“IT’S NOT MY TIME”: UNDERSTANDING METSYN PILOT PROJECT ATTRITION FROM A WOMEN-CENTERED PERSPECTIVE

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Abstract

This research project aimed to understand the lived experience of Saskatoon and area women who had discontinued the MetSyn pilot project from a women-centered perspective. The MetSyn pilot project was a program developed by the Women's *Mid-Life* Health Center of Saskatchewan in coordination with the Chronic Disease Management Program of the Saskatoon Health Region to provide increased awareness, prevention and treatment of metabolic syndrome for women in the Saskatoon area.

Phenomenological methodology was used to carry out the project. A one-time semi-structured interview with two study participants resulted in data that was analyzed using a systematic method of analysis (Moustakas, 1994). Due to the small sample size of two participants, the essence of the experience was unable to be determined. The findings, however, resulted in lessons learned such as the experience being communal with a "women as plural theme" that included feelings of disappointment, frustration, annoyance and loss. These feelings were balanced with a sense of empowerment and autonomy in regards to what decision was best for the women given their health goals and other life commitments. These lessons support suggestions for future MetSyn program development such as attention to attrition as an important component of future evaluation planning, the inclusion of guided fitness programs and greater attention to the psychological aspects of metabolic syndrome.

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Chapter 1: Introduction

According to the World Health Organization, cardiovascular disease (CVD) is the number one cause of death worldwide. By 2030 almost 23.6 million people will die from CVD's with the majority being from heart disease and strokes (WHO, 2011). In addition to the loss of human life, Dr. Margaret Chan (2011, para. 20), WHO Director-General, recently reported that over the next 30 years, noncommunicable diseases (NCD) like cardiovascular disease, cancer, chronic respiratory diseases and diabetes "will cost the global economy over 30 trillion US dollars representing 48% of the global gross domestic product in 2010".

Historically, CVD's were considered primarily a male health issue but that is no longer the case. NCD's such as CVD and chronic pulmonary disease account, globally, for 45% of death in women over the age of 60 (WHO, 2009). The WHO (2009) also reports that the majority of health problems experienced by older women are the result of risk factors that occur in adolescents and adulthood as the result of smoking, sedentary lifestyles and unhealthy diets. For approximately 1 in 5 Canadians, these risk factors also include the presence of metabolic syndrome (Riediger & Clara, 2011).

Metabolic syndrome or MetS "is a constellation of interrelated risk factors of metabolic origin – metabolic risk factors that appear to directly promote the development of cardiovascular disease" (Mittal, 2008, p. 21). Three of the five following criteria must exist for the diagnosis of metabolic syndrome: elevated waist circumference (population and country – specific definitions), elevated triglycerides[1] or taking medication for same, reduced HDL – C[2] or taking

[1] Major form of fat stored in body that comes from food and is produced internally which is affected by recent fat and alcohol intake (MedicineNet.Com)

[2] The "good cholesterol" that is responsible for transporting cholesterol from body tissues to the liver for removal in the bile.

medication for same, elevated blood pressure or medications for same and elevated fasting glucose or medication for same (Alberti et al., 2009) .

Both gender and ethnic analysis have supported differences in prevalence rates where women experience a 60% increase in risk of MetS in the postmenopausal period (Cho et al., 2008) and half of all cardiovascular events in women are related to MetS (Carr, 2003). Aboriginal Canadians also have a greater risk (42%) than non-Aboriginal Canadians (25%) (Liu, Hanley, Young, Harris, & Zinman, 2006) of developing MetS. Given the increasing rate of aboriginal population growth in Saskatchewan (Statistics Canada, 2006) and the recognition that in the next decade an unprecedented 1 in 6 women will reach menopause (Federation of Medical Women of Canada, 2007) , attention to the treatment and prevention of metabolic syndrome in Saskatchewan women is warranted.

Although no specific cause of MetS has been determined, there appears to be growing attention towards obesity and insulin resistance as important etiological factors (Matfin, 2010). These hypotheses are strengthened by study findings (Ivester et al., 2010; Katzmarzyk et al., 2003; Lindstrom et al., 2003; Pettman et al., 2008) that support a positive relationship between healthy lifestyle change programs and the reduction of obesity, type 2 diabetes and metabolic syndrome. Hence, understanding how to reduce attrition from these lifestyle change programs is also salient and the focus of the current study. The following report outlines a qualitative, women – centered research study that aimed to understand the experiences of Saskatchewan and area women who discontinued the MetSyn Pilot Project. The project was developed by the Women's *Mid - Life* Health Center of Saskatchewan in coordination with the Chronic Disease

Management Program of the Saskatoon Health Region and was an "innovative pilot project to reduce the incidence of metabolic syndrome" (WMLHCS, 2010, para. 1).

1.1 Background to the Current Study Project

The Women's *Mid - Life* Health Center of Saskatchewan (WMLHCS) [3]was founded in 2003 as a non-profit organization devoted to the health and well-being of Saskatchewan women in mid-life. The multi-disciplinary center, located in the former St. Paul's Nurses Residence and the Ambulatory Care Unit of the Saskatoon St. Paul's Hospital, is governed by a 13 member volunteer board of directors has three full-time staff (executive director, medical director and nurse) and one part time office assistant which provide a half-day clinic to women aged 40- 64. The current Medical Director is Dr. Vicky Holmes, a Saskatoon family physician who has been accredited as a menopause practitioner through the North American Menopause Society. The center activities focus on education, diagnosis, treatment, research, local and international collaboration with other agencies and groups and the empowerment of women in their ability to make informed choices about their health. In the recent past, board members and staff of the Women's *Mid - Life* Health Centre of Saskatchewan (WMLHCS) became increasingly concerned with the percentage of women (66%) that were presenting at the center with abdominal measurements equal to or greater than 80 cm.

1.1.1 The MetSyn Pilot Project

In October, 2010, WMLHCS began a pilot program, in partnership with the Chronic Disease Management Program of the Saskatoon Health Region, aimed at awareness, prevention and treatment of metabolic syndrome for women in the Saskatoon area.

[3] September, 2011 WMLHCS integrated into the Saskatoon Health Region and now known as Women's Mid-Life Health Program. The program is located at Saskatoon City Hospital.

The purpose of the pilot project was:

> …to determine if a computer-generated telephone follow-up system can be useful in reducing markers of Metabolic Syndrome during a 13 month lifestyle intervention compared to individuals who do not receive the telephone follow-up. (WMLHCS, 2010, p. 14)

The computer-generated telephone follow-up system or TelAsk system was an interactive voice response system where participants assigned to this group would receive follow up calls at 10-14 day intervals to assess goal process and offer additional support for those experiencing goal achievement difficulties. The system flagged participants having difficulties and notified the project coordinator to make personal contact with these participants for the purpose of offering additional support. A copy of the voice response system pathway is located in Appendix A.

The MetSyn Pilot Project had three phases: education and outreach with family physicians and Saskatoon women (April, 2010 to September, 2010), dietary and fitness training and support sessions for women with MetS referred by family physicians (October, 2010 to September, 2011) and a written evaluation report completed by independent evaluators. Funding for the project was provided by AstraZenaca Canada, the Irene and Les Dube Foundation, Blue Cross and through fundraising activities of the board of the WMLHCS. No drugs were used in the program and Astra Zenaca's role was strictly as a partial funder who would receive a copy of the final public report. This current study project was situated in the second and third phases of the MetSyn Pilot Project. For further understanding, a brief description of these phases is warranted.

As previously stated the second phase or dietary and fitness training and support sessions ran from October 2010 to September 2011. In order to be eligible for the program, Saskatoon and area women had to have three of the five following criteria: Abdominal obesity (waist measurement greater than 32 inches), high blood pressure, high triglycerides, elevated blood glucose, and low HDL cholesterol. Women could be referred directly by their family physician or contact the Project Coordinator, Wendy Verity, themselves to obtain a letter to take to their family physician for the completion of the necessary blood work. This letter was then faxed back to the project coordinator by the physician's office to confirm eligibility and enrollment.

The first session took place on October 27, 2010 at Saskatoon's Francis Morrison Library. At the initial session, women were provided information about Metabolic Syndrome and the project goals and objectives and were asked to sign the necessary consent forms. Consent included both the program and research participation aspects of the pilot project. The subsequent sessions took place at various Saskatoon community center locations including the library and health and recreation centers. Table 1.1 outlines the agenda of the six project information sessions. The Chronic Disease Management Program of the Saskatoon Health Region provided fitness and nutrition professionals who completed the health measurement (blood pressure, weight and waist circumference), current lifestyle assessment, fitness assessments and provided participant assistance in individual diet and fitness goal setting.

In addition to attending the six information sessions, participants were asked to complete blood draws at 6 and 12 months. Each participant was provided with physician requisitions that they were to complete by attending a medical laboratory on their own time. The evaluation phase of the program was ongoing, with participants completing questionnaires at baseline (start of

program), six months and one year. Participants were also asked to maintain physical activity and healthy eating throughout the intervention with an understanding that the project was focused on self-management strategies for sustainable healthy lifestyle change. Finally, the participants were stratified by age and household income and then randomly assigned to either the TelAsk interactive voice recognition technology experimental group or the control. Both groups received identical program information but they differed in the way in which they accessed support. Those assigned to the control group were informed that they could access additional support by contacting the program coordinator. Those in the TelAsk group received telephone follow-up calls at regular intervals.

Table 1.1

MetSyn Dietary and Fitness Session Outline

Session Date	Purpose/time	Activities
Oct. 27, 2010	Kick-off session • 2 hours	• learn about Metabolic Syndrome • learn about MetSyn pilot project • sign consent forms
Nov., 2010	Information session # • 3 hours	• assess blood pressure, weight and waist circumference measurement
Jan. , 2011	Information session # • 2 hours	• motivational speaker • revisit goals (or how to recover from the holidays) • small group discussion
May, 2011	Information session # 3 • 2-3 hours	• 6 month measures • life coach speaker • revisit goals and small group discussion
Aug., 2011	Information session # 4 • 2 hours	• review goals • plan for long-term goals and behavior change
Oct., 2011	Information session #4 • 2 hours	• 1 year measures • celebrate success

Note: Adapted from WMLHCS (2010) hand-out included in participant package for session #1

1.1.2 Purpose of the Study Project

The purpose of this study project was to better understand the experiences of attrition from the Women's Mid-Life Health Centre MetSyn Pilot Project so as to support recommendations for MetSyn program improvement, as well as, practice recommendations for social workers and other health care providers who aim to increase their abilities to enhance women's success in fitness and nutrition lifestyle change. The findings will also supplement the larger MetSyn project evaluation objectives which are focused on the effectiveness of the MetSyn pilot project in its ability to reduce markers of metabolic syndrome as well as the role of Interactive Voice Recognition (IVR) computer, telephone technology in goal achievement for women, attrition and metabolic markers for those who use IVR versus those who do not receive regular follow-up contact.

The questions guiding this study were determined via the literature review and in collaboration with my research practicum committee, the MetSyn pilot project coordinator and the WMLHCS medical director. The independent evaluators for the project obtained ethics approval from the University of Saskatchewan Behavioural Research Ethics Board on February 3, 2010 and informed, voluntary written consent was provided by project participants before beginning the program.

Prior to the onset of the "It's not my time" study, ethics approval was granted from the University of Regina Ethics Board and all revisions to the research process were approved prior to implementation. Ethics approval documents are located in Appendix B.

Chapter 2: Literature Review

The literature review supports the rationale for the study as well as how the current research is situated in existing knowledge (Creswell, 2007). The focus of this review was to locate literature that would inform study methods, particularly data collections methods, in their ability to capture a rich description of the participant's experience (Lincoln & Denzin, 2005). The key words or themes of the literature review were lifestyle change programs and metabolic syndrome, metabolic syndrome and qualitative research, attrition or drop-out from health - related interventions, adherence to physical activity/health programs, and mid-life, menopause and health. Information was selected based on its relevance to women, health behavior change and qualitative methodology.

2.1 Lifestyle Change Programs and Metabolic Syndrome

As previously stated in the introduction, study findings (Ivester et al., 2010; Katzmarzyk et al., 2003; Lindstrom et al., 2003; Pettman et al., 2008) have reported a positive relationship between healthy lifestyle change programs and the reduction of obesity, type 2 diabetes and metabolic syndrome. The life style programs evaluated incorporated fitness and nutrition components aimed at increasing activity and improving the dietary habits of participants. For example, Pettman et al. (2008) evaluated a group-based exercise and nutrition program that was based on the Australian national recommendations for diet and exercise in its ability to provide a cost and time- effective program for the management of obesity and metabolic syndrome risk factors. I am explaining this study extensively as it examines a program that shares similar components to the MetSyn Pilot project.

