the flowers and trees. In a short time my tattoo is completed, and I admire the beautiful image… a permanent reminder of life's journey of transformation, beauty and grace -- for the butterfly and for myself. I feel happy, confident + grateful for my life.

Kathryn-Summer 2011

Vignettes Bariatric Coaching – Topic 1 (Vignettes)

Business/Money

I am a success magnet. Every business goal I set and pursue turns to gold. I maintain a comfortably busy balance of coaching clients (bariatric-specific and non-bariatric-specific); BSCI educational programs via live sessions, webinars and telephonic; as a workshop presenter and writer of articles regarding goal-setting, positive thinking, paleo nutrition, etc.; as a personal trainer specializing in services to obese clients; and nurture my creative energy making art quilt and other textile items. I attract positive people to my business endeavors that fuel me to keep moving forward. I learn from the people I help as much as they learn from me. I always maintain a busy but peaceful and energizing pace. I plan and organize my time to run

like a well-oiled machine. I have no concerns about money, as it literally drops off the trees.

Health

I feel the lightness of being cancer-free; physically, mentally, and spiritually. The sun shines in my soul with the knowledge that I am free of this disease. I keep my body healthy and strong by getting proper nutrition/supplementation, focused and intense exercise, and positive-thinking, and appropriate medical care. Every day I challenge myself to do what is needed to remain in a healthy, vibrant state. I feel "strong like bull" (said in a German accent) and can easily do any physical activity I want.

Travel

I live in Greece several weeks a year. I am not a tourist; I live the life of a resident. The daily pace energizes, refreshes, and centers me. The ebb and flow of the waves gently lapping against the beautiful beaches lulls me into a relaxed, calm state. My days are filled with gentle walks through the maze-like streets really seeing everything around me and breathing in the ancient culture that surrounds me. I am one with the sun, the sea, the earth, the air. Every day at dusk I stop to watch the gentle descent of the sun on the horizon, always a breath-taking and life affirming event. Then later, I meet up with new friends and sit along the port at a tavern or restaurant enjoying the evening breeze. Later I spend some time in quiet reflection either working on a hand-sewing project, reading or writing.

Stefanie-July 18, 2011

Introduction to Coaching Skills-Vignettes

1. I am continuing to move forward in my career/occupation. I am continuing my education so that I am going to be the best I can be in my field. By continuing my education I am going to help my patients/clients to the best of my ability. This would make me feel better not only as a bariatric coordinator/coach, but as a person. I would have the ability to help my patients/clients to be empowered and to find their own solutions/answers. In doing this, I would feel more empowered too.

2. I am improving my financial/money situation. I am focusing on making a budget and sticking to it. I am finding ways to save money by using coupons or purchasing things that are on sale. In doing this, I am feeling like a huge weight has been lifted off of me. I am also feeling a great sense of accomplishment in getting my financial/money situation under better control. By getting my financial obligations more manageable I am relieving any extra stress that this causes for me.

3. Tom and I are retiring to our lake house on Lay Lake when we reach retirement age. We are drinking coffee and relax on our sundeck every morning. We are watching the beautiful sunrises daily. We are taking daily boat rides on the lake in our pontoon and enjoy the cool breeze and warm sunshine. In the evenings, we are enjoying the sunset together as our day ends.

Why I had WLS.....By. Jim

To participate in life again (I was existing....NOT living!)

To not need to make EVERY decision...big or small....based on accommodating my size. I wanted to feel good about myself again.....regain my lost self-esteem!

Move forward with work...career....school.... finish what I started!

Regain my independence....in many ways

Regain my health....fitness...mobility....ability to perform.....physical activities

Be able to travel again.

Spend time with family friends again

Get into a meaningful...long term relationship

Enjoy the little things in life again!

To find my voice....personality....humor.... giving soul....and loving heart again!

Life Visions/Purpose: Steve Pavlina's is (Pavlina, 2005) to live consciously and courageously, to resonate with love and compassion, to awaken the great spirits within others, and to leave this world in peace.

Maryn Eisenhart-Intro to Coaching Skills-My Life Vision

I see my life filled with joy, happiness, abundance, freedom, passion, love, bliss, connection, fulfillment, compassion, contribution to others, vibrancy, spirituality, honor, commitment, and peace.

My life is about connections – to myself and to others. I see myself living life with passion and joy as I continually move down this path of personal growth and achievement. I see myself surrounded by many people whom I love and who love me – my wife, our children, our families, and our friends. Everyone in my life gets their worth and contribution to each other. I am a dream maker – I make my own dreams come true and I empower others to make their own dreams come true as well. I experience such joy when others succeed.

CHAPTER 5

SUMMARY, DISCUSSION, AND RECOMMENDATTIONS

SUMMARY

The problem stated in the beginning of this dissertation was the approach professionals' use in educating, teaching, and informing the new weight-loss surgery client about healthy lifestyle behaviors. For years the traditional technique for teaching new information was the expert- or teacher-centered model. This simply may be summarized by saying an expert who has the information presents to the learner with stated objectives, gives the information and then reviews for comprehension or perhaps memorization of the material. Hundreds of studies in the past 4 years have shown that having client/patient-centered, motivational interviewing, bariatric or health coaching improved long-term health behaviors.

There are several challenges with this approach, first there are many terms for this type of approach, such as: motivational interviewing, positive psychology, and health coaching to name the most popular terms. Each one of these terms comes from a different profession dealing with clients and or patients who have chronic health conditions. The most dominant professions to come out with this approach are social work, psychology, medicine, and nursing. The second problem with this approach is there were no specific criteria for preparation to attain the skill set necessary to assist the expert in sharing information for the many behaviors that needed change for a person dealing with a chronic disease. There were many very creative acronyms and methods to approach the client-centered model. The training or teaching of these skills went from several hours to 24 weeks in some cases for a college certificate program.

These programs targeted a particular client population, such as diabetics, or were more general and labeled health coaches. There was no documented literature or studies specific to weight-loss surgery. There were many coaching programs geared toward clients for losing weight. Recently on television I saw a commercial advertising Weight Watchers and their new service of peer coaches who had lost weight with the program and were available by phone. It is not clear if the peer coaches had any preparation for this role.