The sample population (n= 153) of over-weight or obese individuals with metabolic syndrome were recruited from the region of Whyalla, an Australian region with higher that average national rates of overweight and obese individuals. Recruitment occurred via media advertisements for the "*Shape up for life* intervention trial which was aimed at changing lifestyle habit to reduce obesity and improve health" (Pettman et al., 2008, para. 5). The sample population demographics consisted of 111 females, 42 males; aged 45.1 ± 0.8 years. All participants were provided with standard booklets of Australian food guides and physical activities guides. The intervention group, in addition to the booklets, participated in a 16 week information/education and group exercise program. The sessions were held in a peer group setting that was led by a study coordinator with health/science nutrition background and a leader with expertise and experience in chronic disease program facilitation and training. If participants missed an information session, they received a phone call from the program to determine the reason for the absence, schedule a time to gather missed information and encourage individual exercise if they did not want to attend the group session. Data collection occurred using both clinical outcomes and participant feedback that was gathered via questionnaires during the intervention, responses provided during the follow-up absenteeism phone calls and focus groups after the intervention.

Overall, the findings supported positive clinical outcomes related to the intervention program and concluded that

> …guidelines are best accompanied by additional support strategies including active behavioral intervention and practical examples that translate guidelines into everyday strategies that assist individuals from different backgrounds in achieving lifestyle recommendations. (Pettman et al., 2008, para. 40)

These findings are similar to other lifestyle intervention evaluations. The Finnish Diabetes Prevention Study found that greater intensive, guided individual nutrition and exercise interventions provided long-term behavioral changes positively related to the prevention of type 2 diabetes (Lindstrom et al., 2003). The Heritage Family Study (Katzmarzyk et al., 2003) evaluated a 20 week supervised aerobic exercise training program and found a significant reduction in metabolic syndrome where 30.5% of participants (32/105) were no longer classified as having metabolic syndrome after the intervention. The Ivester et al study (2010) also found a positive relationship between a wellness program and weight reduction but the intervention findings are limited given the small, specific sample (41 congregants from the same church) and the lack of control group.

More specific to discontinuation themes, Pettman et al. (2008) found a significant positive relationship ($p > 0.001$) between greater attendance at information sessions and a reduction of body fat and the risk factors of metabolic syndrome including blood pressure, total cholesterol and plasma glucose. Information session attendance was 77% with an average attendance of 12 sessions with a gradual decline in attendance half way through the program. The main reasons provided for non-attendance were related to work and family commitments. The researchers relate the attendance finding to program fatigue, however, “no further data is available to support this” (Pettman et al., 2008, para. 34) suggesting that research aimed at a greater understanding of metabolic syndrome program attrition is needed.

2.2 Metabolic Syndrome and Qualitative Research

Only one qualitative study specific to metabolic syndrome and qualitative research could be located. Hollman and Bertero (2008) examined the relationship between having knowledge of metabolic syndrome, particularly the meaning and consequences of its risk factors and the life

situations of Swedish adults. It was a qualitative study influenced by grounded theory and symbolic interactionalism; “symbolic interactionalism targets the inner process and social interaction builds the human consciousness in time, as well as the consciousness towards a specific situation” (Blumer (1969) as cited by Hollman & Bertero, 2008, p. 301). Theoretical sampling occurred following the criteria of grounded theory where one participant at a time is contacted and interviewed. “Theoretical sampling necessitates building interpretative theories from the emerging data and selecting a new sample to examine and elaborate on this theory” (Marshall, 1996, p. 523). The sample was theoretical as they wanted to capture as diverse a sample possible in regards to gender, age, education, occupation, housing area and cultural background. Data was collected via individual interviews from 13 Swedish adults (male= 6; female=7) 11 of whom were married or cohabitating.

The categories that emerged from the analysis were lifestyle, normal life and a fatalistic approach to life. The core category was the recurrence of behaviour meaning “to fall back to common everyday behaviour” (Hollman Frisman, & Bertero, 2008, p. 302). As a result, individuals attempted to fit in their diagnosis with their everyday life which prompted the researchers to recommend greater attention to the attitudes of people diagnosed with metabolic syndrome and intervention efforts that would challenge these attitudes.

2.3 Attrition or Drop - Out from Health - Related Interventions

Literature highlights the complexity of attrition as it relates to psychological factors , particularly goal ownership and alignment (Davis & Addis, 1999; Eivors, Button, Warner, & Turner, 2003; Huisman et al., 2010), treatment processes (Davis & Addis, 1999), sociodemographic variables (Grossi et al., 2006; Kolotikin & Moore, 1983) and physical health factors (Eborall et al., 2011).

Davis and Addis (1999) completed a systematic literature review of twenty attrition prediction studies in outpatient behavioural medicine treatment program for headache, pain, stress and weight management. On average the studies reported a one third attrition rate. The review recommendations included the importance of a consistent clinically valid definition of attrition which is developed prior to the onset of the study and the importance of focussing on psychological and treatment process variables including the therapeutic relationship and the formation of mutually agreed upon therapeutic goals and tasks. In the discussion section of the study, the writers note what questions they use in their own studies to obtain client/therapist input: "(a) if the client has obtained a sufficient number of strategies to permit more effective coping, (b) if behavioural treatment was helpful, (c) if sufficient progress was made to warrant termination, and (d) the reasons for treatment termination" (Davis & Addis, 1999, p. 347).

Kolotikin and Moore's (1983) examination of attrition in a behavioural weight-control program highlighted socio-demographics relevant to the complexities of individual's lives that affect successful health behavior change. The quantitative study explored the differences between drop outs (n= 161) and completers (n=110) of a 12 week education-based weight control program. The study participants were mostly women (247 women to 24 men) and were an average of 45% overweight. Data collection occurred through questionnaires that were administered pre and post treatment. Drop outs only completed the pre-treatment questionnaires. Data was collected over a two year period with an attrition rate of 59%. T-tests and chi-squared were used for data analysis. Within the demographic variables, the female completers contained significantly more women working in the home than the drop out group which appears to support the importance of collecting occupational status information. The study also recommends further examination of cognitive variables for attrition.

Grossi et al. (2006) conducted an observational study of the causes of attrition reported by obese patients (n= 940; 727 female; mean age 49 years; mean BMI , 38.6 kg/m²) treated at Italian medical centers. Data collection occurred using a semi- structured interview, by telephone, three to four years post-treatment (median time = 41 months) with a specific section related to the cause (s) of attrition. The top three practical reasons for attrition reported were family problems (30%), problems at work (28%) and living far from a medical center (21%). Other reported reasons of attrition included perceived feelings of abandonment and bad interactions with therapists. From a methodological perspective, "over 75% of patients were traced and most of them were collaborative with the interviewer, acknowledged the importance of reporting frankly the reason(s) for dropout, and agreed to answer the 54 questions of the interview" (Grossi et al. 2006, p. 1135). The results appear to support the efficacy of telephone interviews and the willingness of participants to provide feedback regarding attrition

The psychological process of goal ownership is a significant factor in program attrition. A Dutch quantitative study examined the role of goal ownership in its ability to predict drop out from a weight intervention study in overweight patients with type 2 diabetes. Huisman, Maes, DeGucht, Chatrou , and Haak (2010) used a dataset of 1316 diabetes type 2 patients from a General Dutch Hospital where study inclusion criteria were: type 2 diabetes, BMI between 27 and 45, age between 21 and 70, Caucasian and fluency in Dutch. Non-completers were defined as those who actively withdrew and those who stopped attending meetings. Demographic variables included gender, age, educational level, hours of employment and having a partner. Covariant and multivariate analysis resulted in findings that indicated that study completers were employed for more hours and scored lower on goal ownership. "Goal ownership has been shown to be associated with lifestyle changes, medication adherence and disease management

outcomes" (Huisman et al., 2010, p. 179). Non-completers reported higher levels of goal planning. The study hypothesizes that this may have been the result of non-completers remaining in the planning versus action phase of their goal achievement.

Qualitative research has also highlighted relevant physical health themes and methods for understanding attrition and drop-out in older populations. Eborall et al. (2011) explored the accrual and drop out in a primary prevention randomized controlled trial of the use of Aspirin for Asymptomatic Artheriosclerosis trial who chose to decline participation (n= 11) and those who started the trial but stopped taking the medication (N=11). The mean age of the sample was 65.2 years. The sample was a purposive sample and data collection occurred through in-person, semi-structured interviews. The following questions were included in the topic guide for those who stopped the medication: experience of taking part in the 'aspirin trial', reasons for participating in the trial, reasons for stopping the trial medication and subsequent reflections, advantages and disadvantages of taking part in the trial and prior trial experiences. The findings indicated four main categories of explanation for medication stoppage: experiencing medication induced side effects, starting other medication that interfered with the trial, experiencing an outcome event and "changing one's mind" (Eborall et al., 2011).

In order to understand the experiences of drop-out from treatment from Anorexia Nervosa, Eivors et al. (2003) used grounded theory qualitative methodology situated within the theoretical paradigms of social constructivism, feminism and system and personal construct theory. The criterion based sample consisted of 8 women; 7 of which were interviewed, and four who submitted written narratives. The themes of the interviews were:

> (1) background information about the onset of their disorder and how they came in contact with services; (2) the initial assessments and thoughts and feelings about

> engaging in treatment; (3) perceptions of the disorder; (4) expectations of treatment, the type of treatment received and their evaluation of this; (5) the process and experience of dropping out of services; (6) improvements and unmet needs; (7) the present day and effects of dropping out. (Eivors et al., 2003, p. 94)

The central theme of control emerged from the data. The women reported a that they had hoped to gain broader understanding and awareness from treatment and a focus on food and weight loss resulted in increased anxiety and reinforcement of the eating disorder coping mechanism. Other recommendations included contact with recovered anorectics, normalizing ambivalence about treatment as a means of empowerment versus another aspect of their pathology and "whilst the label may well be helpful and useful for those who are close to the sufferer it operates to isolate and distance the person from seeking help" (Eivors et al., 2003, p. 105). Similar to other qualitative studies the author notes the inability to generalize findings as a result of the small sample size. Although the diagnosis of metabolic syndrome is different than anorexia, this study again highlights useful interview guide themes and is situated in a women-centered, qualitative methodological approach.

To summarize the attrition literature highlights the importance of a clinically valid definition of attrition that is developed prior to the onset of the study. Data collection can occur face-to-face but telephone interviews have also been found to be an effective interview method. The impact of social and environmental factors of attrition points to the relevance of collecting data about occupation and geographical location in relation to the program location. Finally themes of motivational stage, therapeutic relationship, goal alignment and ownership and control have been found to be related to health behavior change program attrition.

2.4 Adherence to Physical Activity/Health Programs

Self-efficacy or a "situation-specific self confidence in which an individual has confidence to participate in" (Lloyd & Little, 2010, p. 653) has been shown as a strong determinant in adherence to physical activity for women (Findorff, Hatch Stock, Gross, & Wymann, 2007; Lloyd & Little, 2010). In a longitudinal, cross-sectional quantitative study of older women enrolled in an exercise class aimed at fall prevention for women 70 and older, Findorff et al. (2007) aimed to understand if the transtheoretical model of change explained exercise behavior in a community- based sample of older women. What they determined using the strong and weak principles for decisional balance was that the cons were higher than pros for those study participants who didn't move into action phase of exercise. Hence, the study recommended the importance of exploring cons to exercise with individuals in order to facilitate greater program adherence.

Other factors related to adherence and future participation in women's physical activity are intrinsic motivation and the quality of leadership. Lloyd and Little (2010) conducted a qualitative evaluation study of women who had participated in the 2004 Contours Active Women's Festival in Christchurch, New Zealand. In depth, semi –structured interviews occurred with 20 women who had participated in the festival. Female interviewers conducted the interviews in a location chosen by the participant and the interview was guided by an interview guide approach. "That is questions were asked as they were appropriate to the progress of the interview (Henderson, 1991) and topics (e.g., motivations, benefits, future intentions to participate) were covered in open-ended questions to guide but not constrain the conversation" (Lloyd & Little, 2010, p. 657). The researchers suggested future research on large scale community physical activity interventions with sub-groups of populations.

Social work has been involved in research with a population of older women, but only one study could be located where social work was the affiliation of the primary researcher. The study examined "literature on age, comorbid conditions, socioeconomic factors and perceived susceptibility for an illness" (Lawrence & Rittner, 2009, p. 859) as it relates to adherence. The article describes the health belief model which "posits that the likelihood of an individual's sustaining proactive prevention health care is a function of the degree of threat perceived by the individual" (Lawrence & Rittner, 2009 p. 861). Lawrence and Rittner (2009)stress that social work implications include attention to the factors associated with non-adherence as "likely to be a combination of multiple prescription medications, physical illnesses that require contradictory treatments, economic factors, and significant changes in social supports (Lorenc & Brantwaite, 1993)" (p. 867).

2.4 Mid-life, Menopause and Health

Canadian research and practice efforts have evolved towards more strength- based gender-responsive approaches that respect the intersections of sex, gender, race and class (Clow, Pederson, Haworth-Brockman, & Bernier, 2009). As Gringeri, Wahab and Anderson- Nathe (2010) recommend:

> The first step in moving feminist research forward in social work, we suggest, is for researchers to take on the challenge of destabilizing this central notion that feminism is defined by binary thinking and focus research on multifaceted femininities and masculinities, foregrounding in our work the intersections of identity. (p. 402)

Hence, understanding the particular complexities for women within the mid-life phase of life and its implications on health is relevant for women-centred, social work research.

Though somewhat removed from the experiences of Saskatchewan women, a quantitative study evaluated the quality of life amongst postmenopausal Ecuadorian women (n= 325) participating in a metabolic screening program. Chedraui et al. (2007) used the Menopause-Specific Quality of Life Questionnaire (MENQUAL) as their measurement tool. The MENQUAL (Hilditch et al., 1996) is a 32- item questionnaire that measures quality of life across four domains (vasomotor, psycho-social, physical and sexual) which has been validated in use with older women (Kulasingam, Moineddin, Lewis, & Teirney, 2008). Score is negatively related to quality of life, thus, the higher the score, the lower the perceived quality of life is for the completer. More than 50% of the study participants scored above the median for each domain and impairment of quality of life was "found to be associated with age and related conditions such as abdominal obesity, hypertension and hyperglycaemia" (Chedraui et al., 2007, p. 47). As a result, recommendations were made to support lifestyle change interventions which would increase quality of life for Ecuadorian women and in turn reduce risk for noncommunicable diseases.

Elansky and Mcauley (2005) used quantitative research methods to examine the relationship between physical activity, symptoms and life satisfaction during menopause in 133 American women at different stages of menopause thus reflecting a study population similar to Saskatchewan demographics. The researchers noted that they did not collect descriptive data about those women who declined participation but they did find the following reasons for non-participation: lack of time to complete survey and loss of interest because no exercise or physical activity was offered. Data analysis resulted in insignificant differences among variables across menopausal status. Significant differences were found regarding self-esteem and symptom reporting based on physical activity levels where there was a positive relationship between higher

levels of physical activity, higher self-esteem and decreased frequency of menopausal symptoms ultimately leading the researchers to conclude that the relationship between these variables as being more complex that initially perceived.

Literature also exists regarding the relevancy of the social constructions of menopause and aging. Utz (2011), a sociologist affiliated with the University of Utah conducted a qualitative research study of two generations of women (mothers and daughters) with the purpose of exploring "whether membership in a particular birth cohort is an important social group, like race or ethnicity, in understanding how the subjective experience of menopause varies for women born in different moments in American History" (p. 144). Data was collected using in-depth qualitative interviews with 24 middle-aged (n= 13) and older (n=11) women. The initial questions were "What was/is your experience with menopause like? I would like to know the symptoms you experienced, the age you first started experiencing them, and most, importantly, how you feel/felt about experiencing menopause" (Utz, 2011, p. 145).

Of particular interest to the current study were the finding related to the younger cohort of women and their explanations behind their preference for pharmaceutical interventions over alternative treatments such as diet and exercise. They reported an inability to develop and stick with better eating and activity habits and the opinion that "a pill taken once a day was far easier than maintaining the physician recommended fitness regime and restrictive dietary plan" (p. 148). The findings support the impact of social institutions such as the media and the pharmaceutical industry upon women's cultural conceptualization of health, body and aging. Furthermore, the current cohort of women in this phase of life and their zest for control over their bodies may "result in late life issues of body and health" (Utz, 2011, p. 143). Thus, future program attrition research may be well served to gather information that relate to women's

current experiences of mid-life and whether there was a perceived sense of loss of control regarding health choices that resulted in a need for resistance.

In conclusion, research has highlighted the efficacy of guided lifestyle and nutrition intervention programs in the treatment and prevention of obesity, type 2 diabetes and metabolic syndrome. This literature, however, is limited in its range and scope, particularly within the context of social work literature, women-centered research and conclusions that were based on findings from participants who discontinued these interventions. As a result, research recommendations for adherence and program improvement are primarily speculative or based on the perceptions of those who remained in the intervention.

This being said, other health behaviour change literature provides helpful knowledge of the physical, psychological and sociodemographic variables of attrition, the relevance of a consistent, valid, definition of attrition as it relates to the study's credibility and themes such as goal alignment, efficacy, the cultural construct of menopause and the relevance of control that relate to both health behaviour change program attrition and adherence for women. Thus, the research methods, findings, recommendations and gaps discussed above appear to support a women-centered qualitative research study aimed at understanding the lived experience of Saskatchewan women who discontinued the Metsyn pilot project.

Chapter 3: Method

3.1 Phenomenology

Phenomenology is a qualitative research approach that "focuses on descriptions of what people experience and how it is that they experience what they experience" (Patterson, 2002, p. 107). In other words, phenomenology aims to "describe the world-as-experienced by the participants of inquiry in order to discover the common meanings underlying empirical variations of a given phenomenon" (Baker, Wuest, & Noerager Stern, 1992, p. 1356). Thus, according to Amedeo Giorgi (1985), phenomenology is "the practice of science within the 'context of discovery' rather than in the 'context of verification'" (p. 14).

Phenomenology is grounded in the science of philosophy and its purpose is to discover the core meaning or essence of a shared experience (Creswell, 2007; Patton, 2002). Clark Moustakas(1994), a more contemporary influence in the phenomenological fields, notes that phenomenology was cited in the philosophical works of Kant as early as 1765 but became more clearly constructed by Hegel as "the science of describing what one perceives, senses, and knows in one's immediate awareness and experience" (p. 26). Following these early pioneers Husserl developed a descriptive scientific methodology that contended "that *we can only know what we experience* by attending to perceptions and meanings that awaken our conscious awareness" (Patterson, 2002, p. 106). Merleau-Pontry, a French, existential philosopher, expanded and modified Husserl's ideals towards the phenomenological applications in the human sciences that recognize a "dialectical relationship between the subject and his or her world" (Baker et. al, 1992, p. 1356). Thus, transcendental phenomenology is situated in the philosophical concepts of intentionality, intuition and intersubjectivity (Moustakas, 1994).

Intentionality refers to the interconnectedness between a person's awareness of an experience and the external environment in all its nuances that a person is situated in. "Knowledge of intentionality requires that we be present to ourselves and to things in the world, that we recognize that self and world are inseparable components of meaning" (Moustakas, 1994, p. 28). The noema or awareness of an experience and the noesis or meaning of the experience result in the noemic ,"perceived as such", and the noesis, "perfect self-evidence" (Moustakas, 1994, p. 30) of intentionality. Hence, the understanding of the focus of phenomenology as meaning making via lived experience.

Husserl's concept of intuition was based on the writings of Descarte (Creswell, 2007;Giorgi; 1985; Moustakas; 1994);"Intuition is the indubitable conception of a clear and attentive mind which process solely from the light of reason" (Descartes, Cottingham, & Murdoch, 1988, p. 3). For Descarte, according to Moustakas, "intuition is the beginning place in deriving knowledge of human experience, free of everyday sense impressions and the natural attitude" (1994, p. 32) As a result, the methods of phenomenology that elicit intuition determine "What is a good description as opposed to a bad one?" (Giorgi,1985, p. 45).

For Merleau- Ponty, intersubjectivity was defined as an inability to "describe neither the objective nor the subjective world but only the world as experienced by the subject (Merlea-Ponty as cited by Baker et.al, 1992, p. 1356). Husserl, according to Moustakas, also recognized this co-presence and he concluded that "the method through which the Other becomes accessible to me is that of empathy, a thereness-for-me of others. Empathy is an intentional category comprising my experience of other's experience" (Lauer as cited by Moustakas, 1994, p. 37). However, before the knowing of Other occurs phenomenological philosophy requires a presupposition or suspension "of all judgments about what is real-the 'natural attitude'- until they

are founded on a more certain basis" (Creswell, 2007, p. 58) by a process of epoché which will further discussed later in the methods section.

3.2 Appropriateness of Methodology

Qualitative research approaches "study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them" (Lincoln & Denzin, 2005, p. 3). Amedeo Giorgi, concurred in his explanation of the potential benefits of phenomenology to psychological research:

> The major philosophers of this movement have always respected the complexity and richness of human reality, and they developed concepts and categories that tried to describe that complexity in the most penetrating way. Perhaps situating oneself within that framework could be the answer to the difficulties perceived with the theoretical and research tradition in psychology. (Giorgi, 1985, p. viii)

Social work traditions, analogous to psychology, have been criticized for "too little attention to the dynamic interactions among environmental contexts, personal and cultural experiences and larger sociopolitical arrangements" (Kemp, 2001, p. 8). In response "feminist social workers seek to bridge gaps amongst women by examining the commonalities they share with each other alongside the specificities of their particular positions" (Dominelli, 2002, p. 9).

Feminist researchers cite key elements to inclusive women-centered processes as those that engage, empower and address gender stereotyping (Dell, 2007). Phenomenology's intersubjective, open and participatory methods "grow out of an intense interest in a particular problem [whereby] personal history brings the core of the problem into focus" (Moustakas, 1994, p. 104). Therefore, based on these observations, phenomenology appears to be a complimentary and empowering methodology for this project.

3.3 Recruitment

In May, 2011 the MetSyn project team, Dr. Vicky Holmes and Wendy Verity, and the independent program evaluators, Dr. Judith Martin and Dr. Bonnie Jeffery determined that the evaluation process would be strengthened by an understanding of the experiences of those that had discontinued the project. Dr. Bonnie Jeffery contacted me to determine my interest in this research project as she was aware of my interest and experience in women's health as well as my need to complete the final requirements of my Master of Social Work Program. Upon my acceptance of the project, as well as Dr. Martin's agreement as my field supervisor, telephone meetings and email correspondence with Dr. Martin, Dr. Jeffery and myself occurred to discuss the MSW research practicum requirements, the project work plan (see Appendix C), methodology, and methods including the definition of 'drop-out' or 'discontinuer', relevant literature, recruitment and sampling process and interview guide development. It was also decided that the interview guide, once developed, would be piloted with a convenience sample of two to three women, not known to me, who had participated and discontinued a nutrition and/or fitness lifestyle change program in order to assess for interview time appropriateness, participant comfort level with the questions and interview process and the interview guides ability to capture accurate and thorough details of the women's experience. Ethics approval for the pilot was incorporated into the overall study project ethics approval at the advice of the University of Regina Ethics Board department. Ethical considerations will be discussed throughout the methods section.

In mid-June, 2011, an in-person meeting was held with the Mestyn project coordinator, Wendy Verity, Dr. Martin, Dr. Jeffery and me at the WMLHCS office. Dr. Holmes was unavailable but had been provided the meeting agenda. I provided a brief overview of the project

and the MSW research practicum process. The definition of 'drop out' or 'discontinuer' was confirmed as those MetSyn pilot project participants who attended the November information session but not the May session as these were determined by the MetSyn pilot project and independent evaluators as critical sessions involving goals and health measurements (blood pressure, weight and waist circumference). The interview guide was also edited and the initial sampling selection occurred. Sampling will be discussed in the next session.

Particular attention was paid to how recruitment could maintain the anonymity of the MetSyn pilot project participants so as not to compromise the validity and ethics of the larger evaluation project. As women had not agreed to share information upon discontinuing within the original consent process, it was agreed that neither Dr. Martin nor Dr. Jeffery would be privy to the names of those recruited for this project and the recruitment letter of invitation written by me would be administered directly from the MetSyn pilot project. The letter (see Appendix D) requested all those wishing to participate to contact project coordinator, Wendy Verity, who then transferred the contact information via a confidential process (encrypted email) to me. I then contacted the women to arrange date, time and location of the interview and answer any initial questions. With the confirmed definition of 'drop- out' or 'discontinuer', Dr. Martin contacted Wendy Verity to compile a list of the general sample population.

3.4 Sampling

Purposeful, small samples are recommended for phenomenology as the method to "illuminating the richness of individual experience" (Baker et al., 1992, p. 1358). Consistent with Baker et al.'s suggestions, Creswell (2007) recommends that phenomenology study samples consist of small samples up to 10 people who may or may not be from the same site but with some limitations on diversity as "the more diverse the characteristics of the individuals, the more

difficult it will be for the researcher to find common experiences, themes, and the overall essence of the experience for all participants" (p. 122).