This researcher chooses to focus on the coaching approach specifically, even though there is a great deal of similarity and overlap with motivational interviewing techniques and positive psychology focus. This also proved to be a bit of a challenge with coaching being relatively new profession that is being defined. The coaching profession itself has gone through many changes and for the past 20 years has had the International Coach Federation (ICF) to assist in defining competencies, forming ethics, and creating guidelines for course work and for practice with clients. Health coaching over the past 5 years has become extremely popular due to its cost effectiveness in health care (International Coach Federation, 1995). Again, the challenge is that even as we refine our terminology to health coaching it is defined and preparation is different in various settings such cardiac rehabilitation, diabetic education, and weight loss management without surgical intervention. From health coaching this researcher wanted to refine the model to be more specific to the bariatric coach. A bariatric coach is a person who works primarily with clients who are overweight and living with obesity and then they are preparing to have, having, and recovering from weight-loss surgery. They have chosen weight-loss surgery as the

primary tool to assist with long-term health improvement. These clients are also recovering from severe obesity and obesity thinking. The term *bariatric coach* created some awareness in 2006 with two life coaches who had had weight-loss surgery and believed a more specific approach of coaching to weight wellness and life would assist these clients in internalizing the multitude of lifestyle behavior changes required to remain healthy over the long term. Many of the hundreds of weight-loss surgery clients we had dealt with prior to 2006 has success in the first 2 years after surgery and then began to encounter significant challenges with maintaining and or weight recidivism. A gap was discovered in this whole process of obtaining optimal weight through weight-loss surgery. That gap was long-term behavior change and what does it take to maintain long-term change? This researcher, along with Lassetter, has facilitated weight-loss surgery support groups since 2005 at Good Samaritan Hospital in San Jose, in the community at the Saratoga Community Center in Saratoga, California, and at Stanford University in Palo Alto, California since 2008. The attendance is about 20 participants per month in four groups per month. Many of these participants had on-going challenges after the first 2 years with unhealthy life style behaviors creeping back in.

As soon as the gap of knowledge and behavior change was discovered we began teaching Back on Track courses developed by Colleen Cook and Janean Hall of Bariatric Support Centers International (Cook, 2005). This was a proven course with reliability and validity based on long-term use and results of weight maintenance by the developers of the curriculum, who were both weight-loss surgery people themselves. There was still a noted challenge in long-term behavior change;

knowledge of what change is needed was not enough. Foundational life coaching courses and post-graduate courses had significant transformational effect on this researcher and Lassetter. From this experience we developed and integrated coaching into the Back on Track course and also developed the Introduction to Bariatric Life Coaching Skills, which is a 30-hour course plus observed coaching sessions, that offered 30 continuing education units to nurses or other professionals. The transformation observed in Back on Track participants as well as Bariatric Coaching Skills course was significant. The evaluations from participants were extremely positive, like nothing they had experienced before related to learning about lifestyle behavior change, compared with the pre-coaching approach used for Back on Track. This researcher taught three Back on Track courses before coaching was integrated. However these courses had been given 100s of times by those individuals who had gone through the course at Bariatric Support Center International. They received positive feedback but not the transformational effect seen with the coaching approach. Working with clients from where they are and not where we want them to be was a shift for many professionals as well as participants. Many of our participants were already facilitating bariatric support groups of their own and found this additional skill set transformational for them as well as for their group members. A big challenge was how many hours of preparation for bariatric coaching was sufficient or needed for each of these courses. It was a process of discovery the first couple of years as development took shape.

The second major problem we encountered was how to assist the bariatric client to focus on one area of behavior change at a time using some kind of tool. There

is change needed in the area of physical activity, diet, water intake, vitamins, health thinking, relationships with health-care providers, and many more. The numerous areas of behavior change are overwhelming to the new weight-loss surgery individual, and some give up after a year or less. There were many wonderful life coach wheels developed by Laura Whitworth and others. These wheels and or charts did not speak specifically to the areas of behavior change needed by these weight-loss surgery people. This researcher began looking for tools used in obesity management and weight loss and still did not find any suitable tools specific to the behavior change needed for positive long-term health outcomes. I did find an action plan used in a primary care health clinic for patients dealing with chronic disease that was interesting but still not quite right. This researcher is a study coordinator for weight-loss devices at Stanford. The Empower Study included weekly and then monthly behavior lessons with each client visit, and this researcher delivered those lessons to the study subjects. Each lesson had a pre-determined topic and a few open-ended questions. Through this process, valuable information for long-term health behavior change was delivered. However, the ongoing challenge of how to motivate the subjects into internalizing these new behaviors was still a challenge. This researcher naturally used a coaching approach to deliver these behavior lessons and noted a challenge with the subject not being the center or making the choice of topic for that week or month; the topic was pre-determined. It is critical that behavior change is seen as needed by the client and then understanding where that client or subject is and what they are willing to do to change behaviors to get the desired state of health. A great deal of information and observations were accumulated through the encounter of various study subjects who

had a device implanted for weight loss and the hundreds of clients who had weight-loss surgery and participated in bariatric support groups, Back on Track, and Introduction to Bariatric Coaching courses. It became clear that a specific tool needed to be developed for this specific population of subjects to assist in focusing and to eliminate some of the feelings of overwhelm encountered by so many people after weight-loss surgery.

The method used to conduct this study was observation of behavior change, life satisfaction, motivation over time, and internalization of new healthy lifestyle behaviors using the phenomenological approach. Many of the participants in the two primary courses were observed for significant themes attitudes and behaviors over a 4-year period from 2006–2009. Several themes were observed during this time which will be discussed under results. Typically the observations were noted from the beginning of a course, during the classes in person, or on the phone. This researcher observed the subjects current state of thinking, common behaviors that lead to resistance versus behaviors that lead to change. There was a pre-course questionnaire asking the subjects what they hoped to learn, achieve or get from the course work, and then a verbal checking in each week of class content, followed by an evaluation of what was learned about themselves or what they as individuals were taking away from the course for themselves, as well as instructor feedback from the subjects. The awareness of difficulty in measuring motivation using a double-blind control study with this type of approach was extremely difficult. Many of the other studies were able to measure significant benefit of the coaching approach but not how much preparation of the coach would offer how much benefit for the subjects or what tools would be of

value for this specific population of subjects. It was clear that over-reaching themes in many areas were emerging for all of the subjects participating in the bariatric coaching process. With the addition of a tool for focus in a particular area of behavior change, this allowed for faster progression toward change in overall behavior for optimal health. Small victories were observed in one area and then stimulated confidence in other areas. In the group process either in person or on the phone a noted observable theme of exponential thought change and then behavior change was noted. Many answers to open-ended question were shared, and the subjects volunteered to allow this research to use them, some with first names only, some first and last names and others preferred to be anonymous. All permission for sharing of awareness was oral and by giving the instructor copies of their written responses. Most processing of responses to open-ended questions was done in the group orally and in written documentation kept by the subjects for their own personal growth.