As previously indicated, initial sample selection occurred at the meeting held in Mid-June 2011. During this meeting potential recruits (n=32) were identified in an effort to have six women from the TelAsk computer/telephone support group, six women from the control group and six alternative women. 188 women participated in the MetSyn pilot project; hence the attrition rate was approximately 18 percent. The women were selected based on achieving a balanced representation of age (age range = 36-65), and economic status ($20-40K; $40-60K; $80-100K; $100-140K; $140K+). It was determined that efforts would be made to recruit a study sample of up to 10 study participants.

Following University of Regina Research Ethics Board approval, recruitment letters were distributed by Wendy Verity to the first 12 potential participants in mid-August, 2011. It should be noted that the original ethics approval had the recruitment letter being written on University of Regina Letterhead. Revised REB approval was granted on August 15, 2011 for the letter to be printed on WMLHCS letterhead. This recruitment effort resulted in one participant, hence letters were then sent to the remaining six alternative participants. No further study participants resulted from this effort. It was then decided, in collaboration with the MetSyn project directors and following revised REB approval (October 13/11) that recruitment letters would be sent to the remaining project drop-outs (n=14). This recruitment effort resulted in one study participant, creating a study sample population of two. In a final recruitment effort (Revised REB approval granted November 1/11), a second revised recruitment letter (see Appendix F) was administered by the MetSyn project coordinator to all potential eligible participants (n=32). The letter highlighted the current study sample size (n=2) and the recognition that the first letter was

distributed in the busy late summer/early fall time period which may have inhibited potential participants knowledge and/or ability to take part in the study. Unfortunately, no further participants came forth resulting in a final sample size of two women who had discontinued the MetSyn pilot project.

3.5 Data Collection

Data collection occurred with the use of individual, semi-structured interviews. The interview is a typical way of collecting data for phenomenological studies that involves an "informal, interactive process that utilizes open-ended comments and questions" (Moustakas, 1994, p. 114). The interview guide was informed by the literature review and developed in collaboration with my project committee academic and field advisors and the MetSyn pilot project and medical directors (see Appendix F).

3.5.1 The interview guide pilot process.

As previously indicated, the interview guide and interview process was piloted, following University of Regina REB approval, in a convenience- based sample of two women that were known by people I knew but not known to me personally. Recruitment happened by word of mouth. One woman was retired and resided in Prince Albert, the other was employed full-time and resided in Saskatoon and both women fell within the age range of the original study sample selection. Both women spoke of nutrition change lifestyle programs that they had discontinued. Both participants selected the interview location and both interviews took slightly under 30 minutes to complete with the addition of approximately 10 minutes to complete the consent form (see Appendix G) and follow- up process. Written, voluntary consent was provided by each woman prior to the onset of the interview process. The women were informed and consented to

the audio- taped interview with the understanding that the data would not be used in the formal study. Both women were provided the opportunity to receive a copy of the final written report.

Renzetti and Lee (1993), in the chapter on feminist methodologies located in their book, *Researching Sensitive Topics*, state that "double subjectivity" which is similar to intersubjectivy requires "the rejection of the traditional separation of the researcher from the researched" (p. 177). Thus, Renzetti and Lee suggest that same-sex researcher/study participant may diminish the inhibitions that participants may have about disclosing the experiences of sensitive research topics. It appeared that my shared female gender promoted an atmosphere of comfort and safety as both participants engaged in the interview process and neither became emotionally distraught to the point of stopping the interview or needing a referral for mental health/ crisis intervention services. Both women commented that the interview questions were comprehensive and the interview occurred in a timely, respectful manner. One comment was made regarding the lengthy description of the consent process.

Following the interviews, the interview process was reviewed by Dr. Martin and Dr. Jeffery for the purpose of member checking (Creswell, 2007) regarding the woman's comfort level and the ability of the interview questions and process to capture a rigorous or trustworthy description of her experience. Given the academic/field supervisor review and the feedback of the pilot study participants, the interview guide and process remained unchanged.

3.5.2 Data collection for study

Once potential participants indicated their interest in taking part in the study, MetSyn pilot project coordinator, forwarded their contact information to me via a confidential email. I then contacted each woman and made arrangements for the interview in a location of their choice. Each woman chose a restaurant/coffee shop location during the day.

Prior to the interviews, the women and myself reviewed the consent form (see Appendix H) for the current study which explained my affiliation, the purpose of the research, data collection methods and confidentiality measures, including how their information would be recorded, documented, housed and destroyed . The recruitment letter in combination with the consent form "helps build rapport" (Creswell, 2007, p. 124). The women were informed that their participation was completely voluntary and that they could drop out of the study at any time. Upon giving written consent, each woman provided permission for the interview to be audio-taped using a digital recording device and the use of verbatim quotes in the larger MetSyn pilot project evaluation study. To further confidentiality, each woman was also asked to choose a pseudonym for the purpose of anonymity in the data (Creswell, 2007).

The digital recordings were transcribed by me using a computer-based transcription program. The information that was electronically stored on password protected computers and for files and in instances where this information was transferred over the internet, encrypted web interface over https protocol, IP authentication and session timeouts were used for enhanced security. All existing forms of original data, recordings, field notes and transcriptions will be housed in a secure location of the Prince Albert Campus of the University of Regina, Faculty of Social Work and will be destroyed after a period of six years.

3.6 Epoché

Prior to data collection, I will complete the formal Epoché or bracketing process. The bracketing process developed by Husserl (Ashworth, 1999, Creswell, 2007, Patton, 2002) is completed in order to set aside presupposition or "past associations, understandings, "facts", [and] biases" (Moustakas, 1994, p. 116). The process allows for these presuppositions to be

suspended as a means of "putting out of play the various interpretations and prejudices which would cloud analysis" (Ashworth, 1999, p. 708). As Moustakas (1994) explains, Husserl's philosophy behind Epoché was that this process of transparency opened pathways for new consciousness and knowledge. We are encouraged to see things anew, to be present and to understanding situations as they appear.

Ashworth (1999) in his paper, entitled *"Bracketing" in phenomenology: renouncing assumptions in hearing about student cheating"* provides a thorough and concise explanation of the bracketing process and how it can be used for "entry into the life-world of the research participant" (p. 708). He discusses the previously noted philosophical tenants of phenomenology offered in this proposal as well as helpful summations as to what, in research should be bracketed:

So among the specific kinds of presuppositions to be bracketed according to these authors are "those based on theories or earlier research findings; those drawn from the investigator's personal knowledge and belief; and those assumptions which would dictate specific research methods" (Ashworth, 1999, p. 710). A written statement of my bracketed position is provided prior to the report of the findings.

3.7 Data Analysis

The method of analysis for this study will be a combination of the complimentary methods outlined by Giorgi(1985) and Moustakas (1994) that result in the systematic steps of transcendental phenomenology. Due to the small number of participants, data analysis was a manual approach of thematic analysis. Inter-rater reliability was enhanced by review of data analysis by my field and academic supervisor prior to the presentation of findings and recommendations. Inter-rater reliability is "used to assess the degree to which different

raters/observers give consistent estimates of the same phenomenon" (Trochim, 2005, p. 66). The following is an explanation of the analysis steps.

3.7.1 Reduction.

Reduction begins with the bracketing process and results with the synthesis of a "textural portrayal of each theme" (Patton, 2002, p. 486). Hence, the task of reduction is to use textual language to describe the external object or experience as well as how the person makes sense of their experience. Schostak and Schostak (2008) describe texture as "as a disposition or characteristic of anything which is woven into a fabric, and comprises a combination of parts or qualities, which is neither simply unveiled nor made up" (p. 147). Their description is relevant as the task of reduction is one of repeated looking and describing (Moustakas, 1994) at the meaning units or "'significant statements', sentences or quotes that provide an understanding of how the participants experienced the phenomenon" (Creswell, 2007, p. 61) by the process of horizonalization.

3.7.2 Horizonalization.

Horizonalization is the discovery of new horizons and, according to Moustakas, "Horizons are unlimited…It is a never-ending process and, though, we may reach a stopping point and discontinue our perception of something, the possibilities for discovery are unlimited" (1994, p. 95). As previously noted, meaning units were determined via a manual thematic analysis approach. First, the entire interview was read for a general understanding. Each "non-repetitive, non-overlapping statement" (Moustakas, 1994, p. 122) or meaning unit was recorded. Meaning units were then clustered into themes and finally a pre-reflective natural description of the phenomenon was developed. (Giorgi, 1985).

Initial data analysis resulted in general themes of experiences of attrition from the MetSyn pilot project being: how and why of involvement, history, perceptions of program specifics (location, session format/information, blood work/tests, Tel Ask Experience, Questionnaire, Research), program-external factors affecting discontinuation, feelings about discontinuing, 'woman' as plural, helpful aspects of the program, effects on present lifestyle/nutrition goals and "If you were developing a program for Metabolic Syndrome"- input into future program development. All general themes were included as the small number of participants minimized the ability for saturation; "…saturation is reached when the researcher gathers data to thepoint of diminishing returns, when nothing new is being added" (Bowen, 2008, p. 140).

With further data analysis these broad meaning units became more defined. This process occurred by examining the transcripts and writing verbatim statements within the margins. These statements were then categorized within the broader meaning units. For example, feelings about discontinuing included: don't like to have not followed through, felt bad, wanted to program/totally wanted this, wanted to be there for Wendy but I didn't want to waste my time, Wendy- nice, enthusiastic, felt bad having to say no to her but not bad enough to do it, I don't know if within myself if I was looking for a quick fix, not what I expected, I feel in midlife to see that every option to be and it is not just my goal but that to be a goal for all women who have trouble sticking to their weight, frustrated, didn't feel like they had gone far enough.

3.7.3 Imaginative variation.

The next step was to move from the textural description to the structural description of the experience which aims to explain, "the underlying and precipitating factors that account for what is being experienced: in other words the "how" that speaks to conditions that illuminate the "what" of experience" (Moustakas, 1994, p. 98). The process entailed further reflection of the

textural clusters of meaning units, resulting in structural themes. For the above example the structural themes include: disappointment, failure, commitment, conflicted, responsibility, autonomy, empowerment and frustration.

3.7.4 Synthesis of essence.

The final step is "an integration of the composite textural and composite structural descriptions, providing a synthesis of the meanings and essences of the experience" (Moustakas, 1994, p. 144). In other words, "individual statements are worked through in order to uncover the general description of the phenomenon" (Baker et al., 1992, p. 1358). Based on the small sample size, the essence of the attrition experience was not determined in the current study. Lessons learned and suggestions will be presented in the Discussion portion of the report.

Chapter 4: Findings

4.1 Personal Statement of Social Location

As previously discussed, the process of Époche begins with the researcher situating themselves within the context of the study in order to bracket presuppositions of previous experience. I am a Prince Albert –based social worker who has practiced for 17 years. I am also, to name a few, a mother, wife, friend, daughter, granddaughter, sister and student.

Given that an extensive period of my career has been characterized by the provision of services for marginalized women and children, I often see the lack of social system support and interpersonal abuse as factors related to difficulties with their health or other cardiovascular risk factors like stress and smoking. Concurrent issues of grief, trauma, mental illness and substance use problems also appear to complicate individual's success. From a theoretical perspective, transtheoretical model of change (TTM) has been a prevalent model within the world of mental health and addiction. TTM outline stages of change and the cognitive roadblocks to motivation, action and success where change and progression occur when the cons outweigh the pros for the current behavior and the threat to not change becomes greater than the risk to change.

At present, I am quite a thin, fit individual. This has not always been the case as I was a chubby little girl who lacked coordination, height and confidence to become involved or stay involved in team sports. It was not until I started running and participating in individual exercise programs like aerobics that I began to have success with my weight. Fortunately, this happened for me in my early teens and running has been a passion, weight maintainer and mental health enhancer for the majority of my life since. There were times, however, when I was experiencing emotional pain that food became my comfort and, regardless of how much exercise I did, the weight packed on. It wasn't until the rest of my world became balanced that my weight began to

stabilize making me realize sustainable weight loss isn't all about twenty minutes of cardio and how many servings of bread to eat in a day.

Finally, early in my career as a mental health counselor, a colleague and I were having a conversation about the ability to keep up with one's paperwork. He commented that it was not into his 12th or 13th year of practice that he had been able to do so and suggested that, perhaps, "it's not my time". At the moment, I recall being perplexed by this statement and thought that it was simply an excuse for inefficiency. Over time, however, through personal and professional experience, I changed my mind. I have come to embrace this statement as one that embodies my women-centered philosophy that women are the experts of their own lives. We as service providers need to recognize and respect the complex intersections of history, culture, ethnicity, gender, economics, education and relationships in their lives that ultimately require a specific type of support at that particular moment of which they are free to choose and use in a way that works for them. It is from this position that I now open my mind to hearing the essence of this phenomenon.

4.2 Presentation of Findings

Linda and Rowena (pseudonym's selected by the research participants) were both interviewed in a restaurant/coffee location of their choice. The location offered a relatively quiet atmosphere with a moderate degree of privacy. Both interviews took place in the afternoon; Linda's in September, 2011 and Rowena's in November, 2011. Rowena informed that she was a 66 year old, married woman who was currently retired. Linda stated that she was a 52 year old widowed woman who worked full-time during the week and part-time evenings and weekends. Rowena resided within the city of Saskatoon and Linda resided in the Saskatoon area. Linda

attended one session of the MetSyn pilot project and Rowena attended two. Both women indicated that they had not attended the January information session.

I conducted both interviews using the piloted interview guide and process. Both interviews lasted just under 30 minutes with approximately 10 minutes on either side for the written consent process and friendly conversation at the end. Though no incentive was offered for the study, I purchased the coffee and food each woman had during the interviews as a sign of my appreciation for their knowledge and time.

As previously indicated in the data analysis section, the process of horizonalization and imaginative variation resulted in general and structural themes of MetSyn pilot project attrition. The themes will now be described and supported with verbatim examples. Due to the small number of study participants, not all verbatim statements will be identified for anonymity purposes.

4.2.1 The how and why of involvement.

Linda and Rowena had both been self-referred. Linda gained knowledge of the project through friends and Rowena had read about "the study" (Rowena referred to the MetSyn pilot project in terms of a study) in both the Saskatoon Sun and later the Star Phoenix. Rowena commented that she had been excited after reading the article in the SUN but had not acted right away because she had been confused about how to get involved. It was when she saw the article, again, in the Star Phoenix that she decided to further enquire. Both women contacted Wendy Verity, the MetSyn Pilot project coordinator who then informed them of the medical process they needed to complete to be eligible for the program. Both women said that they had not received any pressure or suggestion to attend by a health care provider such a doctor.

The narratives of both women contained sub-themes of location and action as related to their goals of managing their health, knowledge and weight loss. Linda commented that the reason she thought the project would be helpful for her was she had "looked up MetSyn and saw myself there". Rowena informed that she thought the project would be "the place to go" to "learn more about the body" in order to "get my waistline back". Rowena also expressed excitement about the fact that the project was "medically-based" and the "medical involvement was key" regarding her decision to participate.

4.2.2 History.

Linda and Rowena appeared to be at different points in their health journey. For Rowena she commented that she had been "working for a long time with around my weight". She noted both a family and personal history of high blood pressure and a desire to find proactive treatment measures before she had to use medication. Rowena also spoke of the relevance of learning about metabolic syndrome in menopause because that had been "when so much of the add issue weight came into my life" and a desire to learn if there was a relationship between metabolic syndrome and allergies. For Linda it was a different story.

Linda told of learning of her diagnosis of high blood pressure and diabetes approximately one year prior to the onset of the project. She recalled that "it all came up in a couple of months" and described the precipitating medical incident that resulted in the diagnosis of high blood pressure and diabetes, "when I never had anything wrong with me ever in my life". In retrospect, during the interview Linda expressed, during her time in the project, "I guess I was still reeling from that".

4.2.3 Perception of program specifics.

4.2.3.1 Location.

The geographical location was perceived as well-planned out and there was the recognition that there were several locations to pick from. Linda expressed that she had chosen the location that worked best for her given the other commitments that she had had that evening. Both women expressed that the community settings were too small for the number of participants and the session activities resulting in feeling "crowded". Rowena also stated that she did not think the crowded community location was the best setting for taking blood tests.

4.2.3.2 Session format/ information.

Themes of disorganization, questioning and disappointment were used to describe the women's perception of the session format and information. Linda noted that "it was all going on" and that she "felt like I missed a great deal". She clarified these statements in the context of receiving the education information at the same time as having measurements done and completing the research questionnaires. These multiple tasks made it difficult for her to pay attention to the speaker and created a sense of disorganization. As previously stated, Rowena was concerned about the crowded session environment effects on blood pressure.

The currency, level of difficulty, comprehensiveness and reliability of the project information and format left the women "questioning" the project. Phrases such as "basic", "not up to date", "heard this before", "stuff I could have looked up on the internet" and "needed to be more comprehensive" were used to describe the session information. Rowena also expressed her understanding that this study was underfunded as compared to the B.C. study that the MetSyn project was "emulating". This left, in her perception, participants to voluntarily adhere to the fitness and nutrition guidelines when "you could starve yourself for a week and come back and

say I've lost 10 pounds". This lack of intervention control made her question the reliability of the project outcomes and a sense that "this isn't quite coming off like I would have thought".

Disappointment was a repeated theme for both women. There was a voiced sense of disconnect from what both women were expecting the project to be versus what it was for them. For Rowena, her disappointment came within the sessions when she learned how little medical involvement there was going to be in the project and "it wasn't really a medically-based study as much as much as it was a kinesiology- based study". Linda spoke of the disappointment of the number of tasks they were to complete during their session which became distracting. Her perception, based on a letter she had received, was that they were each going to be assigned a physical trainer and a dietician and "there wasn't even someone slim come in and do exercises in front of us". This disappointment around the physical presentation of the health care provider support she received during the project built when she was referred to a nutritionist and "…she was a rather large lady telling me how to lose weight". As a result, this disappointment led to thinking that the project "wasn't quite what I wanted".

4.2.3.3 Blood work/tests.

In addition to the comments mentioned regarding environmental stressors and the negative impact on blood pressure testing, Rowena questioned why the medical tests needed to be repeated since these medical tests needed to be completed before you started the project. Linda reported no difficulties with the blood work and tests as she was used to these procedures being a type 2 diabetic.

4.2.3.4 TelAsk experience.

One of the women was assigned to the TelAsk group. Overall the experience was described as annoying and non-supportive. She recalled receiving calls once a week but them

increasing to the point that they would be on her answering machine. Even though she could not remember the specific details of the phone-calls, she noted that she could have said anything and that she would "just say yes to get it over with". It was after one of the phone calls, that she said she called Wendy to request the nutritionist referral.

4.2.3.5 Questionnaire/research.

Rowena had difficulty recalling all details of the questionnaire/research aspect of the project but expressed her belief that allergies were not part of the questionnaire materials. For Linda, the questionnaires were long and she wouldn't have minded completing them if she could have filled them out before or after the session so as not to impede her ability to pay attention to the session speakers.

4.2.4 Program-external factors affecting discontinuation.

Both negative and positive factors were described as affecting the women's choice to discontinue. For Linda, it was the reality of being busy that influenced her choice:

> *Umm just the fact that I'm busy a lot and um if I was going to do something that was um I wanted it to be I guess a little more worthwhile that I didn't have time just to do this kind of stuff that I could sit in the internet and find…or yeh I would have made the time if I felt it was um a good program for me or that it was though it was going to be…*

Rowena informed that she had "continued with her own resources" and exploring a raw food diet at the same time she entered into the MetSyn project. She commented that she did lose weight on the raw food diet but "I can't say I held it" which led to further commentary on "everything as a learning experience", the need to look at the "bigger picture" and women's weight issues**:**

…because for us women, um there can be so many yo-yo's going on in food. We're constantly dieting, losing and gaining, losing and gaining. This isn't a one time achievement; it's as continuum of working the balances and trying to keep your weight.

4.2.5 Feelings about discontinuing.

Here, again, the feeling of disappointment was present about the program and within them as one woman commented that she "felt bad" and didn't like to have not followed through. There was also expressed concern about disappointing the project coordinator and "wanting to be there for Wendy", who was described as "nice" and "enthusiastic". Frustration was also related to disappointment in the program and the sense that "I didn't feel like they had gone far enough" and "that it wasn't what I expected".

Discontinuation also appeared to be balanced between feelings of responsibility and autonomy. For example Linda had commented that "I wanted to be there for Wendy but I didn't want to waste my time" and that regardless of feeling bad about disappointing Wendy, she did not feel bad enough to stay in the project. Rowena, too, "wanted it but I did also want the medical component to be stronger". For Rowena, discontinuation also related to a sense of responsibility and right for all women who have "trouble sticking to their weight" to be aware and be made aware of all options for weight control:

I feel in midlife to see that every option to be and it is not just my goal but that to be the goal for all women who have trouble sticking to their weight.

4.2.6 Woman as plural.

From the interviews, it was evident that this experience was not singular for these women both in their project participation and in their decisions and feelings about the project. Both Linda and Rowena attended the program with friends. Rowena commented that she had talked

her friend into joining the project and “if I wasn’t going, she wasn’t going”. Linda, too, came and left with a friend and spoke to the recognition of “other ladies” feeling the way she did about the project. As well the women’s choice to discontinue was balanced between their reasons for discontinuing and their feelings of disappointing the female project coordinator. All of these experiences highlight the female plurality of the phenomenon.

4.2.7 Helpful aspects of the project.

Both women reported that the experience “wasn’t a total loss by any means” and that “there is always something you can hang your hat on”. For Rowena, she experienced a “positive reaction” to her health as she had incorporated the concept of “adding one extra thing” to her fitness regime. Linda stated, as well, that the physical activity ideas had “spoken louder” to her than the nutrition information and the “medical info that came out made me think yikes”.

4.2.8 Present day effects.

Rowena reported that she had continued with her fitness routine changes. She also commented that the experience had created a sense of hope that there would be more projects like this in the future. For Linda she expressed greater knowledge of Metabolic Syndrome which had a positive effect on her body esteem in combination with learning that she “could” and it was a “possibility” for her to cure her metabolic syndrome. Both women did not see their experience as a deterrent to joining other programs and Linda reported joining Curves after she discontinued.

4.2.9 If you were developing a program for Metabolic Syndrome.

The first suggestion both women had was for the inclusion of “more emotional support” as “we can all get emotionally wrapped around food”. The suggestion of counseling or group sessions on emotional eating were made to address increased emotional support. Other program

additions included a guided exercise group like a walking group and greater inclusion of comprehensive medical research knowledge presented by professionals with insight and experience with “you know I’ve been there kind of situations”. In regards to the project sessions, Linda suggested “less turmoil” with “more time to just sit and listen and not to have to multi-task and try to follow the program”.

Finally, Rowena described a “levels of readiness” program model for future Metabolic Syndrome projects:

> *Umm it would be a stages of stages of of it would be a levels of of a readiness There would be those that who would need basic information but there may be other levels. There would be other levels of more you know because to me the people who may have this Metabolic Syndrome are not going to come here in one event.*

Chapter 5: Discussion

This qualitative phenomenological study aimed to understand the lived experience of Saskatoon and area women who had discontinued the MetSyn pilot project from a women-centered perspective. A one-time semi-structured interview with two study participants resulted in data that was analyzed using a systematic method of analysis (Moustakas, 1994) recommended in phenomenology methodology. Using manual thematic analysis, meaning units were clustered in the process of horizonalization to create a textural description of the experience. The analysis procedure of imaginative variation and synthesis of the essence resulted in several statements that reflect the phenomenon of attrition. As previously stated, ethical considerations were discussed throughout the report. This chapter will highlight the strengths and limitations to the study, suggestions for future MetSyn program development that arise from this study, practice implications and future research directions.

5.1 Limitations and Strengths

The small sample size was the primary limitation of this study. The aim was to recruit up to 10 study participants and, regardless of repeated and adapted recruitment efforts, the final sample was two women. Hence, the transferability or "degree to which the results of qualitative research can be generalized or transferred to other contexts or settings" (Trochim, 2005, p. 126) is limited given the inability to reach saturation of the themes of attrition. Chambers, Wedel and Rodwell (1992) in their textbook on the evaluation of social programs, report that "ordinarily dropouts cannot be located in order to give data about post program accomplishments" (p. 167). Though this study had no difficulty locating drop-outs, location did not enhance study participation.

This study has, at least, provided a starting point for those interested in expanding on the results of this study. Qualitative feminist work research has the ability to challenge dualistic,

patriarchal knowledge by "accepting, responding to and validating women's right to speak about and their lives in their own terms" (Dominelli, 2002, p. 74).

5.2 Implications for Social Work, Future Research and Program Development

Jim Ife (2008) a social worker and advocate for human rights based social work identifies the following principles that relate to citizen participation in community affairs:

- people will participate if they feel the issue is important
- people must feel that their action will made a difference
- different forms of participation must be acknowledged
- people must be enabled to participate and supported in their participation
- structures and processes must not be alienating (Ife, 2008, p. 118)

Though the context of community participation and lifestyle program participation is different, Ife's principles provide a useful model of understanding. Each subheading will be used as a guide to discuss implications for social work practice, future research and program development.