The results of the bariatric coaching approach showed several themes throughout all courses. One major theme was a profound change in thinking and openness to new ideas regarding their weight. Concepts like: What has excess weight taught them about life? How did excess weight define their choices in life? What brought them to the profound decision to have weight-loss surgery? How has excess weight protected or helped them in life? Are they ready to release excess weight? How to release negative thinking about excess weight? How do you let go of shame and blame? How to create a healthy vision for the future? Finding the emotional foundation for their choices and decisions can be a major motivating factor in maintaining new behavior changes over the long term.

The Back On Track course was 12 weeks with a focus on healthy weight, versus 3 months for the Introduction to Bariatric Coaching Course, which focused on internalizing many new ideas and possibilities for health and life. It is extremely difficult to measure the amount of motivation, the exact amount of change related to ways of thinking by each subject. The excitement of the subjects during the course was palpable and Lassetter and Schroeder felt it in every class. Many of the subjects wanted on-going classes and did not want the weekly sessions to end. Each subject seemed to gain substantial insight to ways of self-defeating thinking that had been holding them back and learning new ways of thinking to propel them forward toward their optimal desired state of health. The power of positive thoughts in creating positive change was a definitive theme throughout all of the courses.

Through this process the instructors and facilitators of support group became more skilled as time when on using this new bariatric coaching skill set. Not only does this approach improve subject or client outcomes, the coaches benefit as well.

Discussion

It is well known in the health-care arena that the double-blind control studies offer the most concrete results. However, human experience is not concrete and the phenomenological research model was a great option for this approach to weight-loss surgery subjects and long-term behavior changes for optimal health. The most significant findings were the motivation, excitement, and interest for on-going learning toward behavior change noted by all subjects who participated in these courses. Each subject began in a different level of awareness and ability to process in order to change. In each case progress was observed, not in a number on a scale but in the

thinking related to the number on the scale. Each individual was able to find something to think differently about. This process led to a sense of empowerment related to their health and their lives.

There were several non-significant instances of what is called magical thinking (Mosby's Medical Dictionary, 2009). Individuals who have this want someone else to be completely responsible for their problem of excess weight, so there must be a magic surgery, a magic pill, a magic course, or idea that will cure them of their chronic disease. It is completely out of their control, and so they do not need to do anything; the power comes from external sources. A question this researcher has is if we could identify magical thinking before weight-loss surgery, could we improve outcomes? For years we have used the term *tool* for weight-loss surgery and trying to get away from *cure* terminology. Obesity is not cured; it is managed similar to diabetes or other chronic diseases. This researcher is very concerned with the term *cure*. The term to cure for the disease of obesity allows the individual to believe they do not have to do anything more once they have had weight-loss surgery to maintain their weight loss or state of health. This thought of weight-loss surgery has cured my obesity can go on for many years after surgery. These individuals have been observed not to maintain their weight loss and in many instances regain weight.

There were many issues that arose in the process of this research dissertation since 2006, at first it seemed like a work of excellence or a manuscript could more accurately described what was being observed in these courses. As time progressed, more studies were being conducted with health coaching due to this noted phenomena of positive behavior change with chronic disease creating better outcomes than our

long used traditional approach. This researcher began to think of a double-blind control study would be best. The biggest challenges with this are time, money, and overall cost. Certainly there was a noted theme throughout these courses that was being observed: the degree for each individual could be profoundly different. It is not clear that the amount of change matters as much as the ability to be open to change over time.

Recommendations

About 1 year ago at Stanford University one of the medical students was starting a study and asked for my input as a bariatric nurse, weight-loss surgery person, and as a life coach. With the direction of a very skilled researcher and primary investigator in the School of Medicine, Dr. John Morton, a "Peer Coaching" study for weight-loss surgery patients was proposed. It was approved by Stanford's Institutional Review Board and this researcher was able to give the 2.5 hours of peer coach training over web conferencing to the peer coaches. This study is still in progress. It is a double-blind control study looking at the benefits in weight loss, A1C levels, and hypertension in the subjects and weight loss in the peer coaches. This could prove to reduce costs and improve long-term life style behaviors. Many weight-loss programs advertised on television are offering coaching services. The challenge remains what kind of preparation is needed for these bariatric coaches to be optimally effective? This researcher sees the potential for a specific course similar to the Introduction to Bariatric Coaching that could be set up as a double-blind control study; perhaps a bariatric lifestyle satisfaction tool could be used, checking weight, blood pressure, and other potential measurements. For this researcher the experience and knowledge I have

gained through this process has led me to use bariatric coaching skills in my bariatric support groups and has also led to participants requesting more Back On Track classes.

The traditional approach tends to assume clients can be treated with the same protocol for weight loss. This approach does not address the need for individualized treatment. Professionals prefer the didactic approach to weight loss because it is more time efficient in the short term. I believe there is a great deal of opportunity for coaching in bariatrics to assist clients in obtaining and maintaining optimal weight. Bariatric life coaching assists clients to set up their own behavior changes based on their stated need for change in particular areas and therefore increased compliance for long-term change. This approach has been shown in many studies to improve long-term outcomes.

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APPENDIX- A

Coaching the bariatric client toward Creating Optimal Health Weight Wellbeing and Harmony Introduction: Health-Weight Wellbeing/Harmony Wheel

This simple assessment of will help you discover how the client views his/her balance of health areas are at a snap shot in time, and those health areas your client may want to invest more focus and awareness if they want to avoid the problems of stress and ill-health.