5.2.1 People will participate if they feel the issue is important.

Rowena and Linda were at different phases of their health journey. This appeared to be the result of the age difference and how long each woman had been aware of her risk factors that related to metabolic syndrome. Regardless of this difference, both women expressed health goals and that they wanted to "do something about it" (i.e. excess weight, high blood pressure). Both women located themselves within the study and felt that "this was the place to be" giving their perception of the program and a compatibility between their goals and the project description and interventions. This goal mutuality reflects the findings of Davis and Addis (1999) that mutually agreed upon therapeutic goals and tasks related to the ability to predict when an individual

remained in behavioral medicine treatment programs for headache, pain, stress and weight management.

The women began to question the importance of their involvement when their goals started to misalign with the experiences of the pilot project. This misalignment appeared to be the result of ambiguity regarding the importance of autonomy for the women versus the importance of responsibility to the program and care of the program coordinator's feelings. "Ambiguity is illustrated in women's roles as carers when women feel the double bind of being responsible for others and wanting to help, but also wishing to be free of responsibility and focus on themselves" (Dominelli, 2002, p. 38). For Linda, she needed to balance her ability to manage her busy lifestyle and yet "wanted to be there for Wendy". For Rowena, she "totally wanted this" reflecting a commitment or care to the project but felt that the lack of comprehensive medical information limited her right to know every option available regarding her ability to manage her weight. Though the women in this study were not directly care giving, the sense of caring resulted in similar ambiguity about the importance of their participation.

Both Linda and Rowena are early and mid-baby boomers or "persons born after WWII between the years of 1946- 1964(Macunovich, 2002)" (Utz, 2011, p. 144). Parallel to Dominelli's sentiments on autonomy, the findings illustrate the conclusions Utz (2011) expressed on the impact of availability of health technology and autonomy for baby boom daughter's construction of aging and menopause versus their mothers as it relates to health and the body:

> Compared to their mothers, the daughters have substantially greater access to health-related technology, received more education and possess greater overall awareness of their bodies (Blancette & Valcour, 1998; Macunovich, 2002). They also have greater

> financial resources than any generation before them, allowing them to purchase age-related services and products (Dailey, 2000). These resources should ideally put them in a better position to weather the transition into older age. However, aging is not something that you can control…In this regard, the perceived autonomy and need for personal control espoused by the daughters in the sample may actually make them more vulnerable or less prepared to face the realities of old age than their mothers. (Utz, 2011, p. 152)

Linda's comment regarding her uncertainty of whether or not she was looking for a "quick fix" also suggests the influence of the pharmacological technology and the pathologizing of issues of midlife and menopause which reflect a synonymous finding in Utz's study where "a pill taken once a day was easier than maintaining the physician recommended fitness regime and restrictive dietary plan" (p. 148). Hence, this study supports Utz's recommendations that health care providers recognize the historical context of present day mid-life women and the importance control plays in "their internalization of the medicalized paradigm, and their steadfast proclamation to traditional norms associated with previous generations" (Utz, 2011, p. 153). As Rowena proclaimed "I feel in midlife to see that every option to be and it is not just my goal but that to be the goal for all women who have trouble sticking to their weight".

5.2.2 People must feel that their action will make a difference.

Both women questioned whether or not the MetSyn project was going to make a difference in its ability to meet their health and lifestyle goals. This sense that the project was

"worthwhile" appeared to affect Linda's motivation to "make time" to participate. Rowena expressed frustration regarding the lack of medical involvement and uncertainty regarding the voluntary nature of accountability to the project interventions and the effects on the outcomes of the study. Cognitions such as "this wasn't coming off like I would have thought" also related to her motivation to continue with the project.

Huisman et al. (2010) recommended, in the study on low goal ownership as a predictor of drop out from a weight intervention study with overweight type 2 diabetics that assessments of participant goal ownership occur prior to the onset of the intervention. The study was situated in the theoretical paradigm of self- regulation (S-R) theory or goal theory which states that

> Human actions are goal-oriented, and that goal pursuit and attainment are more likely if goals are personally relevant (autonomous or own goals), if individuals feel competent to attain them (goal efficacy), receive the necessary support (goal support), and have an adequate plan for goal attainment (goal planning). (Huisman et al., 2010, p. 177)

The findings of this study, as they relate to the perceived difference the MetSyn project was going to make to the overall goals and the impact on motivation, suggests the relevance of ongoing assessment of the congruence of the participant's plan and the project presentation and implementation.

5.2.3 Different forms of participation must be acknowledged.

Regardless of the experiences of disappointment and goal misalignment for the women, the MetSyn pilot project was "not a complete waste of times by any means" and both women found "something to hang their hat on". There was common ground and difference in the helpful program benefits and present day effects for Rowena and Linda which speaks to the individual and communal experiences of MetSyn attrition. Both Linda and Rowena found merit in the

fitness information aspect of the program which had resulted in new and sustainable fitness efforts. Existing literature supports these findings in relationship to self-efficacy and adherence to physical activity in women (Findorff et al., 2007; Lloyd & Little, 2010) as it appears that learning the importance of "adding something new" to their fitness routine and the self- efficacy or confidence that metabolic syndrome was treatable led to sustainable changes in physical fitness activity for the women.

They veered in their positive and negative perception of the medical information. For Linda the medical information had resulted in a "yikes" moment that created a cognition that she needed to "do something about it". For Rowena, the medical information was perceived as less current and comprehensive than she expected. Conclusions as to what related to the differences in the women's experiences are difficult to determine given the small sample size and the inability to suggest common themes for a particular demographic or variable for a women.

The woman as plural theme that was identified from the data also suggests that gender may also make a difference in participation not within the context of men versus women but rather the specific ways in which women behave that may affect program participation. "Gender consists of the socially constructed roles and relationships, personality traits, behaviors, values relative power and influence that society ascribes to the two sexes" (Clow, et al., 2009, p. 11). Both women commented on the communal nature of their coming and leaving of the MetSyn pilot project with friends. There was also a consensus attitude regarding the negative perceptions of the program as "other women I talked to felt the same way" and the decision to discontinue for Linda balanced between her needs and "feeling bad about not being there for Wendy", the MetSyn project coordinator.

Feminist social work recognizes “the capacity of women to take action on their own behalf and to demonstrate solidarity across a range of social division” (Dominelli, 2002, p. 18). From a research perspective, no literature could be found that examined the relationship between gender and lifestyle behavior change program attrition, hence, the findings support the need for further investigation into the potential links between the two. Based on the discontinuance pattern and decision making reflecting a plural or power in numbers theme future program development would also benefit from attention to methods of addressing cohesion and, again, group goal alignment to mitigate attrition that results from “if I wasn’t going she wasn’t going” attitudes.

5.2.4 People must me enabled to participate and supported in their participation.

Positive reaction was voiced in regards to the geographical location of the MetSyn information sessions that were attended for the women. Linda commented about her awareness of several locations and chose the one that work best for her. Other aspects of the program were viewed as less supportive, particularly the lack of guided fitness programs, attention to the psychological aspects of MetSyn and the TelAsk computer generated telephone follow-up system.

The finding of this study relate to the findings of Ivester et al. (2010) and Pettman et al. (2010) whose research found a positive relationship between adherence and general fitness and nutrition guidelines that were supported with group exercise and education sessions. Lloyd and Little(2010) also found in their qualitative study exploring the experiences of self-efficacy, intrinsic motivation and leadership during the Contours Activity Festival in Christchurch, New Zealand that leadership played a strong role in self –efficacy “where respondents felt they could and had achieved despite their initial lack of experience and confidence” (p. 666). The positive

relationship between mental health, quality of life and metabolic syndrome (Chedraui et al., 2007) also support the need for greater attention to the psychological aspects of Mets. Hence, this highlighted research supports the suggestions put forth by the women regarding the inclusion of guided exercise programs and greater psychological support for program adherence.

5.2.5 Structures and processes must not be alienating

The Merriam-Webster online dictionary (2011)provides the following definition of alienation: "a withdrawing or separation of a person or person's affection from an object or position of former attachment". Alienation is also synonymous with disgruntled or discontinued. Thus, it is within this definition that the women's attrition experience will be discussed.

Person in environment is fundamental to social work practice (Kemp, 2001). This theoretical perspective,

> views the individual and his or her environments as forming an ecosystem, consisting of the individual, all the systems with which the individual has reciprocal relationships, the wider environment in which the individual acts, and all the mutual interrelationships that occur between the individual and the various subsystems. (Weis-Gal, 2008, p. 65).

Kemp (2001) challenges women-centered social work to see women in their environments through a gendered lens. A gendered lens pays "careful attention to the content, texture and meaning of women's environmental experiences" (p. 18) in an attempt to mitigate systemic and relational barriers that estrange or alienate women.

The attrition experience for Linda and Rowena reflect themes of alienation. The multi-tasking required by the participants during the information session in order to complete the research questionnaires resulted in Linda "missing a great deal", thus limiting her ability to concentrate on the speakers and the educational information being provided. For Rowena, the

location, process and lack of resources for the number of women in attendance appeared alienating in her confidence and comfort with project environment as a suitable environment for blood tests. The physical presentation of the speaker and nutritionist alienated Linda from engaging and trusting the information provided as “it was a rather large woman telling me how to lose weight” which did not align with Linda’s perception of a leader who role modeled healthy eating. The TelAsk computer program, a program that was to enhance support was described as “annoying” and resulted in resistance of the woman assigned to this group in her “just saying yes to get it over with”. The overall structure of the program information was also alienating for the women in its lack of comprehensive, beyond basics make-up that was not looking at the “big picture”.

Confidence and efficacy relate to women’s “ability to participate and learn new skills with other women who have similar personal goals and skill levels” (Lloyd & Little, 2010, p 665). The skill level that Rowena and Linda voiced was not the same as the “basic” information presented at the information session. Where they did learn new skills related to physical fitness and metabolic syndrome knowledge was where the women experienced sustainable change and holistic health improvement.

The lack of goal mutuality and comprehensive, current and supportive program components were salient themes of the Metsyn pilot project experience that ultimately led to the final form of alienation, leaving the program. Potentially, the “levels of readiness” program model outlined by Rowena may indeed be the “vision” of more inclusive, women- centered MetSyn program. This model, however, would require further investigation and need to be balanced within budget and resource constraints that are also often shouldered by the marginalized and alienated members of society.

5.3 Conclusion

The aim of this research project was to understand the lived experiences of Saskatoon and area women who had discontinued the MetSyn pilot project from a women-centered perspective using phenomenological methodology. Though the small sample size limited the ability to fully understand the essence of the attrition experience the following were valuable lessons learned from the two participants:

- The women were in various stages of their health journey and had been actively searching for comprehensive knowledge and support related to their needs and objectives in the prevention and treatment of metabolic syndrome.
- Their experience was communal with a “woman as plural theme” that resulted in feelings of disappointment, frustration, annoyance and loss; these feelings, however, were balanced with a sense of empowerment and autonomy in regards to what decision was best for them given their health goals and other commitments of their lives.
- Regardless of discontinuing these women experienced positive and sustainable changes including enhanced knowledge regarding Metabolic Syndrome and physical fitness, increased self- esteem, empowerment, a sense of efficacy for health improvement, hope and a continued desire to access healthy lifestyle programs.
- Future program development would recognize the need for a holistic stepped model or level of readiness program model that incorporated current and comprehensive medical research, knowledge and support regarding emotional eating, activity groups and physically fit and experienced facilitators/speakers. Information would be presented in an adequately sized, calm and organized context that does not

require multi-tasking. There would also be closer attention to intervention control and reliability of the study process.

Thus, the study highlights the unique, ambiguous, disappointing and communal journey of Saskatoon and area women in mid-life searching for control and efficacy regarding their holistic, multi-level health needs in the prevention and treatment of metabolic syndrome.

The project attempted to give voice to a population of women that are often not heard from and listened to in their ability to provide "unanticipated but meaningful insights into a program's inner working" (Royse, Thyer, & Padgett, 2010, p. 85). Unfortunately, the small sample size limited the ability to do so and begs the question as to why more past Metsyn participants did not want to offer their views. Further, in order to strengthen these voices, I would recommend the inclusion of consent and method for follow-up contact following program discontinuation in the initial project or study planning process to advance potential study recruitment and larger sample sizes.

Social work practise is situated in a strengths-based approach that "requires an accounting of what people know and what they can do, however inadequate that may sometimes be" (Saleeby, 1996, p. 297). Hence, in agreement with Saleeby, I would suggest that, regardless of the study's inability to produce credible outcomes, the strength of this study is found in its ability to model rigorous study methods such as the interview guide pilot process, and repeated, varied and ethical recruitment efforts. The study also illustrates how qualitative research methods can enhance evaluation studies in their ability to add the specifics of historical, relational and environmental intersections of women's lives that may influence healthy lifestyle program participation or, in other words, whether or not, "It's my time".

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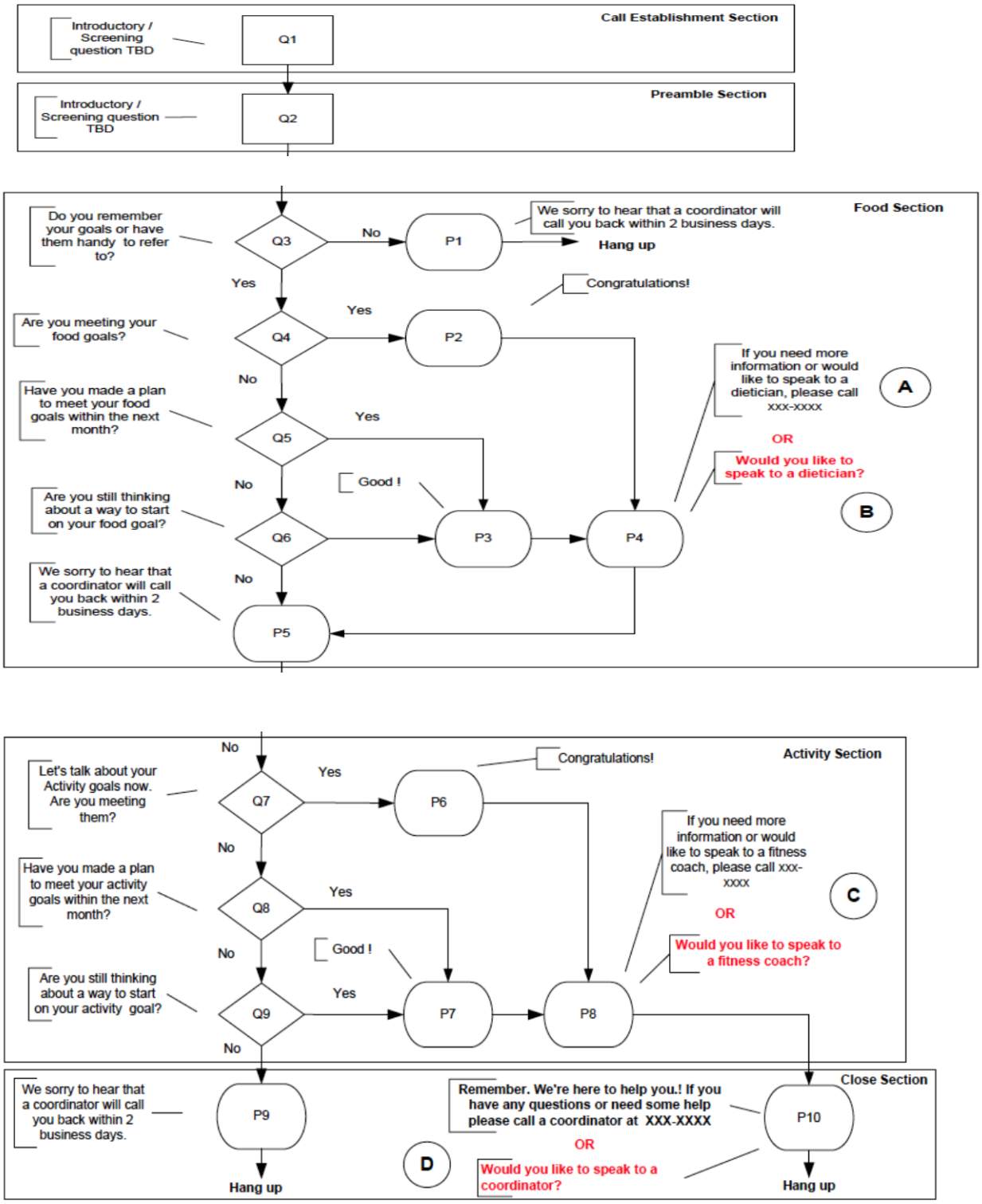
World Health Organization. (2009, November). *Women's Health* (Fact sheet N 334). Retrieved from http://www.who.int/mediacentre/factsheets/fs334/en/index.html

Appendices

Appendix A – TelAsk Computer Phone Pathway



Appendix B – Ethics Documents

University of Regina

OFFICE OF RESEARCH SERVICES

MEMORANDUM

DATE: August 3, 2011

TO: Jennifer Katherine Suchorab
RR 5, Site 27, Comp 4
Prince Albert, SK S6V 5R3

FROM: Dr. David Senkow
Acting Chair, Research Ethics Board

Re: **'It's Not My Time'; Understanding MetSyn Pilot Project Attrition from a Women-Centered Perspective (File # 05S1112)**

Please be advised that the University of Regina Research Ethics Board has reviewed your proposal and found it to be:

☑ 1. APPROVED AS SUBMITTED. Only applicants with this designation have ethical approval to proceed with their research as described in their applications. For research lasting more than one year (Section 1F). **ETHICAL APPROVAL MUST BE RENEWED BY SUBMITTING A BRIEF STATUS REPORT EVERY TWELVE MONTHS.** Approval will be revoked unless a satisfactory status report is received. Any substantive changes in methodology or instrumentation must also be approved prior to their implementation.

☐ 2. ACCEPTABLE SUBJECT TO MINOR CHANGES AND PRECAUTIONS (SEE ATTACHED). Changes must be submitted to the REB and approved prior to beginning research. Please submit a supplementary memo addressing the concerns to the Chair of the REB.** Do not submit a new application. Once changes are deemed acceptable, ethical approval will be granted.

☐ 3. ACCEPTABLE SUBJECT TO CHANGES AND PRECAUTIONS (SEE ATTACHED). Changes must be submitted to the REB and approved prior to beginning research. Please submit a supplementary memo addressing the concerns to the Chair of the REB.** Do not submit a new application. Once changes are deemed acceptable, ethical approval will be granted.

☐ 4. UNACCEPTABLE AS SUBMITTED. The proposal requires substantial additions or redesign. Please contact the Chair of the REB for advice on how the project proposal might be revised.

David Senkow

Dr. David Senkow, Acting Chair

cc: Dr. Bonnie Jeffery – Faculty of Social Work

** supplementary memo should be forwarded to the Chair of the Research Ethics Board at the Office of Research Services (Research and Innovation Centre, Room 109) or by e-mail to research.ethics@uregina.ca

Phone: (306) 585-477
Fax: (306) 585-489

University of Regina

OFFICE OF RESEARCH SERVICES

MEMORANDUM

DATE: August 15, 2011

TO: Jennifer Suchorab
RR 5, Site 27, Comp 4
Prince Albert, SK S6V 5R3

FROM: Dr. Bruce Plouffe,
Chair, Research Ethics Board

Re: **'It's Not My Time'; Understanding MetSyn Pilot Project Attrition from a Women-Centered Perspective (File #05S1112)**

With reference to your August 11, 2011 request for changes, this memo confirms the approval given by e-mail on August 12.

Please contact us if you have any further questions.

Sincerely,

a Bruce Plouffe

Dr. Bruce Plouffe

cc: Dr. Bonnie Jeffery – Faculty of Social Work

Research and Innovation Centre, Room 109
Phone: (306) 585-4775
Fax: (306) 585-4893
www.uregina.ca/research

University of Regina

OFFICE OF RESEARCH SERVICES

MEMORANDUM

DATE: October 13, 2011

TO: Jennifer Katherine Suchorab
RR 5, Site 27, Comp 4
Prince Albert, SK S6V 5R3

FROM: Dr. Bruce Plouffe,
Chair, Research Ethics Board

Re: **'It's Not My Time'; Understanding MetSyn Pilot Project Attrition from a Women-Centered Perspective (File # 05S1112)**

Please be advised that the changes outlined in your memo of October 11, 2011 have been approved.

Please contact us if you have any further questions.

Sincerely,

D. Bruce Plouffe

Dr. Bruce Plouffe,
Chair, Research Ethics Board

cc: Dr. Bonnie Jeffery – Faculty of Social Work

Research and Innovation Centre, Room 109
Phone: (306) 585-4775
Fax: (306) 585-4893
www.uregina.ca/research

University of Regina

OFFICE OF RESEARCH SERVICES

MEMORANDUM

DATE: November 1, 2011

TO: Jennifer Katherine Suchorab
RR 5, Site 2, Comp 4
Prince Albert, SK S6V 5R3

FROM: Dr. Bruce Plouffe,
Chair, Research Ethics Board

Re: **'It's Not My Time'; Understanding MetSyn Pilot Project Attrition from a Women-Centered Perspective (File # 05S1112)**

Please be advised that the changes outlined in your memo of October 31, 2011 have been approved.

Please contact us if you have any further questions.

Sincerely,

D. Bruce Plouffe

Dr. Bruce Plouffe,
Chair, Research Ethics Board

cc: Dr. Bonnie Jeffery – Faculty of Social Work

Research and Innovation Centre, Room 109
Phone: (306) 585-4775
Fax: (306) 585-4893
www.uregina.ca/research

Appendix C – Research Project Work Plan

Date	Activity	Follow-up
May 29, 2011	Telephone meeting with Bonnie, Judith and Jennifer to discuss work plan, initial literature review, interview guide and next steps	Agreed that Judith would schedule an in-person meeting with MetSyn Medical and Project Director (Vicky and Wendy) Jennifer to complete necessary documentation (ethics form, consent, letters, project summary) prior to meeting
June 16, 2011	Meeting at Mid-life Women's Health Centre for Jen to meet MetSyn team , review of documentation and interview guide	Jen will forward application for ethics approval Jen will make revisions to documentation
4-6 weeks	Awaiting ethics approval	
End of July-Beginning of August	Once ethics approval is granted, women can be contacted for both the pilot and the actual study	Wendy to contact potential participants, introduction letters sent.
Beginning of August	-Women will be contacted for pilot and interviewed by Jen	Comments about interview guide/process will be summarized by Jen. Revisions made in consultation with Judith/Bonnie
Two weeks from letters being sent to potential participants	Jen will contact by phone to enquire about participation	Arrangements made for interviews, copies of consent mailed for review
Mid- August – Mid September	Interviews	Ongoing transcription by Jen and transcriptionist. Transcription approval by participants. Beginning of analysis
Mid September – End of November	Analysis and Report writing	Jen in consultation with committee
December 15, 2011	Final Project report completed	Jen celebrates

Appendix D – Study Project Recruitment Letter

To be printed on Mid-Life Health Centre letterhead

October 27, 2011

Dear past Metsyn Project Participant,

We would like to invite you **to have input into future metabolic syndrome program development** by participating in an additional research evaluation project. The research project entitled, *"It's not my time"; Understanding Metsyn Pilot Project Attrition* (loss of participants) *from a Women-Centered Perspective* aims to understand the experiences of Saskatoon and area women who discontinued the MetSyn pilot project. The primary researcher is Jennifer Suchorab. Jennifer is a registered social worker who is completing the final requirements of the University of Regina, Masters of Social Worker Degree. Her project is being supervised by Dr. Bonnie Jeffery and Dr. Judith Martin.

You may have received a letter like this in the recent past. Our first recruitment efforts resulted in two participants. It is very common for participants in programs such as MetSyn to not finish the program and there is little research in this area. It was our hope to recruit at least 4-6 women for the study and this is the reason for the second invitation. The first letter we sent you went out over the summer and busy early fall period and we are thinking that perhaps it that was not the best time to be in touch.

Your voluntary participation would involve a 30- 45 minute one-to-one interview with Jennifer that would be audio-taped at a location and time of your choice. Prior to beginning the interview a consent form explaining the study process, risks, benefits and confidentiality measures will be explained and signed. All efforts will be made to ensure confidentiality and you have the opportunity to withdraw at any time.

If you are willing to participate, please contact Wendy Verity at (306) 716-5248 by November 15, 2011. Wendy will then provide your contact information to Jennifer who will make arrangements for the interview.

We thank you for your consideration of this project.

Yours sincerely,

This study has been reviewed by, and received ethics clearance (file05S1112) through the Office of Research Ethics, University of Regina

Appendix E– Revised Recruitment Letter

To be printed on Mid-Life Health Centre letterhead

October 27, 2011

Dear past MetSyn Project Participant,

We would like to invite you **to have input into future metabolic syndrome program development** by participating in an additional research evaluation project. The research project entitled, *"It's not my time"; Understanding MetSyn Pilot Project Attrition* (loss of participants) *from a Women-Centered Perspective* aims to understand the experiences of Saskatoon and area women who discontinued the MetSyn pilot project. The primary researcher is Jennifer Suchorab. Jennifer is a registered social worker who is completing the final requirements of the University of Regina, Masters of Social Worker Degree. Her project is being supervised by Dr. Bonnie Jeffery and Dr. Judith Martin.