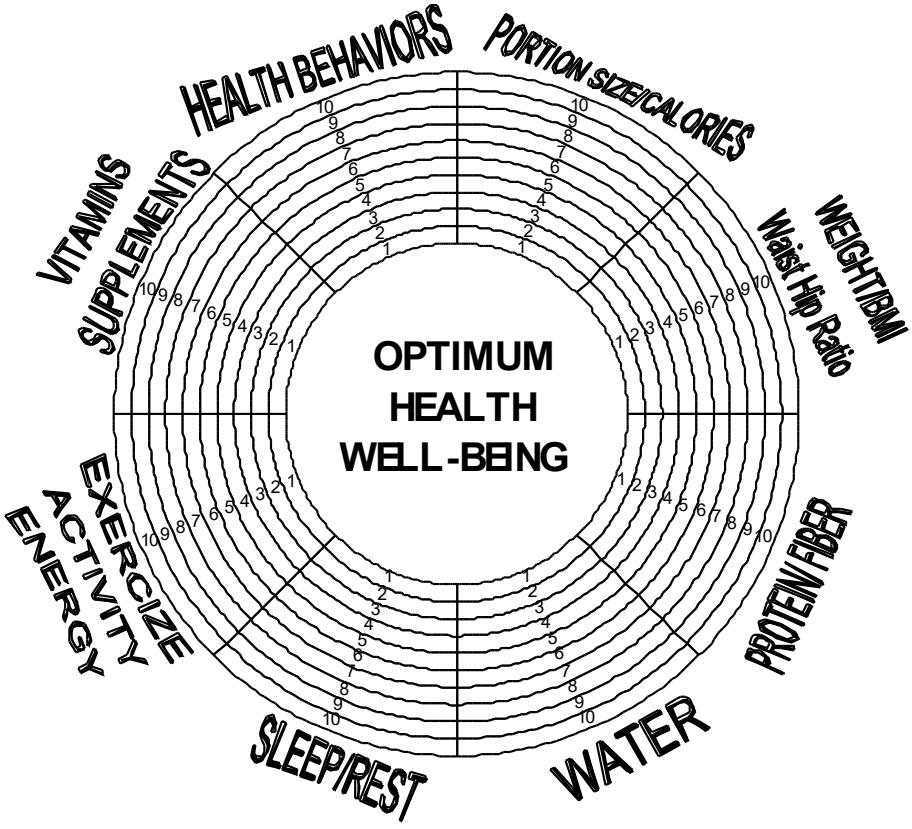
Step 1: Have the obese client evaluate each health area of the circle in relation to where they are in their life right now.

Step 2: Now beginning with Health Behaviors: Doctor's visits, Lab work, addictions-sugar, smoking, alcohol, sex, shopping etc. Portion size: ½ cup, 1 cup etc., Weight/BMI-Waist Hip Ratio, Protein in grams, fiber in grams, Water-ounces per day, Sleep/Rest: combine sleep in hours plus rest in time as well, Exercise, Vitamins and Supplements as recommended, then allow the obese client to decide how invested they are with each piece in turn (invested means giving time and energy, both physical and mental to that area of health). Have the obese client rate each area of investment on a scale of 1-10 (1 is little or no investment and the inner ring of the circle, 10 is maximum investment and the outer edge of the circle).

Step 3: Once your client has decided on their level of investment, for each area of health, count from the center along that spoke, towards the outer rim of the wheel. If the client believes their investment in Health Behaviors is 7 then they will count 7 from the center along that spoke and mark it with an X. Have the client do this for each spoke in turn. When you they have all 8 spokes marked you as the coach will

have a picture of the clients view of balance of health areas in their lives.. The client can re-label each spoke to fit their personal situation. Then they can collect all the points to acces how balanced they believe their wheel is. Perhaps in an ideal world the client would be fully invested mentally and physically in most health areas of their life, and their diagram would resemble the outer circle. In reality it is more likely that the diagram will be shaped towards one or two health areas and they may be dominating your wheel and your client's life.

Step 4: Look at the client's wheel and ask the client which health areas they wish to focus on right now. It may not be the ones with the lowest number but the ones that they feel most drawn to.



Let us begin by looking at Health Habits. Health habits are defined as habits, behaviors, beliefs and values related to health. Some questions to have your obese client consider:

1. How often do they see their physician for lab work, check-ups? Do they keep records of lab work trends?
2. Do they consider themselves to have any addictions, such as: smoking, refined sugar, exercise, shopping, sex, obsessive/compulsive disorder, alcohol/drugs or?
3. What do they consider important health behaviors?
4. Do they see benefits in Eastern and Western health care?
5. What benefits do they see with Eastern Health Practices?
6. What benefits do they see with Western Health Practices?
7. Do they have any chronic diseases, co-morbidities or conditions? Such as:

- Diabetes Mellitus or Adult Onset Type II
- Obstructive sleep apnea/OSA
- Hypertension/ high blood pressure
- Heart disease
- Pulmonary hypertension
- Restrictive lung disease
- Depression
- Hypercholesterolemia
- Degenerative joint disease/DJD
- Degenerative disc disease/DDD

- Gastro Esophageal Reflux Disease/GERD
- Cancer
- Panniculitis
- Urinary incontinence
- Plantar Fasciitis
- PCOS
- Insulin, Leptin or Dopamine resistance
- Pseudo-tumor

6. Have your client describe their level of functioning if they do have any of the above conditions?

7. Have your client describe in as much detail as possible the level of functioning they want given their health challenge?

Coaching increased awareness of the bariatric client with optimal portions/calories specific to them. How can the coach assist the obese client to discover the number of calories, and portion sizes that are needed to optimize their client's state of health?

Portion Size is the next area to consider in health wellbeing. It is well known in the United States that we have portion distortion! You can go to any restaurant or fast food place and see that bigger seems better. How do you as a coach assist the obese client in defining proper portions?

Coaching increased awareness of the bariatric client with optimal Body Mass Index (BMI)/Waist Hip Ratio. How can BMI be useful in creating optimal health beliefs and values in the obese and bariatric client?

Weight is the next area of health that can give your client some specific information about health status. It can be a baseline to determine where the client is now and where the client may want to be. Weighing one time per week is recommended, more often may indicate and obsession with the number on the scale, less often may indicate some denial of the data. There are many different types of scales; a scale that gives multiple pieces of information will be the most beneficial. One that is useful in the home and healthcare setting is a scale that does Body Composition Analysis. The weight scale I have has a print out with all of the following information:

- Body Type: Standard or Athletic
- Gender: Male or Female
- Age
- Height
- Weight
- BMI
- BMR: Basal Metabolic Rate measures the energy expended by the body to maintain normal body function such as respiration and circulation. (24)
- Impedance: This value reflects how hard a mild electrical signal has to work to travel through the body. Lean mass (containing water and electrolytes) conducts the current, while fat mass acts as a resistor to the current. A standard range for

impedance is 200-650 Ohms. Do no compare impedance values among different people.

- Fat Mass: Actual fat mass (in pounds, kilos, or standard pounds) in the body.
- FFM: Fat Free Mass is comprised of muscle, bone, tissue, water and all other fat free mass in the body. A healthy ratio for Fat Free Mass to Fat Mass is approximately 5:1 for females, and 7:1 for males. Generally speaking, males carry more muscle than females; therefore they will report a higher FFM.
- TBW: Total Body Water reflects the amount of water in the body. To monitor hydration level, use the following formula: TBW/eight x 100= % Hydration. According to dialysis standards, women should be approximately 50-60% hydrated, and should be approximately 60-70% hydrated. (25)

Tanita Body Scale with Print out

24- David C. Nieman, Fitness and Sports Medicine: A Health-Related Approach, 3rd Ed. (Mountain View: Mayfield Publishing Co., 1995) 382

25- Rodney Rhodes and Richard Pflanzer, 858

BODY MASS INDEX TABLE- APPENDIX C, P. 117-119. THIS IS CURRENTLY THE MOST POPULAR MEASURE OF HEALTH. IF THE CLIENT IS A BODY BUILDER BMI IS NO LONGER AN ACCURATE ASSESSMENT OF OVERALL HEALTH.

Hip to Waist measure is the most recent and accurate way to determine metabolic health risk. Neck circumference is one way to measure cardiac risk. (BMI Table, 2003)

Coaching increased awareness of the bariatric client with the benefits of intake of sufficient Protein/Fiber. Assisting the obese client in defining how awareness of

sufficient protein and fiber can lead to optimal health. The current guidelines for protein post-op have increased for men 80-100 grams daily and for women 70-80 grams daily related to height. (Litchford, 2011) Whey protein isolate is considered the most digestible form of protein.

Coaching increased awareness of the bariatric client with the benefits of intake of sufficient amount of water daily. How to coach the obese client around their water intake and how it impacts their state of health and potential health outcomes.

Coaching increased awareness of the bariatric client with the benefits of sufficient sleep and rest. Assisting the bariatric client to discover how sleep and rest impact their current health and life and future possible outcomes.

How satisfied is your client with the quality of their sleep or rest? How does your client describe the quantity of their sleep? What does your client believe are their sleep needs? When does your client experience the most energy? Sleep is the cornerstone to health well-being. Shakespeare described sleep as "the chief nourisher in life's feast" If a person goes to sleep at 10 pm our bodies will begin the physical repair cycle between 10pm-2am. Stage one is the first 10 minutes of drifting off to sleep, stage two is the next 20 minutes of deeper sleep, stage 3 is deep sleep for about 90 minutes that will allow for delta waves rapid eye movement (REM) phase to follow. REM is the sleep we need for our bodies well-being and to regenerate and recover from our day. Our immune cells patrol our bodies, eliminating cancer cells, bacteria, viruses and other harmful agents. Then from 2am to 6am, we enter the stage of psychic regeneration. During this phase the brain releases chemicals that enhance our immune system. Sleep cycles consisting of rapid eye movement (REM) and non-

REM sleep states or light and deep dream states. Each cycle is about 1 ½ hours. The immune system does not refresh and if cortisol (the stress hormone) levels remain high during the night due to anxiety the immune system is compromised and can succumb to illness and disease. Therefore sleep deprivation can be dangerous to the individual as well as society. (Conrad Stöppler, 2010)

What determines adequate rest and sleep? To continue, let us talk about what the normal sleep cycle looks like. The benefit of adequate sleep is essential for an optimally functioning immune system, physical and mental well-being are determined by the body's ability to recover from stress, fight off infections, maintain normal blood pressure, keep memory and learning at their optimum, stave away depression and irritability and avoid mistakes on the job. Prevent auto accidents. When your clients are sleep deprived stress takes a greater toll, they are more susceptible to viral and bacterial infections, high blood pressure, cardiovascular disease, diabetes and obesity. What is the 24-hour cortisol cycle? Cortisol regulates the immune system on a 24 hour cycle, cortisol levels drop at night and immune cells become highly active at night. The immune cells then begin to kill large numbers of bacteria and viruses causing greater mucous production at night. That is why people with cold or flu experience more congestion and coughing at night to get rid of the mucous. Then in the morning when the cortisol levels increase, the immune cells taper off. The immune cells will then reset rest and rejuvenate for the next night's cycle. Significant problems arise when cortisol levels are off balance by changes in time zones with flying, which will negatively affect the cycle of immune rejuvenation. Sleep and rest can be a time of

creative output and enhance well-being, enhanced insights and new ideas. This is a place where paradigm shifts are created.

For the immune system to function properly sleep is necessary. Natural sleep is the best, due to its providing the essential Rapid Eye Movement (REM) or dream sleep, which improves memory, learning and moods. However if natural sleep is elusive there is a new class of sleep aids that may be of help.

Ambien, Lunesta and Sonata for excessive stress like pain or grief or when loss of sleep is affecting job performance. Typically these drugs should not be taken longer than a few days to a few weeks. Some nutrition supplements that may offer assistance are Tryptophan and amino acid, must be ordered by a doctor, 5HTP is a metabolic product of tryptophan produced in the body and is available over the counter. It is believed to increase serotonin in the brain- the body's own feel good hormone. Magnesium is especially useful for people with Restless Leg Syndrome, and nightly muscle cramps or muscles spasms that disturb sleep. Vitamin K is helpful in reducing pain.

Herbal supplements that may improve sleep such as Valerian Root. Other natural products are:

- Aspirea
- Indian Pipe
- Snake Root
- Lemon Balm
- Hops
- Skullcap

- Theanine

Hormonal Supplements that may improve sleep are Melatonin which is secreted by the Pineal Gland in the body. Progesterone is a hormone that is produced by the Adrenal Gland, Ovaries, and Brain tissue. Some women have an increased level of Estrogen which can cause insomnia, anxiety, mood labiality, fluid retention and bloating. Progesterone can counterbalance the Estrogen in many cases. Growth Hormone promotes growth in the young and tissue health in adults. Someone with low levels of growth hormone experience low energy, sleep disturbances and daytime fatigue. Hormonal therapy is best when considering the interactions between hormones, hormonal metabolism, diet and activity, as well as stress levels. Acupuncture that addresses underlying energy imbalance can be very effective in restoring healthy sleep well-being. (Conrad Stöppler, 2010)

Cognitive Behavioral Therapy (CBT) can be used instead of prescribed sleeping aids or supplements. Coaching can be critical. If CBT is based on the concept that how you think affects the way you feel and behave. I believe this is true so that as a coach we can assist our clients in becoming aware of their though processes, behaviors and beliefs about sleep. To begin we need to ask our clients what are their beliefs about sleep and how do they serve the client?

If a client believes that if they do not get eight hours of sleep every night they will get sick then guess what? Chances are they will get sick. How can your client determine how much sleep they need? Here is a list of things the experts say lead to good sleep: Ask your client which of any apply to them.

- Get up at the same time every day, holidays and weekends included establishing a regular sleep pattern for your client's needs. Take regular breaks during the day and vacations to assist in rejuvenating the mind and body year-round.
- Get as much natural light as possible during the day, and limit light when you want to sleep.
- Go to bed only when you think you can fall asleep, go to bed early if you feel you need extra sleep. If you don't dose off in 20-30 minutes then get out of bed and do something else.
- Avoid napping during the day or take a nap, whatever works for the client.
- Avoid caffeine, nicotine and alcohol, especially late in the day. More than one alcoholic drink per day can cause sleep disturbances.
- Get regular exercise daily. Generally 30 minutes 6 days a week. Consider exercises that balance energy like Tai Chi, Chi Gong or Yoga. Meditation is a great stress reliever. Prayer with gratitude in mind.
- Environmental toxins like heavy metals, pesticides and herbicides.
- Food allergies
- Start winding down an hour or two before bedtime. Turn down the light. Stop watching television and using the computer.
- Take a warm bath, deep breathing exercises to slow down.
- Invest in a good bed, pillows and linens that will make your sleep ultra-comfortable. We sleep about 1/3 of our lives it would be great to have it cozy and comfortable!

- Assist your client awareness in their individual Insulin Resistance, one indicator is awakening with hunger.
- High protein foods at breakfast and lunch with the carbohydrates at dinner and evening.
- If your client consistently has sleep disturbances that assist them in becoming aware of any underlying concerns, for example stress, depression, apnea, diet pills, or other medications.
- Avoid factors that contribute to fatigue, such as: overeating, lack of exercise, excessive stress, stale or polluted air, not drinking enough water.
- Sleep in one day on the weekend; let your body wake up without an alarm clock.
- Take a nap or rest break at work, 5-10 min. eyes closed quiet your brain and connect with your breath. Relaxation breathing. Take a few moments daily just "being" not reading or watching television or talking or writing. This can be your most creative space. (Mayo Clinic, 2010)

Diseases or conditions associated with Insomnia or not enough sleep are Chronic illnesses such as Chronic Fatigue Syndrome, Fibromyalgia, depression, excessive daytime sleepiness, motor vehicle and work related accidents. Scientists have demonstrated that sleep disturbances can cause hormonal dys-regulation that can lead to cancer vulnerability, hypertension, heart disease, diabetes and stroke. Most people need from seven to eight hours of sleep, with others needing only five and some need ten. Sleep needs vary based on age as well.

"Laziness is nothing more than the habit of resting before you get tired." Jules Renard

What is adequate rest for your client?

Coaching increased awareness of the obese client with the benefits of plenty of exercise/activity/energy. Assisting the obese client to discover what optimal exercise, activity and energy is for them. Coaching the obese client to discover how much of an impact exercise, activity and energy affect optimal health and wellbeing.

What are Health Behaviors that support Optimum Health Well-Being? Health care visits, awareness of addictions, and managing your energy. The Harvard Business Review came out with an assessment to determine your level of Energy management related to your mind, body, spirit and emotions.

See if your client may be headed for an energy crisis by giving them this tool.

Are You Headed for an Energy Crisis?

Please check the statements below that are true for you.

Body

○ I don't regularly get at least seven to eight hours of sleep, and I often wake up feeling tired.

○ I frequently skip breakfast, or I settle for something that isn't nutritious.

○ I don't work out enough (meaning cardiovascular training at least three times a week and strength training at least once a week).

○ I don't take regular breaks during the day to truly renew and recharge, or I often eat lunch at my desk, if I eat it at all.

Emotions

○ I frequently find myself feeling irritable, impatient, or anxious at work, especially when work is demanding.

○ I don't have enough time with my family and loved ones, and when I'm with them, I'm not always really with them.

○ I have too little time for the activities that I most deeply enjoy.

○ I don't stop frequently enough to express my appreciation to others or to savor my accomplishments and blessings.

Mind

○ I have difficulty focusing on one thing at a time, and I am easily distracted during the day, especially by e-mail.

○ I spend much of my day reacting to immediate crises and demands rather than focusing on activities with longer-term value and high leverage.

○ I don't take enough time for reflection, strategizing, and creative thinking.

○ I work in the evenings or on week-ends, and I almost never take an e-mail free vacation.

Spirit

○ I don't spend enough time at work doing what I do best and enjoy most.

○ There are significant gaps between what I say is most important to me in my life and how I actually allocate my time and energy.

○ My decisions at work are more often influenced by external demands than by a strong, clear sense of my own purpose.

○ I don't invest enough time and energy in making a positive difference to others or to the world.

How is your client over all energy?

Total number of statements checked:____

Guide to scores

0-3: Excellent energy management skills

4-6: Reasonable energy management skills

7-10: Significant energy management deficits

11-16: A full-fledged energy management crises

What does your client need to work on? (I would ask Want? To work on?)

Number of checks in each category:

Body___ Mind ____Emotions ____Spirit____

Guide to category scores

0: Excellent energy management skills

1: Strong energy management skills

2: Significant deficits

3: Poor energy management skills

4: A full-fledged energy crisis

Coaching increased awareness of the obese client with the benefits of taking vitamins/supplement daily. Coaching skills to assist the obese client, in discovering how their health would benefit from vitamins, and supplements taken on a daily basis.

How to coach the obese client to create optimum health in harmony and wellbeing. Coaching skills that can be used with the obese client are essential for promoting the clients best outcome. Assisting your client in discovering their vision for optimum health in harmony, and wellbeing is the ultimate reward for a skilled coach. How will the coach assist the client to achieve their vision based on where they currently are? The coach and the bariatric client can discover together what the client is willing to do to achieve the health they want, as well as what they are not willing to do. The 10 Most Common Mistakes Weight Loss Surgery Patients Make (Jay, 2005) "In a November 2005 poll conducted by NAWLS, the following were identified as the top 10 mistakes WLS patients make:

APPENDIX B

Bariatric Life Coach

Training Course

Syllabus w/ scheduled class meetings

Week 1 "Health, Hope and Help"
Week 2 "You Did What?"
Week 3 "Get A Timer. Ding! I'm Done."
Week 4 "Ah believe! Ah believe!"
Week 5 "E=MC2; It's all Relative!"
Week 6 "Look, Ma. I'm a Magnet!"
Week 7 "When I Grow Up, I wanna be…"
Week 8 "How many elephants can you juggle?"

Materials shall include:

Course Syllabus & Outline
Course Schedule
Required Texts
Workbook and Log
Final Exam
Certificate of Achievement

Texts for BLC Course:

BACK-ON-TRACK Coursework and Texts, Cook, C., Hall, J., Miller, K., Bartz, T., Pub: BSCI, Intl, Inc., Salt Lake City, UT, 2003.

BLC Training the Bariatric Life Coach: Course Syllabus and Participant Workbook; Lassetter, S.; Schroeder, D., BSCI Intl, Inc., Salt Lake City, UT, 2006.

CO-ACTIVE COACHING. Whitworth, L., Kimsey-House, H., Sandahl, P., Pub: Davies-Black Publishing, Palo Alto, CA, 1998.

HUMAN BEING, Ellis, D., Lankowitz, S., Pub: Breakthrough Enterprises, Rapid city, S.D., 1995.

SUCCESS HABITS OF WEIGHT LOSS SURGERY PATIENTS, Cook, C., Bariatric Support Centers International, Inc., Salt Lake City, UT., 2003.

APPENDIX C

Table 2.1 ***Body Mass Index Table***

To use the table, find the appropriate height in the left-hand column labeled Height. Move across to a given weight (in pounds). The number at the top of the column is the BMI at that height and weight. Pounds have been rounded off. (Good Samaritan Bariatric Program San Jose CA, 2003)

BMI	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**	**32**	**33**	**34**	**35**
Height (inches)	**Body Weight (pounds)**																
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230

To use the table, find the appropriate height in the left-hand column labeled Height. Move across to a given weight (in pounds). The number at the top of the column is the BMI at that height and weight. Pounds have been rounded off. (Good Samaritan Bariatric Program San Jose CA, 2003)

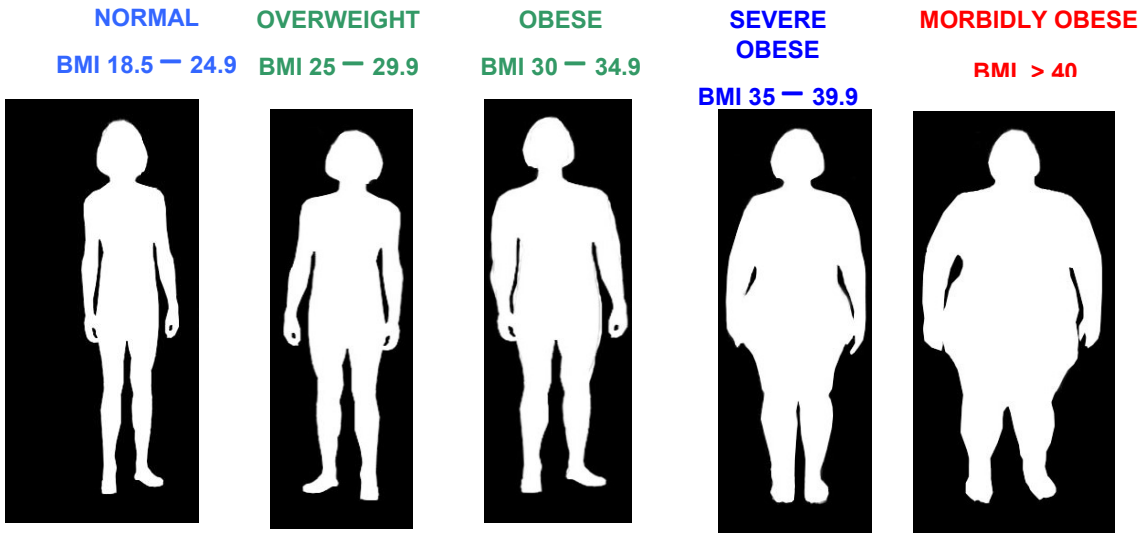
BMI	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**	**32**	**33**	**34**	**35**
Height (inches)	**Body Weight (pounds)**																
69	128	135	142	149	155	162	169	176	182	9	196	203	209	216	223	230	236
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287

BMI	**36**	**37**	**38**	**39**	**40**	**41**	**42**	**43**	**44**	**45**	**46**	**47**	**48**	**49**	**50**	**51**	**52**	**53**	**54**
Height (inches)	**Body Weight (pounds)**																		
58	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258

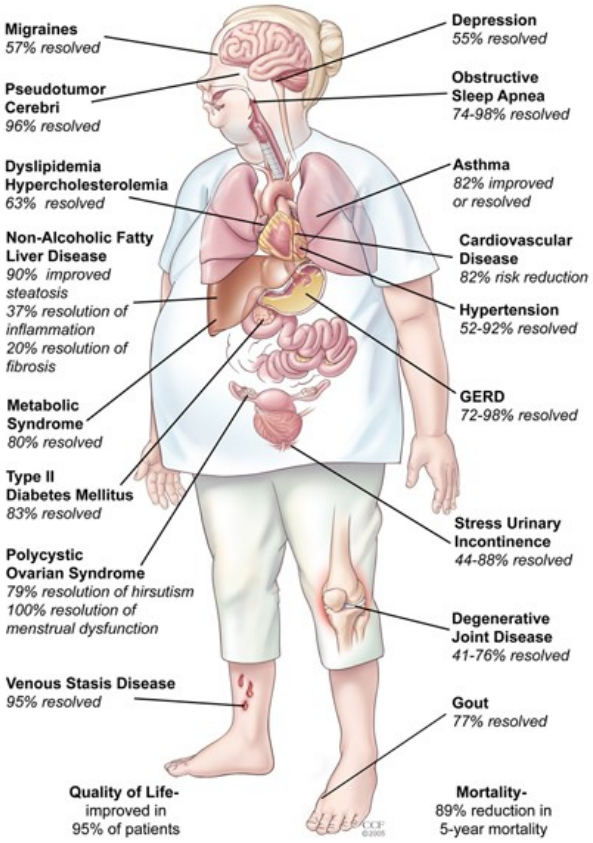
To use the table, find the appropriate height in the left-hand column labeled Height. Move across to a given weight (in pounds). The number at the top of the column is the BMI at that height and weight. Pounds have been rounded off. (Good Samaritan Bariatric Program San Jose CA, 2003)

BMI	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**	**32**	**33**	**34**	**35**		
Height (inches)	**Body Weight (pounds)**																		
59	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267
60	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285
62	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295
63	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304
64	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334
67	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344
68	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354

APPENDIX D

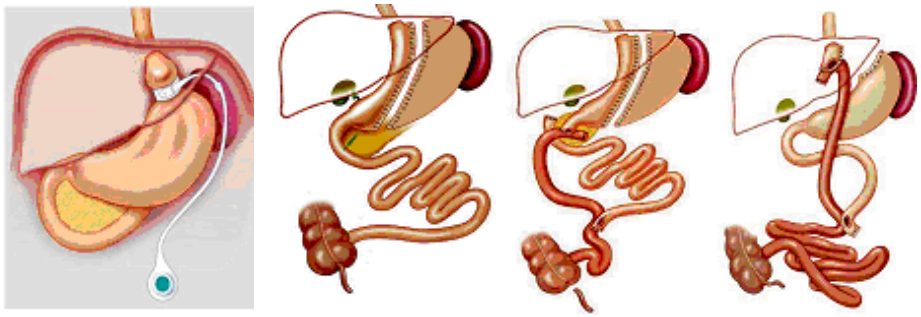

NORMAL
BMI 18.5 – 24.9
OVERWEIGHT
BMI 25 – 29.9
OBESE
BMI 30 – 34.9
SEVERE OBESE
BMI 35 – 39.9
MORBIDLY OBESE
BMI > 40

APPENDIX E

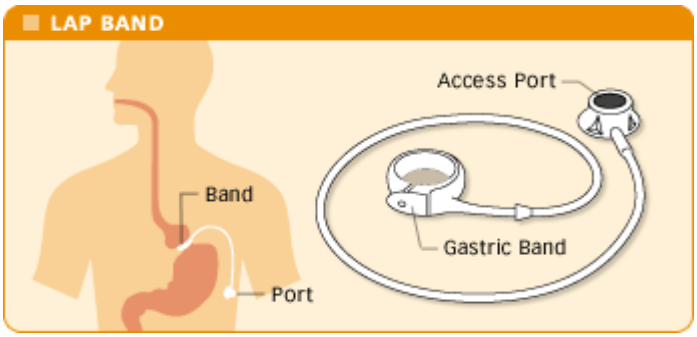


(http://asmbs.org/benefits-of-bariatric-surgery/, 2011)

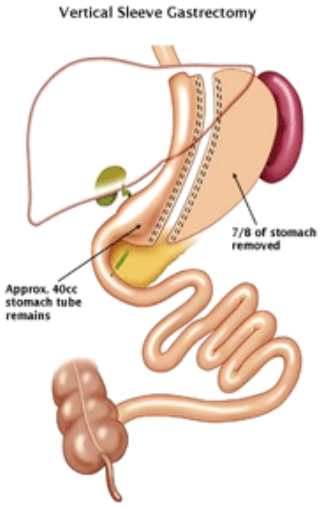
APPENDIX F



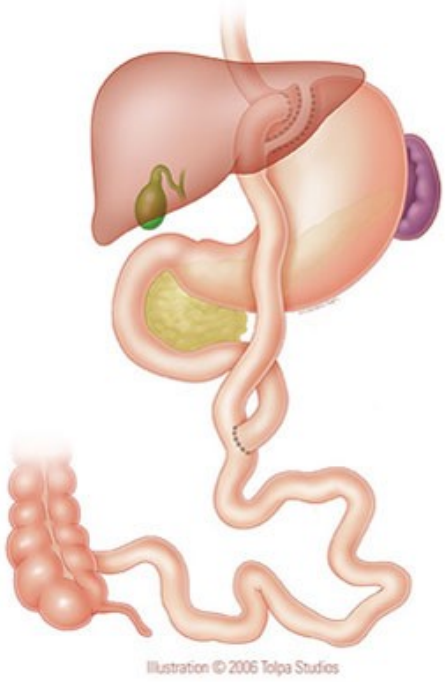
SAGES 2001 Diagram 3 Types of weight loss surgery in pictures:



http://www.yourbariatricsurgeryguide.com/gastric-banding/



http://www.lapsf.com/vertical-gastrectomy-weight-loss-surgery.php



http://www.checksutterfirst.org/bariatrics/rouxeny.html

I have been a Registered Nurse since 1978 and worked in all areas of the hospital including administration. I have also worked in many areas of Community Nursing. During this time I continued my education from an Associate degree to Bachelors and now onto a Master's in Nursing and PhD in Philosophy. I also obtained my Associate Coaching Certification in 2007. My weight loss surgery journey began with my own surgery in 2001 and the transformative process it offered me. This experience allowed me to want to discover, question and if possible together as a team or group improve each individual's outcome for a healthy and satisfying life. I have had the great honor of working with thousands of weight loss surgery patients or clients as they discover their own unique journey. I plan to continue working with this very unique and wonderful population for many years to come.

Dana Schroeder PHN, RN, CBN, NP-c Adult-Gero

Life Coach-ACC