You may have received a letter like this in the recent past. Our first recruitment efforts resulted in two participants. It is very common for participants in programs such as MetSyn to not finish the program and there is little research in this area. It was our hope to recruit at least 4-6 women for the study and this is the reason for the second invitation. The first letter we sent you went out over the summer and busy early fall period and we are thinking that perhaps it that was not the best time to be in touch.

Your voluntary participation would involve a 30- 45 minute one-to-one interview with Jennifer that would be audio-taped at a location and time of your choice. Prior to beginning the interview a consent form explaining the study process, risks, benefits and confidentiality measures will be explained and signed. All efforts will be made to ensure confidentiality and you have the opportunity to withdraw at any time.

If you are willing to participate, please contact Wendy Verity at (306) 716-5248 by November 15, 2011. Wendy will then provide your contact information to Jennifer who will make arrangements for the interview.

We thank you for your consideration of this project.

Yours sincerely,

This study has been reviewed by, and received ethics clearance (file05S1112) through the Office of Research Ethics, University of Regina

Appendix F – Interview Guide

Interview Questions (bullets are prompts)

Topic: Initial project involvement

1) How did you first hear about and become involved in the MetSyn Pilot Project?

-advertisement, some told you
-Did you ask your doctor for information or a referral or did your doctor suggest it to you?
-Did you contact the Women's Mid-life Health Centre or the MetSyn Project Director Wendy Verity directly for information or to sign up?

2) What made you decide that this project would be helpful for you?
- Did anyone or anything in your life have an influence on your decision?

Topic: Project experience

1) First, which group, the Telask computer group or the control group, were you assigned to?

2) Please, tell me about the time you spent in the project?
- What were your impressions of the location, time, speakers, information and the way the sessions were run?
- Did you have a clear understanding of the goals and objectives of the sessions? How did you come to this answer? What helped you understand? What could have been done differently?
3) What was the blood draw or blood work part of the project like for you?

4) How did you find the questionnaire and taking measurements part of the project?

Topic: Leaving the project?

1) What made you decide to discontinue with the project?

2) were there other things going on in your life that affected your ability to continue?
- query employment, family life, health reasons

3) How did you feel about discontinuing?

Topic: What worked, didn't work and outcomes

1) How was the project helpful?

2) What didn't work about the project?

3) Regardless of your decision for discontinuing, how has the project affected your lifestyle goals regarding physical activity and/or nutrition?
- Have you joined other programs because of your experience with the project or did your experience keep you from joining other programs? Help me understand.
- Did the project affect other parts of your life; If so, how?

4) If you were developing or running a program for women with metabolic syndrome, what would it look like? What things would you include? What things would you pay special attention to?

Appendix G - Interview Guide Pilot Consent Form

It's Not My Time'; Understanding MetSyn Pilot Project Attrition from a Women-Centered Perspective– Consent Form for Pilot Interviews

Researcher: Jennifer Suchorab BSW, RSW, Faculty of Social Work, University of Regina Graduate Studies. jsuchorab@inet2000.com Tel 1 (306) 981-2875

Academic Supervisor: Dr. Bonnie Jeffery PhD, Faculty of Social Work, University of Regina, (306) 953-5322, bonnie.jeffery@uregina.ca

Field Supervisor: Dr. Judith Martin PhD, Department of Sociology, University of Saskatchewan, (306) 664-1938, jmartin@sasktel.net

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You are invited to participate in a pilot of the interview guide and process for a research project entitled, *'It's Not My Time'; Understanding MetSyn Pilot Project Attrition from a Women-Centered Perspective.* Please read this form carefully and feel free to ask any questions that you may have.

Purpose: *The 'It's Not My Time'; Understanding MetSyn Pilot Project Attrition from a Women-Centered Perspective* study is a research project that is being conducted in connection with a larger evaluation study of the MetSyn pilot project. The primary researcher of this project is Jennifer Suchorab who is a student of the Faculty of Graduate Studies at the University of Regina. This project completes the final requirement of her Master of Social Work Degree. The goal of this study is to better understand the experiences of Saskatoon women who discontinued the MetSyn program. The findings of this research will support recommendations for program improvement, as well as, practice recommendations for social work and other health care providers who support women participating in nutrition and physical activity education programs.

The purpose of the pilot interviews is to evaluate the interview guide and process for their ability to capture an accurate and full understanding of the research participant's experience in a respectful and comfortable manner, as well as the interview process and length. You were selected to participate based on your gender and previous experience with a nutrition or fitness education/ behavior change program such as a weight loss program or guided exercise program.

How and to Whom will these Findings be Distributed and Reported: The data collected during these interviews will not be included in the final report. Your comments and recommendations regarding the interview guide and process will be recorded in field notes taken by the primary researcher following the interview. Once the pilot interviews are completed, the comments will be synthesized into a summary that will be presented by the primary researcher to both the Academic and Field Supervisors noted above. The findings will then be used to make necessary alterations to the interview guide. If significant changes are made, the revised interview guide will be resubmitted to the University of Regina Ethics Review Board for approval prior to beginning the formal research study.

Potential Risks: There are no known or anticipated risks to you by participating in this research. Should you feel any level of discomfort during the interview, please let the researcher know. The researcher does not anticipate that there will be difficulties and will keep checking with you during the interview. The researcher is willing to make referrals to counseling and support services if necessary. The interview will be terminated by the researcher if extreme emotional responses are observed.

Potential Benefits: By participating in the research project, you will have an opportunity to influence the development of future health care support services for women from the perspective of someone with lived experience. You will also assist the primary researcher in her development of research skills that will have long term benefits to the social work profession.

Procedure: This interview should take approximately 30-45 minutes to complete. The interview consists of answering a series of semi-structured (some yes/no and some opened- ended) questions that are part of a consistent interview guide. Following the interview you will be asked about your perceptions of the interview guide and process and asked to provide any suggestions for improvement. **Your participation is completely voluntary**. You do not have to answer any question or questions you choose not to and you may stop the interview at any time. If you choose to withdraw from the study no information collected about you will be kept.

The interview will be audiotaped but the data will not be used in the final research report. Please let the researcher know if this is okay with you. When you sign this consent form, you will be agreeing to the taping of the interview.

Confidentiality: Because the pilot research sample was purposefully selected by individuals known to the researcher, this research project cannot guarantee anonymity. In order to help ensure confidentiality your name will not be used in the research and will exclude all identifying information. Your data will be assigned a number whose relationship to you is only known to the researcher.

Storage of Data: During and after the study, your information, the research data, field notes and audio tapes will be housed in a locked cabinet at the Prince Albert Campus of the University Of Regina Faculty Of Social Work. The information that is electronically stored and analyzed will be stored on password protected computers and for files and in instances where this information is transferred over the internet, encrypted web interface over https protocol, IP authentication, and session timeouts will be used for enhanced security. Original interview data and any other documentation will be stored for six years at the named location and then destroyed.

This research project has been approved on ethical grounds by the University of Regina Research Ethics Board on August 3, 2011 (file # 05S1112) . Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (585-4775).

Consent to Participate:

I have read and understood the contents of this consent form and agree to participate in this interview and this study:

____*Yes* ____*No*

I understand that my interview data will not be used in the final report: ____*Yes*

I have received a copy of the consent form for my files: ____*Yes* ____*No*

I agree to have my interview audio taped: ____Yes ____No

_____ _____

*Participant Name (**Print**)* *Date*

_____ _____

Signature of Participant *Signature of Researcher*

Appendix H-Study Consent Form

'It's Not My Time'; Understanding MetSyn Pilot Project Attrition from a Women- Centered Perspective – Consent Form

Researcher: Jennifer Suchorab BSW, RSW, Faculty of Social Work, University of Regina Graduate Studies. jsuchorab@inet2000.com Tel 1 (306) 981-2875

Academic Supervisor: Dr. Bonnie Jeffery PhD, Faculty of Social Work, University of Regina, (306) 953-5322, bonnie.jeffery@uregina.ca

Field Supervisor: Dr. Judith Martin PhD, Department of Sociology, University of Saskatchewan, (306) 664-1938, jmartin@sasktel.net

---

You are invited to participate in a research project entitled, '*It's Not My Time'; Understanding MetSyn Pilot Project Attrition from a Woman- Centered Perspective.* Please read this form carefully and feel free to ask any questions that you may have.

Purpose: The '*It's Not My Time'; Understanding MetSyn Pilot Project Attrition from a Woman- Centered Perspective* study is a research project that is being conducted in connection with the larger evaluation study of the MetSyn project. *The 'It's Not My Time'; Understanding MetSyn Pilot Project Attrition from a Women-Centered Perspective* study is a research project that is being conducted in connection with a larger evaluation study of the MetSyn pilot project. The primary researcher of this project is Jennifer Suchorab who is a student of the Faculty of Graduate Studies at the University of Regina. This project completes the final requirement of her Master of Social Work Degree. The goal of this study is to better understand the experiences of Saskatoon women who discontinued the MetSyn pilot project. The findings of this research will support recommendations for program improvement, as well as, practice recommendations for social work and other health care providers who support women participating in nutrition and physical activity education programs.

How and to Whom will these Findings be Distributed and Reported: These findings will be analyzed by the primary researcher who works in consultation with her Project Committee. The Project Committee consists of the

academic supervisor and field supervisor noted above, as well as, a second Faculty of Social Work Member. The project will follow University of Regina ethical guidelines during the entire period of the research study project. The report will be submitted to the Project Committee for revisions and approval where it is then submitted to the MSW Chair. The MSW Chair then forwards the completed accepted document to the Faculty of Graduate Studies signifying that the Project has been satisfactorily completed. A final copy of the report will be placed in the Resource Centre of the University of Regina Social Policy Research Unit and an informal presentation of the project work will likely occur to the Project Committee and the Medical and Program Director of the MetSyn Project. **You will be given the opportunity to provide a follow-up address at the end of this form if you wish to receive a copy of this final project report**. The findings may also be included in the final evaluation project of the MetSyn Project which will be sent to participants, government, key health agencies, and will be made public.

Potential Risks: There are no known or anticipated risks to you by participating in this research. Should you feel any level of discomfort during the interview, please let the researcher know. The researcher does not anticipate that there will be difficulties and will keep checking with you during the interview. The researcher is willing to make referrals to counselling and support services if necessary. The interview will be terminated by the researcher if extreme emotional responses are observed.

Potential Benefits: By participating in the research project, you will have an opportunity to influence the development of future health care support services for women from the perspective of someone with lived experience. You will also assist the primary researcher in her development of research skills that will have long term benefits to the social work profession.

Procedure: This interview should take approximately 30-45 minutes to complete. The interview consists of answering a series of semi-structured (some yes/no and some opened- ended) questions that are part of a consistent interview guide. **Your participation is completely voluntary**. You do not have to answer any question or questions you choose not to and you may stop the interview at any time. If you choose to withdraw from the study no information collected about you will be kept.

The interview will be audiotaped and then transcribed as part of the research process. Please let the researcher know if this is okay with you. When you sign this consent form, you will be agreeing to the taping of the interview.

Confidentiality: Because the research sample was purposefully chosen from women who dropped out of the study, this research project cannot guarantee anonymity. In order to help ensure confidentiality your name will not be used in the research and will exclude all identifying information. You will also be asked to choose a pseudonym to further protect your identity. Direct quotes will be used in the results section of the report, as well as in the evaluation study being conducted by Dr. Judith Martin and Dr. Bonnie Jeffery, but, again, all information that might identify you will be removed.

Storage of Data: During and after the study, your information, the research data, field notes and audio tapes will be housed in a locked cabinet at the Prince Albert Campus of the University Of Regina Faculty Of Social Work. The information that is electronically stored and analyzed will be stored on password protected computers and for files and in instances where this information is transferred over the internet, encrypted web interface over https protocol, IP authentication, and session timeouts will be used for enhanced security. Original interview data and any other documentation will be stored for six years at the named location and then destroyed.

This research project has been approved on ethical grounds by the University of Regina Research Ethics Board on August 3, 2011(file # 05S1112) . Any questions regarding your rights as a participant may be addressed to that committee through the Ethics Office (585-4775).

Consent to Participate:

I have read and understood the contents of this consent form and agree to participate in this interview and this study: ____Yes ____No

I have received a copy of the consent form for my files: ____Yes ____No

I agree to have my direct quotations used in the results of the study with the understanding that all personally identifying information will be removed: ____Yes ____No

I agree to have my direct quotations used in the MetSyn Project Evaluation Study being completed by Dr. Judith Martin, PhD, and Dr. Bonnie Jeffery, PhD: ____Yes ____No

I agree to have my interview audiotaped: ____Yes ____No

_____ _____

*Participant Name (**Print**)* *Date*

_____ _____

Signature of Participant *Signature of Researcher*

I wish to receive a copy of the final research project report

____ Yes ____No

Below is the address that the final report can be mailed to. I understand that my address will only be used for these purposes: