A FEMINIST APPRAISAL OF THE EXPERIENCE OF EMBODIED LARGENESS: A CHALLENGE FOR NURSING

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ABSTRACT

To be a fat woman is to experience a prolonged, personal battle with the body. The battle is enacted in a social context which is the site of remarkable consensus about the personal culpability of fat people for their bodily largeness; for women in particular the sanctions are especially powerful. In this research nine large women have engaged in a prolonged dialogue about the experience of being 'obese'. In the course of a feminist research endeavour, with a researcher who is similarly positioned, they have both contributed to and gained from a project which illuminates the experience of largeness alongside a critical examination of the discourses which shape body size.

This dissertation critiques a dominant medical discourse which ignores conflicting research and supports a narrow view of health by simplistically linking increased body weight with poor health outcomes. Such is the hegemonic power of medicine that an examination of both nursing and popular literature in the area of study, reveals wide-spread acceptance of the notion that to be thin is to be healthy and virtuous, and to be fat is to be unhealthy and morally deficient. For nursing, the unquestioning obedience to medical teaching, raises serious questions about nursing's autonomy and separateness from medicine.

Nurses have perpetuated an unhelpful and reductionist approach to their care of large women, in direct contradiction to nursing's supposed allegiance to a holistic approach to health care. Current strictures on women's body size and continued support for reduction dieting leave large women with the choice between two binary opposites; to diet or not to diet. Either choice has consequences which are traumatic and not health promoting. The experience of largeness emerges as a socially constructed disability in which many women are denied the opportunity to be fully healthy.

PREFACE: The Journey

This thesis encapsulates a journey in which the personal, the professional and the political are closely linked. I have chosen this particular area of study because it arises from the intersection of three sets of experience: my life as a large woman, my work as a nurse, and my engagement with feminism. Each experience contributes vitally to the work, and the project would have lacked balance and meaning had any of the viewpoints been omitted.

Personal

I have a life-long engagement with the process of reduction dieting and have lived the consequences of the repeated failure of that dieting to permanently alter my body size and shape. As a rigorously determined dieter it took me years to realise that the end result of each prolonged diet was an increase in weight. Certainly I knew that having a large body was not well regarded, and as a woman it posed particular problems in reaching acceptable standards of beauty. I also believed that I was seriously damaging my health by remaining large, and that in later life I would reap the consequences in terms of health outcomes. Every facet of my life was coloured by what I saw as my temporary deviance, which only greater and more vigorous dieting attempts on my part could ultimately rectify.

The deep-seated prejudice in Western society against the overweight or out-of-control body provides a particular context in which large people live. Fontaine (1991) suggests that the stigmatisation is more intense for women and that there are clear messages in many settings that nothing is worse than being obese. Wadden and Stunkard (1985) note that women, adolescent girls and people who are extremely obese appear to suffer the most deleterious consequences of social contempt for the obese. They further report research which demonstrates that physicians feel antipathy to the obese, which is based on the belief that the overweight are self indulgent, weak willed, ugly, awkward and even immoral. Fontaine (1991) suggests that no price (perhaps even death) is too high for achieving thinness. As a large woman my daily existence is lived out in recognition and acknowledgement of such prejudice.

Professional

My theoretical preparation as a nurse suggests that nursing is a practice discipline based on a unique body of knowledge, which is different from medicine as explained below. This difference involves nursing's role in working alongside whole individuals as they negotiate the various pathways to health or are supported to recover from illness or injury. Nurses have asserted that our caring labour is contextual, individual and highly personal.

Lawler (1991, p 216) notes that since the 1970s 'nursing writers have philosophised, theorised, and proselytised "holistic practice".' Nursing has thus long touted the concept of holism which is said to oppose the reductionism of the medical model and, furthermore, to offer a potential pathway for cementing and clarifying the separation from medicine. Holism suggests that nursing considers the whole person in their family, socio-political and cultural context in terms of planning and providing appropriate care. Holism allows that people are unique individuals, who will each experience health and illness differently and require different degrees and types of care and support. Moreover, holism avows that health is a great deal more than the absence of disease.

Conversely, the philosophy of medicine arises from the Cartesian and dualist perspective which posits a separation of mind and body and supports the occurrence of illness in isolation from contextual contribution. The body can be repaired in much the same way as a machine and treatment is purportedly based on controlled clinical trials. Medicine has gained power and dominance from its presumed adherence to the scientific method, while holism remains as a relatively marginalised concept.

As a nurse with a large body I have frequently cringed inwardly listening to my nursing and medical colleagues describe fat patients in terms of loathing, visible disgust and contempt. I have noted that whereas people suffer from *severe* asthma or diabetes, large people suffer from *gross* obesity. Even if the terminology were accidental (and it is not likely that language would ever be accidental) the tone and facial expression accompanying the description are often unmistakable. I have come to feel that should I need treatment and care in a hospital I would feel extremely unsafe. I often wonder if my status as a person who has allegedly been unable to care for herself effectively will compromise the care I might receive.

Feminist

I will discuss feminism as a theoretical perspective and set of practices in more detail at the beginning of chapter four which deals with the methodological aspects of this thesis. Here I briefly outline its particular relevance to this project.

As a feminist I recognise that the appearance of women's bodies defines their acceptability in a variety of settings. The social construction of femininity requires that women are required to be both fragile and decorative, and that considerable work must be undertaken to preserve the appearance of youth and slenderness which form an integral part of female beauty (Bartky, 1990). I am also aware of the feminist analyses of woman's allocation to the private sphere (Park, 1991), demonstrating that woman are cast in the role of food preparers and providers. The provision of food is inextricably combined with the care and nurture of family members and often of the wider community as well (Mennell, Murcott & van Otterloo, 1992). There are contradictions for women who must feed others as an expression of their nurturing feminine role, yet deprive themselves of nourishment in order to appear appropriately female.

My introduction to the arena of nursing scholarship coincided with a growing awareness of feminist thinking. My interest in women's health offered an area of intersection for both interests as I began to focus on the expressed concerns about body size made by many women.

Where the journey began

With these issues in mind I elected to give a paper at the International Women's Health Congress at Massey University in 1990. My intention was to explore the area of health professionals' reactions to women of large body size, and the general efficacy of reduction dieting as a medically and nursing sanctioned procedure. I gave a paper entitled 'Women, body size and dieting: What are the myths, what are the realities'? The response from conference delegates was somewhat overwhelming and the paper was one of two selected to be read on National Radio. It seemed that the ideas in the paper spoke to many women of all shapes and sizes and brought to the surface, feelings of concern and sometimes outrage.

In conducting the literature search for that conference paper I was strongly affected by the focus of nursing literature which covered working with people (invariably women) whose body size fell outside medically-defined norms. The insurance table norm prepared many

years ago had been accepted as desirable with no allowance for a range of weight, and no allowance for age or culture or family history. I saw that nurses had, almost universally, accepted their medically delegated duty of teaching people how to make their bodies comply with this medically-sanctioned norm regardless of any individual or holistic consideration. I will examine this in greater detail in chapter three.

Management of body size is an area of nursing practice in which nurses clearly complied with medical teaching, and practised in a way that was oblivious to any remotely holistic considerations. Literature in the area of women's studies, illuminated women's experience in this area in a way which felt more congruent with my own personal experience and appeared to provide a powerful and relevant critique of so called medical wisdom. But crucially the feminist literature tended to argue for my right to exist in however large a body I happened to have. This is a simplistic perspective. Living as a visible challenge to feminine propriety is not comfortable, in much the same way that physical habitation in a very large body is also not always so comfortable.

I began to see women and body size as an important area of health experience where nursing was providing care which was neither useful nor grounded in nursing interpretations of health and illness. I became curious about the potential for nursing to negotiate the gap between the binary opposites of thin, beautiful and healthy and fat, ugly and diseased.

Discussions about women and body size are clearly both complex and far-reaching and all of these are pertinent to nursing. This research will consider just one aspect of a wider problem in focusing specifically on women's experience of being overweight in a context in which it is the subject of vigorous treatment and considerable negative sanction. I would have liked to have captured and analysed some of the violence I have seen and heard expressed toward large women in medical and nursing contexts. My sense was that as a large woman I would have been unlikely to hear the honest revelations which might have been shared with an appropriately thin researcher.

I began this study aware of a growing public comment that reduction dieting offered only short-term weight loss and did not work in the long term except for a very small percentage of dieters. I knew that this critique was not endorsed by either the diet industry or the public statements of many medical or allied health professionals. Personally I knew that my own vigorous reduction dieting over a twenty-year period had failed, but I still suspected that perhaps I had not been sufficiently vigilant.

I also began this study believing that being overweight was very undesirable for a number of reasons, but especially in terms of health outcomes. However I remained unclear as to how that could best be addressed from a nursing perspective. I had a growing conviction that nurses could offer a great deal in this area, but I had no idea what focus or direction that help should take.

I began this research aiming to weave personal, political and above all professional threads in a manner which would best generate useful nursing knowledge. The impetus of this research is to provide a basis for improved nursing practice in the area of women and body size.

CONTENTS

CHAPTER ONE: The Focus and Context of this Research

1.1 Introduction.

A group of large women have entered into a dialogue with me to explore their battle with their large body size, in a manner which increases our mutual understanding of the experience. We have asked 'What is it like to be labelled as a fat woman? '. The knowledge generated from the women's contribution and from my intensive study of the area will provide information which could support nurses to develop practice strategies which will potentially make a difference for large women in terms of their pursuit of good health. It is argued that an exploration of the literature will begin to expose the networks of power and knowledge within the discursive field of women's body size.

In this first chapter I will demonstrate that the issue of women and body size as a political and practice concern is well grounded in many areas of literature, even though nursing has largely ignored it. I will describe the escalating nature of constraints on women's body size, and the concomitant increase in overall body weights now becoming a focus of public and medical concern. I will signal some of the links to the socio-political context which are explored throughout the thesis. Finally, this chapter articulates the aims of the research, sets out the argument to be developed, and concludes with an outline of the thesis.

It is very important to me that the outcome of this research creates possibilities for improvement in the nursing care of women who are large. My aim is to demonstrate the applicability and usefulness of feminist scholarship as a tool for exploring an important aspect of women's lives, and for problematising some areas of currently acceptable nursing practice.

Foucauldian analysis will be utilised in order to provide socio-political insights into medicine and nursing practice. I argue that this analysis allows for an exploration of the hegemonic assumptions which provide a taken-for-granted reality in the context of health care delivery, and it exposes nursing practice to scrutiny and potential change. It can be argued that the existence of such a thesis in itself creates a space for the possibility of resistance by deconstructing the networks of power and knowledge which support dominant discourses.

1.2 Background to the study.

It can be demonstrated that the female ideal for both weight and shape has fluctuated over time (Walden, 1985). In recent decades there has been an increasing societal preference for women to become thinner. Women in western countries are experiencing a period where the desirable body for a woman is particularly thin. Walden (1985) noted that whilst size consciousness became quite focused at the turn of the century, requirements for women to have a slender body had become especially pronounced within the twenty years prior to 1985. In the last ten years this phenomenon, the focus on slenderness, has escalated unabated. Simultaneously the opportunity to mediate discourse textually has become particularly intense, with increasing levels of visual media representation ensuring that few if any Western women remain unaware of current constructions of beauty (Carryer, 1997).

Body size and shape is no longer viewed as a serendipitous genetic trait (Wooley & Wooley, 1985; Atrens, 1988), and slenderness has become an integral aspect of beauty. Caputi (1983) notes that whereas thinness signifies beauty, health, class, grace, discipline and goodness; fatness is equated with ugliness, stupidity, illness, sloth, self-indulgence and even moral weakness. Wadden and Stunkard (1985) note the strong prejudice against obese persons, which has been demonstrated in research with children as young as six years of age; they describe silhouettes of the obese child as lazy, dirty, stupid, ugly and dishonest.

As the ideal body size becomes increasingly thin, there is evidence that a simultaneous overall increase in body weight is occurring for both men and women. In the midst of a vigorous public health campaign to keep people thin are recent suggestions that so-called obesity is increasing markedly. Swinburn (1995) notes that there is a major epidemic of obesity affecting all developed countries and even some developing countries. Such statistics suggest that despite medical and public anxiety focusing on obesity, and despite high levels of women undertaking reduction dieting, body weight continues to rise.

The *British Woman and Home* magazine surveyed thousands of its readers in March 1996. A random selection of 1,000 of the replies revealed the level of distress experienced by women. They variously reported acute preoccupation with their body size and an almost universal desire to be smaller, regardless of actual size at the time of completing the survey.

Oppressive ideals concerning female body size and shape in Euro-American culture have been extensively documented (Brown, 1985; Ritenbaugh, 1991; Nichter & Nichter, 1991). There is no evidence to suggest that New Zealand women are any less subject to such pressures. Prevalent ideals of thinness are physiologically difficult for many women to achieve. There is strong evidence that reduction dieting and other reducing techniques are at best useless and at worst of greater risk to health than extra weight in itself, (Bennett & Gurin, 1982; Stunkard, 1982; Polivy & Herman, 1985). I will discuss this in chapter three.

It is not my intention to suggest that obesity is a problem only for women, nor do I suggest that only women are distressed by issues of size and appearance. However I do contend that the distress being exhibited by women and the sanctions experienced by women are significantly greater than they are for men, and it is women who are the subject of this thesis.

Wolf (1990) notes that, while variations in body size and the occurrence of eating disorders affect both male and female, research shows that at least 90% of those with eating disorders are female. Laffrey (1988) finds that women consistently overestimate their body size and Atrens (1988) notes research showing that reduction dieting behaviour is becoming almost universal in females from a very young age. This finding has also been reported in New Zealand by Jane and James Ritchie (widely reported in the media but as yet unpublished; personal correspondence) who noted evidence of female children as young as eight and nine years engaging in reduction dieting, or at least in manipulation of food intake with the expressed aim of reducing body size.

Women's particular relationship with food appears fraught as we are required to nurture others with food but refrain from nurturing ourselves in order to meet cultural requirements for decreasing size and the imposition of dominant constructions of femininity (Kaplan, 1980; Brown, 1985; Bordo, 1993). There is evidence of a continuum of distress experienced in some degree by almost all women. At one end of the spectrum is the daily discourse of girls and women which reveals constant concern and conflict with their right to eat, their need to reduction diet and their size and appearance (Brown, 1985; Atrens, 1988; White, 1991; Kissling, 1991; Bordo, 1993). At the other end is the increasing epidemic of behaviours currently defined and treated as eating disorders, and those women experiencing steady weight gain following each episode of reduction dieting.

Polivy and Herman (1987) suggest that the increasing requirement for women to be thin has supported a prevalence of dieting to the point that 'normal eating', for North American women at least, is now characterised by reduction dieting. They argue that the

extent of preoccupation with dieting is so great that it may now be accurate to regard dieting and the associated diet mentality, as normative behaviour for women. They suggest that:

> Terms such as normal, acceptable and overweight can be understood only in the context of societal realities and ideals. Normal for instance is more often used in the prescriptive evaluative sense than in the descriptive/statistical sense (Polivy & Herman, 1987, p. 635).

The pathologising of variations in body size and eating habits has been acknowledged and consistently challenged by feminist authors, (Brown, 1985; Spitzack, 1988b & 1990; White, 1991). That the shaping of the body is related to struggles over the shape of power was suggested as long ago as 1792 by Mary Wollstonecraft when she wrote of the production of the docile body of the domesticated women of privilege:

> To preserve personal beauty, woman's glory! the limbs and faculties are cramped with worse than Chinese bands, and the sedentary life which they are condemned to live, whilst boys frolic in the open air, weakens the muscles and relaxes the nerves .. //.. That a girl, condemned to sit for hours together listening to the idle chat of weak nurses, or to attend to her mother's toilet, will endeavour to join the conversation, is, indeed very natural; and that she will imitate her mother and aunts, and amuse herself by adorning her lifeless doll, as they do in dressing her, poor innocent babe! is undoubtedly a most natural consequence ..//.. Genteel women are, literally speaking, slaves to their bodies, and glory in their subjection...women are everywhere in this deplorable state....Taught from their infancy that beauty is woman's sceptre, the mind shapes itself to the body and, roaming round its guilt cage, only seeks to adorn its prison (Wollstonecraft cited in Bordo, 1993, p. 18).

Chernin (1981) noted that fluctuations in required weights for women are not arbitrary but are linked to the sociocultural and political constraints experienced by women at any one time. She noted that in periods where women are involved in mothering and nurturing and have diminished social power, dominant images are of soft women, and extra weight and curves are allowed. At times and in cultures where women are challenging their social positioning and gaining political and social power the requirement for extreme thinness becomes more intense. Spitzack (1988b) argues the historical evidence that in a time of female strength and liberation, where women are demanding more rights concerning their bodies, the current obsession to beautify the female body through reduction is worthy of

investigation. In contrast, Seid (1989) argues that the drive for slenderness is congruent with the goals of liberal feminism. She refers to the quest for control, for androgynous bodies and the right to compete with men on their territory through fitness and mastery of the body.

The background to this study is, therefore, one of conflict and distress for women in terms of their efforts to maintain an acceptable body size. I have begun to identify the links between body size and cultural constructions of femininity. At this point I will clarify the focus of this study, which is to work specifically with women whose body size already falls outside medical sanctions for assumed normality.

1.3 The key arguments of this thesis.

It is argued that a fat woman generates medical concern, social disapproval and personal pain. The discourse of medicine in the area of the study is powerful, authoritative, and yet flawed in ways which will be discussed. There are important connections and intersections between medical discourses and populist discourse and similar connections to nursing discourse, particularly that which relates directly to nursing practice in the study area. An examination of the nursing literature in chapter three will demonstrate the degree to which medical discourse pervades nursing. Paradoxically, there is much nursing literature which recommends an holistic, non-reductionist way of working with people toward individually appropriate health goals or outcomes. I accept this as nursing's preferred approach and question why the approach is so different in the area of large women's embodiment.

The experience of being fat is explored with a group of nine women, and the interview material is analysed to provide a basis from which an improved nursing response can be developed. It will be argued that current strictures on women to conform to limited body-size specifications and continued approval for reduction dieting have offered women grappling with their size, a choice between two binary opposites. Literally this has been to diet or not to diet. Choosing either option brings consequences which are traumatic, not health-promoting, and which potentially exacerbate the perceived problem of being too large. The experience of bodily largeness emerges as a socially constructed disability in which women are denied the opportunity to be fully healthy through social sanctions rather than biological deficit. In essence many of the constraints on the life of a large woman arise from her perceived stigmatisation rather than any physical limitation

In order for nursing to be useful in this area and to work within its own espoused tenets of holism, it will be argued, nurses must practice in the area between the binary oppositions of dieting or not dieting. This will involve an engagement with what Kermode and Brown (1995) call the radical critique, whereby nursing not only focuses on the one-to-one relationship with clients or patients, but also includes a wider focus on the socio-political and cultural context of health and health care delivery.

1.4 Aims of the study.

In embarking on this thesis my thinking is first influenced by the literature which shows that issues of weight, size and appearance are clearly different for women from what they are for men. At the outset it was my intention that the research process would have an emancipatory intent. I wanted to know how large women could be supported to feel free of the stigmatisation and misery associated with being fat in a society which considers fatness to be self inflicted and unhealthy, and most damningly, very unattractive. But prolonged consideration of my own experience as a large woman suggested that attempting to free the participants from the constraints pertaining to women's appearance within the study duration was unrealistic. I had thought that nurses should be able to support and teach women to accept their size and to focus on other aspects of healthy behaviour not related to the relentless pursuit of slimness. In time I came to see this as a naive and overly optimistic viewpoint.

Following a long period of reflection after the introductory interviews, I decided that it would be more meaningful to embark on a process whereby a group of women could come to explore their life battle with weight, and the differences in their lives as a result of living that battle. I felt that telling their stories in a reflexive manner would have value to them. Furthermore, in the process of thematic qualitative analysis underpinned by a feminist perspective their stories could provide nurses with an insight into some large women's experience. This might generate knowledge which would support and encourage nurses to work differently with women across the whole continuum of distress related to variations in body size. I wanted to know what is particular to women in their relationship with food and size and to know more about the pain of continual dieting. I wanted to develop a standpoint from which to explore what could characterise appropriate nursing strategies for such women should they require care.

Searching for a methodology which would meet the requirements of my research questions created a period of profound reflection. I wanted to know these women's lived

experience, yet the intense gender issues involved begged something essentially different from either a phenomenological or grounded theory approach. I could not countenance listening uncritically to women describe their successes and failures in the long battle against fat. Such talk is already part of the daily discourse of all women and is also heard through popular magazines and television programmes. Anguish about appearance and size is seen as a normal feminine preoccupation, and I believe that my interest as a nurse would be seen by women as further evidence that there is a problem which they have not been strong enough to conquer and which health professionals want to know more about in order to support their battle toward the imagined desirable outcome of effective and permanent weight loss.

Given the above, I decided that this research needed a period of mutual dialogue and learning. I wanted to share the benefits I had gained from several years steeped in the literature related to women and size, with women living that battle, and to give women the opportunity to speak their experience with some perception of the hegemony which characterises the discourse of weight-loss clinics and women's daily experience. The research is intended to give this group of women the opportunity to illuminate their experience with fewer constraints on their knowing, and with the ultimate purpose of contributing to the knowledge of nurses who need to be vitally concerned with such a key area of health promotion.

In this work I want to move beyond considering a woman's large body size as pathological and beyond seeking to understand the cause of her body size having fallen outside what is seen as accepted normal limits. Such exploration has been considerable and has served only to place the large-bodied woman in a position of silence. In examining the situation of embodied largeness for women I will consider women's body size as a discursive field in which multiple competing and conflicting discourses are played out.

1.5 Overview of the study.

Chapter One: This chapter has provided a background to the area of research interest, presented a synopsis of the argument and explicated the research aims. It has also clarified my goal, which is to challenge current nursing practice in the research area whilst simultaneously offering a beneficial experience to the women who have contributed.

Chapter Two: The study continues with a description of the concept of discourse as it is used in this study. My interpretation and utilisation of a Foucauldian notion of discourse is explored, followed by an examination of some feminist appropriations of Michel Foucault's work which have focused on body size. Relevant work by Susan Bordo, Sandra Bartky and Carole Spitzack is utilised. The concept of women's bodies as an area of surveillance and regulation is introduced.

Chapter Three: An examination of the separate discourses of medicine and nursing is presented, utilising a review of literature in each area. A populist discourse about women's body size and the diet industry is also described, using a selection of literature and some examples of topical humour and advertising. The environment which large women negotiate and the context which informs practice has been critiqued.

Chapter Four: An overview of the development of feminist research is provided. The use of feminist methodology is reviewed. I argue the applicability of feminist research for areas of nursing research and probe the implications of the use of this methodology for this project.

Chapter Five: This chapter explicates the details of participant selection, a full description of the interviewing process, and the method of analysis employed. Issues of an ethical nature are examined.

Chapter Six: Each participant is introduced in this chapter in order that their story will be fully present and their enormous contribution acknowledged.

Chapters Seven to Eleven: Interview material is presented within a framework provided by thematic analysis and continuing dialogue with the participants. A schematic representation of embodied largeness has been generated from the framework and from ongoing reflexive communication with the research participants. This is presented at the culmination of chapter eleven.

Chapter Twelve: This chapter sets the model of embodied largeness against the concepts of marginalisation, medicalisation and consciousness raising. The notion of marginalisation here is drawn from the nursing literature, and the experience of stigmatisation is discussed as induced from the interview material. Medicalisation arises from the powerfully dominant medical discourse which imposes a template of normality on women's bodies. This chapter discusses research as social change and concludes with some reflection on the value of a postmodern approach for nursing research.

Chapter Thirteen: Implications of the study are raised in this chapter. I argue that as it is impossible to justify the practice of reduction dieting on medical and health grounds, it is unacceptable for nurses to either condone or advocate such a practice. Because nursing is a practice profession the preceding exploration, critique and to some extent deconstruction is crucial but in itself is insufficient. Nurses have an added responsibility which is to act. Suggestions for improved nursing practice include a closer relationship with feminism and evolving a practice based in a partnership with clients. I consider what a truly holistic practice in this context would involve. In conclusion I suggest increased nursing input at policy-making level which would involve identification with what has been called the radical critique.

Conclusion: Background for the study has been presented, demonstrating that concern about appropriate body size is a dominant feature of many women's lives regardless of their actual body size. I have alluded to feminist analyses of the particular socio-political context in which women experience body size. I have signalled my intention to explore one aspect of a spectrum of distress by working with women whose body size already falls well outside medical and social norms. This is done with the explicit aim of generating useful knowledge for nursing practice.

This chapter has presented the argument contained within the thesis, and presented the aims and an outline of the study. The study now moves to review the Foucaldian notion of discourse and relevant feminist derivations of his work.

CHAPTER TWO: The Discursive Field of Women's Body Size

2.1 Introduction.

In the previous chapter I discussed the high level of concern women demonstrate about gaining or maintaining a certain body size. It is now necessary to explore the context in which women experience and assess their bodies and the context from which authoritative voices arise to speak of body size. This will inevitably be the source from which nursing is informed. Accordingly, I now present a critical review of the major discourses which can be identified as impacting on women's experience of body size.

In this chapter I begin by describing the interpretation of discourse as it is applied in this project. I then examine the particular discourses which are relevant to the discursive field of women's body size. This is achieved first through an exploration of femininity as discourse, particularly as it relates to the area of body size and the disciplinary practices which are required of women. In the next chapter there will be a comprehensive examination of the relevant literature in medicine and nursing, and a sampling of populist discourse about body weight and weight reduction. These areas are selected for their obvious pertinence and because they create a network of power relations which structures a field of possibility for large women and for nursing practice.

2.2 The concept of discourse as used in this project.

Foucault's theory of discourse was first explicated in *The archaeology of knowledge* (Foucault, 1972). Foucault shows how discourse both serves and covers over desire, power, reason, truth, falsity and other relations. He identifies discourses as historically variable ways of specifying knowledge and truth, in other words a way of identifying what it is possible to speak about and the manner and content of the speaking at any given moment in time. From Foucault the notion of discourse refers to the arrangement of 'statements' within a 'conversation' which is continuously mediated by texts and between speakers and listeners. Smith (1990, p. 161) comments that the notion of discourse 'displaces the analysis from the text as originating in the writer or thinker to the discourse itself as an ongoing intertextual process'.

The term discourse in this work draws on the work of Foucault, and refers to sets of ideas and beliefs displayed through language and practices and embedded in texts and institutions. Purvis and Hunt (1993) argue that people in effect live and experience within discourse, because discourses constitute a framework which determines what can be experienced and the manner in which that experience is interpreted. From within each discourse there is encouragement for certain things to be spoken, and equally there are clear impediments to the speaking of others. Critically Purvis and Hunt note that 'meaning' is never fully referential and is always contestable.

Foucault rejects the distinction between science and ideology and in so doing rejects the notion that there is such a thing as a discernible and objective truth. Because the production of power is linked to historically specific regimes of power, each society generates its own truths which then serve to normalise and regulate (McNay, 1992). The connection thus made between science and ideology is especially pertinent at the intersection between medicine and women's bodies. As Foucault points out:

> from the nineteenth century medical science was characterised not so much by its objects or concepts as by a certain *style*, a certain constant manner of statement. For the first time, medicine no longer consisted of a group of traditions, observations, and heterogeneous practices, but of a corpus of knowledge that presupposed the same way of looking at things .. //.. in short it seemed to me that medicine was organised as series of descriptive statements (Foucault, 1972, p. 33).

Foucault's further (1980) analysis of the links between knowledge, power and discourse shows that claims to knowledge by exponents of dominant discourses such as medicine are more accurately, claims to power. Medicine has been a powerful and dominant discourse for at least the last fifty years. There is a particular degree of coherence within discourses which can be recognised as specialised or technical, or grounded in seemingly authoritative research (Purvis & Hunt, 1993). It can be presumed that a high degree of coherence within a discourse will contribute to its greater degree of visibility and prescription. Certainly it can be seen that a discourse such as medicine has almost unlimited authority derived from the ways in which it is made authoritative. This will be seen to be particularly pertinent to the area of women's embodied largeness and to nursing practice in that context.

The utilisation of theories of 'discourse' represents a move away from or beyond the concept of 'ideology', according to Purvis & Hunt, (1993). They note that Louis

Althusser's revision of the theory of ideology was the forerunner of a move away from the 'distorted ideas' and 'false consciousness' which characterised notions of ideology. Althusser's work allowed for what could be described as a discursive concept of ideology by introducing a focus on the manner in which ideology becomes represented and internalised. An important aspect of Althusser's work in this area was the concept of 'interpellation' which seeks to explain the ways in which we become hailed by aspects of discourse and then take up its meaning so that our subjectivity is both constituted by and of a particular discourse or discourses. As Althusser says:

> I shall then suggest that ideology 'acts' or 'functions' in such a way that it 'recruits' subjects among the individuals (it recruits them all), or 'transforms' the individuals into subjects (it transforms them all) by that very precise operation which I have called *interpellation* or hailing, and which can be imagined along the lines of the most commonplace everyday police (or other) hailing: 'Hey you there!' (Althusser, 1971, p. 162-3).

Parker (1992, p. 9) also refers to the containment of subjects within discourse, and clarifies this by stating that a discourse 'makes available a space for particular types of self to step in'. It is easy to understand why some discourses are so powerful and others so marginalised. It is perhaps less easy to understand why some people have a comfortable affinity with dominant discourses and yet others consistently position themselves from within those discourses which critique or offer a position of resistance or competition to more central discourses. This too is pertinent to this thesis in that as a registered nurse it would be more usual (albeit unacceptable) for me to be accepting of medical teaching about body size and health, while my positioning within feminist discourses promotes questioning and critiquing of medicine rather than bland acceptance.

Foucault saw discourses as identifiable by four criteria. McHoul and Grace (1993) list these as, *objects*, meaning the focus of interest in terms of study or production; *operations*, meaning the methods and techniques which typify the discourse; *concepts* referring to the terms and ideas which characterise the discourse, and finally the *theoretical options*, which include underpinning assumptions and theoretical frameworks. Such criteria readily apply to the discourse of medicine but become less obvious in less coherent discourses.

In the Foucaldian sense discourses are considered able to overlap and intersect and to develop and disappear as time progresses. They may gain or lose ascendancy and they will transform, merge, disappear or re-emerge in new forms. Weedon (1987) says that discourses, in Foucault's work, are ways of constituting knowledge and involve social

practices, forms of subjectivity and the relations of power. They arise out of and simultaneously give rise to beliefs, practices and ideas about individual behaviour and social practices. As well as constructing social practices and institutions, discourses become a part of an individual's conceptualisation of oneself as a particular kind of person with particular ways of acting.

Foucault argues that the importance of discourses lies in the effects of power and knowledge ensured by the existence and relative strength of any one discourse. In this context power is not viewed as something which one group holds and then utilises to oppress or constrain the actions and rights of others. Rather than operating in a top down manner, power, as Foucault identified it, is a series of relations which arise in the interaction between different discourses and subjects and is differently constituted in differing historical and socially located situations. Powerful discourses become so because of their embeddedness in significant institutional bases. Alternative or more marginalised discourses are less powerful because they lack the conferred authority of an institutional base. They do however offer a position from which others may speak and be heard. Historically we see differing discourses gaining or losing power as they compete for recognition. Central to Foucault's notion of power is his argument that it is a productive rather than simply a repressive force. As Foucault states

> ... discourse transmits and produces power; it reinforces it but it also undermines and exposes it, renders it fragile and makes it possible to thwart it (Foucault, 1980, p. 101).

Foucault's earliest work emphasised the ways in which power is deployed. He noted the exercise of power as discipline through a number of techniques manifest in new systems of control such as the education and prison and hospital systems. Foucault used the term bio-power to denote the general regulation of populations, and specifically the discipline and docility of individual bodies. Because discourses define what is normal, and thereby what is not normal, a process of normalisation is supported, whereby there is an impetus of conformity.

Ramazanoglu (1993) notes that feminist scholars have found these concepts useful as a means of theorising the social pressures on women to submit to discipline in the management of their own docile bodies. Amongst these are the work of Bordo, (1989; 1990 & 1993) and Spitzack (1987; 1988b & 1990). Bartky (1988 & 1990) has used the notion of a disciplinary project of femininity to critique the processes and procedures in which women engage to be more feminine.

2.3 The disciplinary project of femininity.

According to Bartky (1990, p .71), the disciplinary practices in which women engage are 'part of the process by which the ideal body of femininity ~ and hence the feminine body-subject ~ is constructed; in doing this, they produce a "practised and subjected body", i.e. a body on which an inferior status has been inscribed'.

Bartky (1990) goes on to suggest that the disciplinary project of femininity requires such unrelenting attention and offers so little chance of success that the majority of women who participate in the project are destined to fail. This generates shame that the body she inhabits is deficient. The battle against the burgeoning body is aptly described within this context, and participants in the study will be shown to be thoroughly engaged in a protracted and ongoing project which never entirely relinquishes its hold.

The disciplinary project of femininity incorporates the concepts of bodily inscription and utilises the concept of docile bodies drawn from the work of Foucault (1977). Foucault argued that the body is an essential practical and direct locus of social control. He described docile bodies as bodies whose forces and energies are habituated to external regulation, subjection, transformation and improvement.

Foucault, as previously discussed, reconceptualised the understanding of power in a manner which is especially relevant to understanding embodied largeness. He explains power not in the sense of a downward force exerted by the activities of a dominant individual or group, but rather, as an immanent or integral part of manifold relations of force (Foucault, 1979). McHoul and Grace (1993, p. 22) explain this by saying, 'the subject which power has *constituted* becomes part of the mechanism of power. It becomes the vehicle of that power which in turn, has constituted it as that type of vehicle'.

Through a minutiae of daily actions and activities, culture is made body, to a degree which goes beyond consciousness. The body becomes a docile regulated body habituated to the rules of cultural life. In this respect Foucault was arguing in effect for the primacy of practice over belief, particularly in the workings of power. I understand him to mean that the very action of focusing on the appropriateness or otherwise of the body shape and size, and the myriad of regulatory activities this involves in itself, generates or gives power and authority to the rightness of acquiring a body which fits with current cultural norms.

Foucault argues that a docile body is one that may be subjected, used, transformed and improved. But at no time did he distinguish between the body of a man and the body of a woman. In terms of this project I am arguing that the docility of the female body is particularly enacted through the disciplinary project of femininity, and that inhabiting a female body brings particular qualities to the experience of embodied largeness. In so doing I agree with Bartky (1990 p. 65) who asserts that Foucault was 'blind to those disciplines that produce a modality of embodiment that is particularly feminine'. Bartky goes on to argue that to fail to make explicit the particular forms of subjection imposed upon the female body is to perpetuate the silence and powerlessness of those who endure the disciplines. In carrying out this research and illuminating the experiences of this group of large women there is the opportunity to challenge just that silence.

Women's continuous engagement with reduction dieting can also be understood in Foucauldian terms. The widespread adoption of reduction dieting can be viewed as a technique of rigid self surveillance in which Foucault's theories of panoptic power and the confession are pertinent. Foucault's concept of panopticism was derived from the early design of a prison by Jeremy Bentham. In contrast to the incarceration of criminals hidden away in dark dungeons, the panopticon was a spatial arrangement whereby each prisoner could at any time be seen by the jailer but could not discern when surveillance was present or absent. In other words, prisoners could be seen but could not see and therefore felt themselves to be under constant monitoring and the constant object of information. 'Hence the major effect of the Panopticon: to induce in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power' (Foucault, 1977, p. 201). The importance of this, as Foucault explains, is that it both automates and disindividualises power, and it is an arrangement whose internal mechanisms produce the relation in which individuals are caught up.

The concept of panopticism is especially useful and pertinent to the area under consideration. Having suggested, in chapter one, that the shaping of the body is related to struggles over the shape of power, it is necessary to examine how power operates in this context. As discussed in chapter one, large numbers of women strive vigilantly for an artificially desirable and imposed goal of perfect body shape. They behave in remarkably similar ways and each one individually takes the problem into themselves. They become walking, talking and similarly starving (or planning to starve) embodiments of the pursuit of slenderness. They talk, not often to each other but to a distant imagined arbiter, of the success or otherwise of their adherence to a code of behaviour. They each monitor their behaviour against an unseen moderator who at any time may find them to have transgressed (Spitzack, 1990).

Bartky (1988) has explicitly identified the panoptic tendencies which are part of the production process of female bodily perfection. Of interest here is the manner in which panoptic-like structures are imposed. The beauty and diet industries take up the power and status accorded to scientific and medical knowledge, and exploit the authority thus gained, to establish an apparent 'truth' about the limits of normality for female appearance. This is, says Foucault (1977 p. 209), a discipline mechanism, 'a functional mechanism that improves the exercise of power by making it lighter, more rapid, more effective, a design of subtle coercion for a society to come.' No central authority publicly or even audibly censures all women who are large and do not diet. Rather, the power is deployed through the individual actions and reactions of each dieting woman who adheres to a seemingly invisible standard of dieting behaviour. Bartky (1988) describes this effectively, although I would differ with Bartky in assigning a gender to the connoisseur. She says:

> In contemporary patriarchal culture, a panoptical male connoisseur resides within the consciousness of most women: they stand perpetually before his gaze and under his judgement. Woman lives her body as seen by another, by an anonymous patriarchal 'Other' (Bartky, 1988, p. 72).

Spitzack (1990) notes that the discourses of reduction dieting weave the language of science, deviance and theology in presenting at once both the image and the means to achievement of the acceptable female body. The language of science is appropriated from medicine and is subsumed in the usage of weight charts, body mass index ratios, scales, target weights and disease outcomes as the penance for failure. Such usage effectively gives reduction dieting all the power of being embedded in the very dominant discourse of science through medicine. Diet clinics or diet organisations weave together these languages; the scales and charts and goal weights representing scientific authority. The use of public announcement and applause or castigation for success or failure isolate and identify the deviant, who often, as will be indicated by women in this research, quietly retreats in the face of failure.

The language of deviance and theology is also implicit in the continuous acts of confession which are associated with either success or failure at reduction dieting. The confession, according to Spitzack (1990 p. 59), 'forces one to see the truth about oneself through continuous self inspection, accepting with humility and graciousness, absolution from those who legislate the truth'. Women's casual talk is redolent with confessional statements as to their apparent weakness around food, their lack of resistance to food

and the possibilities or reality of eating and thereby succumbing to temptation. The act of confessing to imagined dietary excess is identified by Spitzack (1990) as a way of both asking absolution for wrong doing and identifying oneself as a wrong doer. There is also some sense of confessing quickly before one is exposed by others and identified as a sinner.

Implicit in the act of confession is an admission of awareness of standing outside dominant values and simultaneously a promise to improve. When a woman says "Tomorrow I will start my diet" she is reassuring both herself and those listening that she is aware that her current body does not measure up and that she intends to address the problem. Foucault's concept of panoptic power is considered to be maximised when tower guards are unnecessary for the preservation of order within a prison, when instead just the possibility of their presence prevents transgression. This situation is mimicked by the dieting or would-be dieting woman who monitors her own behaviour and finds it continually unsatisfactory and in need of improvement. The large woman (and even many smaller women) is always planning to take herself in hand. Intense self surveillance without the need for external regulation has been achieved. Spitzack, (1990 p. 61) notes that 'the keepers of the scripture or law are no longer required for a legislation of "truth" when their wrath is fully embedded in their subjects'.

The quite extraordinary and continuing proliferation of diet books, manuals and articles in the last twenty years constitutes a discursive explosion, which Spitzack (1990) describes as inspirational reading, assuring the would-be dieter that she need only follow a set of simple rules in order to achieve the desired transformation. Reading a diet article or a weight clinic advertisement makes it all seem so effortless and attainable, requiring only adherence to the rules in order to secure everlasting slenderness.

2.4 Bodily inscription, or the body as a text of femininity.

In this context Bordo (1989) develops Foucault's argument about docile bodies further, by describing the body as a text of femininity. She suggests that the discipline and normalisation of the female body is perhaps the 'only gender oppression that is manifest across age, ethnicity, class and sexual orientation and that this has been a particularly pervasive and enduring form of social control' (Bordo, 1989 p. 14).

The allocation of women to the private world (Gatens, 1996) and the construction of femininity as an acceptable way for women to be in the world has far-reaching

consequences. Femininity in the post-modern sense may more appropriately be seen as femininities, as it is most certainly multiple and modified by issues of class and ethnicity at least. There are a range of taken-for-granted assumptions about appropriate female demeanours, appearance and behaviours. Femininities carry connotations of emotion rather than reason, consumption rather than production and object rather than subject. Women as objects are frequently required to fill a decorative role, being expected to pay endless attention to their appearance (Bartky, 1990).

Bordo (1989) suggests that the bodily inscription of femininity is especially problematic as current cultural norms for femininity have become increasingly contradictory and conflicting. She sees women as having two options. They can choose earth mother type images of the nurturing and feeding of others whilst simultaneously controlling and denying their own hungers. Alternatively they can choose to learn to embody traditionally masculine language and values which involve concepts of self control, determination, mastery and emotional discipline.

Chernin (1981) also addresses the contradiction in suggesting that femininity is both feared and revered, and both sought after and denied. She suggests that struggling to embody and enact a femininity which is simultaneously emphasised yet also devalued creates, for women, a double bind and an essentially unwinnable situation. Bordo (1989) argues that the pursuit of slenderness offers the chimera of meeting through the body, the contradictory demands of the contemporary construction of femininity.

By this I understand her to mean that the process of losing weight embodies masculine ideals of control, discipline and strength, whilst concurrently and paradoxically supporting a movement towards a goal of smallness, delicacy and presumed attractiveness. Complex notions of women as passive victims of the dominant framings of femininity or as active agents of success are equally but inextricably bound into the dieting process. And it is just this double bind which casts the web of reduction dieting so tightly around the woman who knows that her body is growing, or has become, 'too large'.

It is notable that even the reduction of women's body fat is in itself contradictory. It represents a move towards femininity in the attainment of smallness and fragility, but at the same time increasing slenderness eradicates those parts of the body which are clearly female. Caskey (1986:176) illuminates this by considering the relation of body fat to femininity. She suggests that 'from sexual maturation to the end of life, body fat, by its relation to female hormones is essentially resistant to the conscious wishes of its owner'.

The parts of the female body which are clearly different from men's bodies are those where fat accumulates, namely the breasts and hips. As women gain weight their female shape is more and more defined; as they become smaller the differences are less exaggerated. In just this way the competing discourses of femininity are embodied and the scene set for the bodily battle which ensues and which will be explicated in the later chapters which deal with the analysis of interview material.

This chapter has explained the understanding of discourse present in this work and considered some feminist derivations of Foucault's work which have focused on discourses of femininity and women's body size. As a large woman I have been a subject of dominant discursive constructions of femininity. Understanding the notion of discourse disrupts the automatic positioning of a large woman as one who has transgressed. Work in this area has been a vital aspect of my understanding of the discursive field of body size. In the next chapter I turn to the various discourses of medicine, nursing and the populist or dominant media discourse in the field of interest. In so doing I move to the areas most accessible to the participants of this research, and to most nurses in practice.

CHAPTER THREE: Medical, Nursing and Popular Discourses

3.1 Introduction.

In the preface to this study I noted nursing's argument that it is a practice discipline based on a unique body of knowledge and standing separate from medicine. I noted nursing's allegiance to holism and to working alongside individuals to support their personal negotiation of health. In this chapter the discourses of medicine and nursing are interrogated as they are present in pertinent literature. In addition the dominant popular discourse is explored, thus acknowledging its influence on public perceptions of large body size.

3.2 Medical Discourses.

Discussing the discourse of medicine immediately raises the issue of whether this is one or multiple discourses. Whilst there are clearly contradictions and conflicts within medical research and medical practice, for all practical purposes there is an overarching set of beliefs which both underpin and dominate in the area of body size. The body-as-machine or reductionist perspective which informs bio-medicine focuses on disease or its absence. This particular world view does not leave space for multiple truths or multiple realities, and espouses a simplistic notion that certain body sizes equate with the disease 'obesity', and obesity equates with ill health. As I will argue, in the area of study, the situation is a great deal more complex.

The centrality of medicine to any public discussion of health means that it is that overarching belief system which interpellates consumers of health care delivery. Similarly there is a dilemma in deciding exactly what constitutes medical discourse. Much of what is loosely called medical research is performed by nutritionists or scientists or biologists or others. Such is the authority of medicine it seems that when research addresses the anatomy or physiology of the human body it is subsumed under a general description of medical research. The persistent use of the word 'allied' to describe any activity which is related to health and illness but not directly medical signifies the hegemonic centrality of bio-medicine.

Rather than simply argue that there are contradictions within medical discourse, it may be more accurate to say that research related to medical practice has produced findings which do not appear to be incorporated within the general teachings and practice of medicine. In order to provide a coherent discussion of current literature related to medical research, medical practice and obesity I have juxtaposed the threads of what is overarchingly perceived as medical discourse.

Appropriately in this context, Foucault (1973) refers to the body as an anatomical atlas constituted by the medico-scientific gaze. In addition, Lupton (1994, p. 30) notes that 'in public health discourse the body is regarded as dangerous, problematic and ever threatening to run out of control.' As medical concern has moved from infectious to degenerative disorders, the rhetoric of public health discourse states that disease is the product of a faulty lifestyle and improper attention to the maintenance of a healthy body. Medicine, embedded in the natural sciences, is the primary means by which this particular discourse is manifest. Disciplinary power in the form of medical authority is acted out in health risk appraisal, charts which define normality and abnormality and health education campaigns which provoke guilt and anxiety for those whose behaviours or results do not measure up (Lupton, 1994).

When a larger body is labelled as obese and the person inhabiting that body is said to be suffering from obesity, they are then recognised as having a disease state. Once a person is identified as diseased they are then considered to warrant medical attention. I plan to devote considerable attention to the discourse of medicine in recognition of the dominance it holds in pathologising women's body size and the impact it has had (and continues to have) on nursing practice and on all popular discourses as will be demonstrated later in this chapter.

3.2.1 The discourse of medical practice

The Consensus Development Conference (1985), held in the United States of America, discussed the topic of obesity (Ernsberger & Haskew,1987). Statements released afterwards were unequivocal in their conclusion that fatness is dangerous to health and highly undesirable. Ernsberger and Haskew, in an overview of current medical research, observe that medicine consistently argues for a close relationship between increased body size and poor health outcomes. In this section I consider the diagnosis and management of body size and the contradictions which exist within the discourse of medicine.

3.2.2 Diagnosis of body size as pathology

The BMI (body mass index) is the person's weight in kilograms divided by the height in metres squared. This is used as a measure of obesity with BMI less than 25 generally regarded as normal and BMI more than 25 regarded as overweight. BMI over 30 is generally categorised as obesity and a BMI greater than 40 constitutes serious and even morbid obesity. The most frequently used criteria for determining normal weight have been the Metropolitan Life Insurance Tables. This benchmark has been increasingly criticised, as the figures were based on a survey of over four million individuals who took out life insurance between 1934 and 1959 in America. This was a non representative population, not least because it was almost entirely male (Atrens, 1988). The quality of the measurements of height and weight have also been criticised (Allan, 1988; Atrens, 1988). The figures for normal weights were revised upwards in 1983, but not significantly.

Recently Dr. Boyd Swinburn medical director of the New Zealand Heart Foundation, reported back from the November 1995 CIBA Foundation international symposium on the origins and consequences of obesity. As previously mentioned Swinburn has noted the major epidemic of obesity occurring internationally, which he said had been described as a tidal wave because of its relentless advance. The increase in obesity is of particular note given the focus on achieving leanness. There is no readily apparent explanation for this development. According to Marston and Raper (1987), caloric intake has been stable or declining during this century, but there is concurrent evidence that life styles and work requirements have reduced levels of spontaneous physical activity.

Obesity is particularly likely to occur in minority and low socio-economic status populations (Sobal & Stunkard, 1989), and it is considered that the prevalence of this disorder increases with age. Van Itallie (1985) notes that when age, minority status and low socio-economic status intersect as in middle aged to elderly African American women the prevalence rates of this 'disease' are as high as sixty percent. Swinburn (1995) reported that in developing countries, high socio-economic status is associated with higher BMI, especially among women, and the reverse is true in developed countries.

Brownell & Wadden (1992), in an article reviewing research into the cause of obesity, note that much of it has looked for a single cause to explain a single entity. Theories have ranged from psychoanalytic and behavioural (Stuart, 1967) to genetic (Stunkard, Harris, Pedersen & McClearn, 1990). Research has looked both at the behaviour of overweight people and the physiological status of the human body, in order to understand variables

such as the resting metabolic rate, fat cell numbers and genetic components of weight variation.

It has been suggested that the resting metabolic rate may be significantly heritable (Bouchard et al., 1989), and it is also known that people with a low resting metabolic rate do gain weight more easily than those with normal or elevated levels of resting metabolic rate (Ravussin et al., 1988). Stunkard et al. (1986) and Stunkard, Harris, Pedersen and McClearn (1990) found that body weight has a considerable genetic component, as does the distribution of that weight to different areas of the body. Swinburn (1995) noted that there is now general agreement that, given a similar environment, the inheritability of obesity is about 33%. Recent media reports, in particular a radio programme by Dr. Boyd Swinburn (Wednesday, January 30th, 1997), are beginning to suggest a substantial genetic base with a variety of genes controlling regulation of fat storage, distribution of fat storage and other aspects of body size.

3.2.3 Medical management of variations in body size.

Placing irregular body size within the medical gaze has resulted in a vigorous response by practitioners of medicine. Historically, medicine has approved a number of treatments for large body size, the most universal being supervised reduction dieting. Swinburn (1995) notes that the slimming industry in the United States is currently estimated to be worth approximately 33 billion dollars. Various pharmaceutical measures have been tried, including appetite-suppressing drugs, especially amphetamines (Ernsberger & Haskew, 1987). Pharmaceutical measures included the use of the rainbow pill which combined an amphetamine (central nervous system stimulant), a diuretic (to remove excess fluid), and thyroxin (to speed the metabolism). This was in vogue from the 1940s through to the early 1970s'. As a student nurse in the late sixties and early seventies I remember the availability and prevalence of this particular cocktail remedy. It was used frequently by young women (including myself) who had barely discernible levels of excess weight.

Ernsberger and Haskew (1987) report widespread use of jaw wiring from 1974. This involved admission to hospital for a period of months, during which time the jaws were wired to allow only the passage of liquids. I remember clearly the mute misery of the women I saw subjected to this ritual, and the pliers which sat on their lockers so that the wires could be removed urgently if they choked. I also recall the ill-concealed mirth as they were escorted to the hospital bulk store for weekly weighing on scales with a suitably high range. No effort was ever made to protect them from the derision of orderlies or bulk store staff to whom they were exposed in the process. Ernsberger and Haskew also

report the annual performance of thirty thousand gastric bypass operations in the United States by 1980, increasing to fifty thousand by 1982. Such surgery continues to be available in New Zealand and elsewhere, with increasing refinement of technique.

Such vigorous (even inhumane) treatment of obesity stems, ostensibly at least, from the widespread medical certainty that large body size is closely related to poor health outcomes particularly increased morbidity and mortality. Obesity is clearly regarded in medical terms as a serious, prevalent and refractory disorder, (Brownell & Wadden, 1992). It is believed to be associated with increased risk of hypertension, diabetes, cardiovascular disease and other illness (Bray, 1986; Pi-Sunyer, 1991). Such certainty is both supported and contradicted by medical and 'allied' research and I intend now to review some of the contradictions which exist to this dominant view.

3.3 Contradictions within the discourse of medicine.

In a monograph edition of the *Journal of Obesity and Weight Reduction* Ernsberger and Haskew (1987) suggest that the automatic linking of large body size with poor health needs considerable modification. In a comprehensive review of significant and relevant research they argue that the 1985 American Consensus Statement on the health implications of obesity represented an unbalanced view of adiposity and health.

In their research review they note that although medical literature has documented elevated risk factors in heavy people, these risk factors fail to translate into high mortality rates. Ernsberger and Haskew (1987) review a wide range of research which demonstrates that adiposity protects against many diseases and is associated with a more favourable outcome in others. They also note that many studies show that maximum longevity is associated with above average weight, particularly for women. They note that mortality and morbidity are seen to increase at both very low and very high weights, but there is very little change in risk over a 30-60lb range of what is called, excess weight.

Ernsberger and Haskew (1987) suggest that research to date shows that where body composition is taken into account, the ill effects of excess lean tissue are greater than those of adiposity. They clarify this by saying:

> Persons at highest risk are muscular, have a large skeletal frame and have fat deposits predominantly in the abdomen. The hazards of obesity which are associated with fatness per se rather than body build may themselves be due

> to the ill effects of treatment for obesity .. //.. Given that the net adverse effects of adiposity are relatively modest and may be partly attributable to the hazard of treatment, the risks associated with radical weight loss methods are unjustified (Ernsberger & Haskew, 1987, p. 3).

Abernathy and Black (1996) cast considerable doubt on the automatic link between body weight and health outcomes. They note that consistent, significant findings for mortality are found only when $\geq$ 20 000 healthy people are studied over a long period, there is control for smokers, and early data is discarded to reduce the effect of undetected illnesses. They conclude that statistical height and weight standards as universal guidelines should be downplayed.

Bodroff & Bjorntorp (1991) suggest that the female pattern of fat distribution with heavy hips, thighs and buttocks (pear shaped) is associated with virtually no impairment of health except possible joint damage. The male pattern of small hips and thighs but rotund abdomen (apple shaped) is thought to be more closely associated with elevated risks of many of the degenerative diseases. Swinburn (1995, p. 2) appears to agree to some extent in commenting that 'it is clear that visceral fat is the bad guy in the fat story'.

Brown & Rothblum (1989) note two major design flaws in the medical research investigating the relationship of health status to weight levels. They note that there has not been control for the variable of a history of reduction dieting. Furthermore it is reported that the prevalence of obesity is much greater in lower socio-economic groups (Sobal & Stunkard, 1989), yet this variable is also not controlled for. It is well known that health status is related to socio-economic status with low socio-economic groups having the poorest health and higher incidences of many disorders (Nelson, 1994; Moore & Harrison, 1995).

There is, therefore, good reason to question the validity of medical support for reduction dieting on health grounds, but there is also reason to question it on grounds of its degree of usefulness in achieving the stated goal. Brownell and Wadden (1992) discuss the repeated reduction dieting which characterises the lives of large people, and acknowledge that it does not produce a lasting solution. They note that:

> obese persons may bear a legacy of shame and failure from cycles of weight loss and regain. Our patients have undertaken an average of five major diets on which they lost and eventually regained a total of 56kgs. Despite their

> efforts they have watched their weight increase from 70kgs at seventeen to 100kgs at forty (Brownell & Wadden, 1992, p. 513).

Despite such information it has been reasonably common practice for medical practitioners and nurses to support reduction dieting. There are several problems with any advocacy for reduction dieting. A review of the literature suggests that reduction dieting is ineffective because there is both a physiological and a psychological response to calorie restriction. Many investigations by medical and 'allied' researchers have demonstrated that the body responds to caloric restriction with a reduced metabolic rate (Pavlou, Hoefer & Blackburn, 1986; Brownell, 1987; Dulloo & Girardier, 1990). This would account for the steady reduction in the amount of weight lost each week as a reduction diet progresses.

The majority of people who do lose weight return to baseline levels after one year and often gain more later (Goodrick & Foreyt, 1991). The chronicity of dieting is in itself an indication of the failure of reduction dieting. Most dieters experience frequent weight fluctuations, which have been linked to a greater risk of coronary heart disease and death (Lissner et al., 1991). Other researchers have also suggested that the fluctuations caused by reduction dieting are in themselves unhealthy (Brownell, 1980; Ernsberger, 1985).

Some sources suggest the existence of a body weight set point as controlled by the hypothalamus in the brain (Bennett & Gurin, 1982; Keesey, 1986; Atrens 1988; Leibel, Rosenbaum & Hirsch, 1995). Body weight is closely regulated by a complex interaction of neural, hormonal and metabolic factors. It has been suggested that reduction dieting causes a raised set-point, which ensures post diet regain with the new weight in excess of the pre-diet weight.

Cowen, Clifford, Williams, Walsh & Fairburn (1995) have studied the impact of calorie restriction on neurotransmitters in the brain; specifically 5-hydroxy-tryptamine (5-HT), which regulates appetite and food intake, is found to have decreased after comparatively short periods of reduction dieting. During dieting it is thus likely that urges to overeat will occur, compromising the dieter's best efforts at food restriction. Cowen et al. note that this builds on previous work which has noted a relationship between reduction dieting and disordered eating (Polivy & Herman, 1987).

At the psychological level it is asserted that people may respond to the deprivation of dieting with the desperation of bingeing (Hirschmann & Munter, 1995). These authors review literature suggesting that the conflict between the biological drive for food and the

cultural drive for thinness has generated levels of binge or compulsive eating not seen in persons who have not engaged in deliberate manipulation of food intake.

Medical practitioners continue to speak from the vantage point of assumed authority to assert both the danger of fatness and the advantages of caloric restriction. What follows is an example of medical advice in a public forum: a lifestyle health column presented by general medical practitioners (*Evening Standard*, September 11th 1995). It stated that:

> 'anyone who is overweight should diet to reduce the risk of developing diabetes, high blood pressure, hardening of the arteries, back injuries, muscle and ligament strains, osteoarthritis, diverticular disease, bowel cancer and maybe even breast cancer.'

This is a contentious list of diseases to attribute to bodily fat, and several are directly contradicted in an extensive review of medical research reported by Ernsberger and Haskew (1987). The newspaper article contains sensible advice about healthy eating, but also states that the aim should be to lose half to one kilogram per week and adds, 'if you're not losing weight despite following the general guidelines, too great a volume is still being consumed'.

In an interesting combination of roles, Dr. John Birkbeck is director of the New Zealand Nutrition Foundation and advisor to Weight Watchers. He has stated 'To imply that diets don't work is ridiculous' (*New Zealand Listener*, June 12th 1993) and more recently, in *Next* magazine, December 1995 he comments that negativity toward reduction dieting is overly pessimistic and 'people have to be prepared to change their eating habits and exercise for the rest of their lives.'

There is, therefore, some degree of discrepancy within the discourse of medicine between knowledge available from research and knowledge which reaches the public domain. It has been my experience in working with and speaking to or teaching medical practitioners and nurses that they are generally unaware of the long-standing criticism of reduction dieting, or that there is any challenge to their belief that obesity universally constitutes a major health risk. This belief is not publicly modified with reference to gender difference or to variables of fat distribution and their significance. There appears to be no modification in respect of degrees of obesity, or the relationship between weight gain and age increase. There is a growing awareness in the popular press that reduction dieting is not a permanent solution, but no evidence that reduction dieting has decreased. It is of interest that some information remains as a marginal discourse while other information

carries the weight of dominant discourse firmly embedded in institutions such as medicine.

Medical discourse is characterised by a simplistic tendency to generalise. Research findings suggestive of gender variation, age difference and many other moderating factors in the body weight and health equation are subsumed in an overarching condemnation of any divergence from the imposed norm. Ancel Keys made a statement which neatly summarises the assessment of medical discourse I made eleven years later. He said:

> the risk of premature death is not a simple direct function of relative body weight. Apparently that fact, well established from various prospective studies, is not yet common knowledge in the medical profession, let alone the general public (Keys, 1986, p. 1023-1024).

3.4 The discourses of nursing in the context of body size.

At the beginning of this chapter I noted nursing's allegiance to holism. This is a key philosophical assumption which underpins nursing research and practice, and illuminates the difference between medicine and nursing as related but intrinsically different applied disciplines.

Nurses agree that health is a central concept to their profession (Laffrey, 1986 ; Woods et al., 1988; Kenney, 1992). Kenney (1992) comments that a critical review of the literature reveals that there is a significant discrepancy between clinical definitions of health and those which underpin nursing theory. She notes that whereas nursing research and practice have continued to define health in clinical terms, nursing theories incline toward broad holistic definitions of health. This discrepancy is very pertinent to the critical review of nursing literature related to health and body size.

In theory then, the discourse of nursing is separate from that of medicine, but in practice as I will demonstrate there is evidence of considerable overlap. Both discourses share human well-being as the object of concern, and specifically focus on the achievement or maintenance of health. The point of intersection is the restoration of health to those who are sick or injured but nursing's sphere of interest is much broader. The operations differ in terms of methods and techniques and can be shown to have become increasingly different with the growth of nursing knowledge developed by specifically nursing research. There is considerable sharing, in practice forums at least, of concepts. Nurses use medical terminology, but they increasingly have unique language which is unrelated to medicine.

Of interest is the degree to which the unique language of nursing theory is present in practice settings. This review of nursing literature suggests almost no acknowledgement of any nursing theoretical perspective being brought to bear on the area of body size.

The greatest divergence between medicine and nursing is seen at the level of theoretical options. It can be argued that medicine is firmly grounded in positivism but nursing is beginning to develop a focus in interpretivism, critical theory, feminism and more recently some post-modern focus. What this supports is a growing incongruence between an emerging theoretical nursing discourse and its expression in practice. As already noted, a careful review of nursing literature in the area of women's body size demonstrates this incongruence.

3.5 Nursing Literature.

3.5.1 Introduction and overview of nursing literature.

A review of nursing literature reveals almost no critique of the biomedical model by a profession which purports not to subscribe to it. It will be seen that there is minimal research, remarkably little discussion, and virtually no debate, in the important area of health care related to body size.

Available papers fall into two relatively distinct areas. First there is general acceptance by nurse authors that the medical term obesity is a satisfactory way of describing increases in weight which are even slightly over determined norms by Insurance Company tables. There is strong adherence to a behaviourist model assuming that 'obesity' results from inappropriate eating, therefore eating and exercise behaviour change must be taught and supported. In addition there is support from a psychosocial framework, suggesting support and counselling for clients who are assumed to overeat and for emotional reasons. The goal of supported weight reduction is retained without criticism. This represents the vast majority of papers examined, and there is little appreciable change in focus over the ten year period studied.

The other recognisable area is extremely small. This literature demonstrates recognition of the dominance of the medical discourse and attempts to challenge the hegemony involved. There is a socio-political critique of the gender-related issues which confuse and obscure women's relationship to food, and there is recognition of the dangers of reduction dieting. There is also acknowledgement of the object status of women's bodies in a capitalist society. This extremely small group represents the only published attempt by nurses to

relate some of the available material in the social science and women's studies literature to their own practice. It also represents the only visible adherence to a feminist critique of women, body size and reduction dieting.

3.5.2 Nursing literature that complies with the discourse of medicine.

In this area of nursing literature the diagnosis of obesity is applied to size variations from 7kgs to 50kgs over currently accepted guidelines for 'normal weight' from Insurance Company tables. There is general acceptance of the previously described medical belief that deviation from the imposed norms is highly detrimental to health and carries significant health risk. Most articles begin with a recitation of the assumed risks of obesity and there is no acknowledgement that this is not nursing's own research but direct and uncritical borrowing from another discipline. Reduction dieting is sanctioned and it is assumed and expected that 'the obese' will have to make permanent adjustment to their bad habits in order to remain slimmer.

Much literature argues a role for nurses in supporting clients to make these changes in their lives, frequently **after** a doctor has informed them of the need to embark on the process of weight loss. This literature and other examples lends support for the supposed myth that doctors 'think' but nurses just 'do'. Articles pursuing this theme include Mogan (1984); Miller, Jay and Smith (1987); Shaban and Galizia (1989); Cerrato (1988, 1991); Jonides (1990); Alexander and Sherman (1991); Gatenby (1991); Sherman, Alexander, Gomez, Kim and Marole (1992); Mellin and Frost (1992); Vickers (1993) and Beyea (1996).

The following three excerpts capture the essence of many of the above articles:

> Notwithstanding the inconclusive nature of the research data regarding the causes of obesity, innumerable treatment methods have been tested with equally conflicting results... Nurses, in all practice settings, encounter obese patients and might assist them to shed some of the superfluous weight before any of the unpleasant sequelae of obesity appear (Mogan, 1984, p. 312).

and

> Patients were first seen by the G.P. who impressed upon them the medical importance of weight reduction. He then explained the diet and gave them a printed sheet listing the items to be eliminated. They were then referred by him to the obesity clinic (Westwood & Boulton, 1986, p. 286).

and excerpts from a collection of critical pathways for collaborative nursing care — this one relates to a weight loss programme.

> client verbalises understanding of dietary plan and behaviour modification strategies to change eating habits; client maintains diet diary; client loses up to one pound each week. (Beyea, 1996, p.83).

A close reading of the above excerpts reveals support for my contention that nurses in this context have acted in a singularly unthinking manner. Mogan (1984) notes the inconclusive nature of research about the causes of obesity and the conflicting results of treatment methods, but proceeds to advise nurses on the desirability of weight loss anyway. Westwood and Boulton (1986) do not criticise a practice setting in which they comply uncritically with a situation in which the medical practitioner thinks and orders and they act accordingly. The passivity of the nurses is translated to an expectation of complete obedience from the client who is the focus of Beyea's 1996 nursing care plan. Here the client is the unwitting recipient of translated belief systems in which the nurse is little more than a conduit and is far removed from notions of autonomous practice.

Following the positivist notions inherent in medical research, there is a tendency in the sparse nursing research available in this area to focus on single variables related to weight gain and weight control, thus obscuring the complexity of factors involved. Of note is Mallick (1981), who surveyed 144 female high school students pursuing weight control activities to find factors that motivated weight control efforts. In an uncritical study she found motivational factors to be related to the need to feel good about oneself and to have a good figure. White (1984) also found, in a study of 89 obese women enrolled in weight loss programmes, that loss of attractiveness was a stronger motivator than health concerns. Again, motivation is the theme of a quantitative study of attributional dimensions and success and expectations of weight control behaviour by Brubaker (1988, p. 285).

Allan (1988) is rare as a nurse author who acknowledges the scientific controversy about the relationship of body size to health. She notes the paucity of specific nursing research in this area. Allan carried out an ethnographic study of thirty-seven middle- and working-class women in America to determine how they decided what they should weigh. She found that health concerns are not a strong motivator for weight loss, because overweight women do not necessarily define themselves as unhealthy. Issues of appearance and conformity were more important.

Laffrey (1988) carried out research on the health behaviour choices of a group of overweight people. She describes a person who is 7kgs overweight as obese without questioning norms. She notes that the health behaviour choices of an overweight group were as health promoting as those of the normal weight group, and that the overweight group did not see themselves as unhealthy. She further notes that 30% of the normal weight group thought they were overweight. In conclusion, Laffrey suggests alternative ways must be found to convince the overweight of their need for intervention as, despite their good self concept, they *are* unhealthy.

The preceding literature is interesting because it suggests that cultural requirements for thinness have more impact on the general public than medical anxiety about health consequences. In direct contrast, nurses appear profoundly influenced by medical teaching. This influence must be garnered indirectly, as medical practitioners virtually never make actual contribution to programmes of nursing education.

The unhealthy state of the obese is considered by Black and Mangan (1991) to be sufficient justification for nurses to support surgical procedures to control weight and improve body contour. Liposuction is included as an effective surgical technique for someone who is 5-10lbs overweight or at an ideal weight with areas of localised fat accumulation. An unreferenced statement is made about the below-average intelligence of very heavy people, who may not do well post-operatively because of their limited ability to understand dietary advice. Familial obesity is said to be possibly related to family cooking and eating patterns.

Miller (1992), in writing about middlescent obese women, believes that middle aged female individuals who have never been concerned about controlling food intake and balancing dietary discretion with adequate energy expenditure are likely to be obese or overweight. She appears to imply that control of food intake and weight is a normative state for women. In this article Miller makes many revealing assumptions, including advocating the need to 'help the patient feel some sense of accomplishment in having changed the bedtime snack from an ice-cream sundae to a more acceptable, lower calorie treat'(Miller, 1992, p. 115).

Miller states that 'Whatever the underlying etiology, middle aged obese women must struggle against weight gain and fight for control to maintain any weight loss achieved; weight control must continue for the rest of life' (p. 123).

Amongst many behaviourist suggestions for managing 'the obese', Miller suggests having 'the obese client eat in front of a full-view mirror, paying attention to body size, double chin, rotund appearance and so forth ' (130)

Johnson (1990) provides a rare qualitative study on the process of losing weight. In a large and otherwise uncritical article, one small paragraph reveals the author's possible awareness of other issues. She says:

> The stories of dieters in this study emphasised that daily social pressures include contradictory messages that create obstacles to achieving the desired weight. The pressure to be thin also causes many to follow fad diets and encourages others who are only 10-20% overweight to continually diet. In trying to maintain an ideal weight, some individuals may be inducing psychological strain more harmful to health and quality of life than the consequences of additional pounds (Johnson, 1990, p. 17).

Only one paper addresses the issue of nurses' feelings towards overweight clients. Peternelj-Taylor (1989) acknowledges the social distaste for excess weight, and challenges the accepted premise that nurses adhere to affective neutrality in their practice of nursing. She examined the effect of patient weight and sex on evaluations, attributions and care delivery decisions formed by nurses. Analysis demonstrated that obese patients were evaluated more negatively than normal weight patients, although nurses did not indicate withdrawal from them.

A study by Santopinto (1990) explores the relentless drive to be ever thinner using a phenomenological method and the nursing theory of Rosemary Parse. While clearly illuminating the pain of such a relentless drive, in keeping with the chosen methodology and this theory of nursing there is no critique of the source of such a relentless drive, and what its consequences might be. Boyd (1990) describes the use of a belief clarification approach to intervention in order to examine and describe twenty women's attitudes and beliefs about being overweight. The overweight experience is discussed in terms of unrealistic expectations of dieting and weight loss.

Promotion of exercise is an area frequently covered, usually as an adjunct to reduction dieting but occasionally as a programme to increase the feeling of well-being for large women. Jackson (1992) describes some pioneering work by Health Visitors in Britain, who run shared swimming sessions for very large women who might be unlikely to swim more publicly. They write enthusiastically of the benefits described by the women and

appear, unusually, to regard weight loss as a serendipitous outcome. Gillett (1988) selected moderately overweight middle aged women to study factors that influenced their compliance with an exercise programme. This paper contains a realistic assessment of the issues women in general and large women especially may face in trying to exercise. Gillett describes issues of comfort, size, alienation, poverty and transport and in so doing moves closer to the articles in the next section.

White (1982, 1984, 1986, 1991) represents the only example found of ongoing nursing research into this area, but her focus is more particularly on the area of eating disorders with little and sometimes no mention of obesity. White and Schroeder (1986) attempt to determine if femininity, body image and feminism were related to a decision to seek treatment for obesity. Amongst other findings, White discovered that whilst obese women had more negative body images they did not have more negative self images. This finding is interesting, in that it is quite contrary to the wealth of psychology and nursing literature on self esteem and obesity, which associates obesity with a negative self esteem and self concept. White uncritically uses the term obesity to describe women who are only 16lbs overweight, and also assumes that being feminist would cause increased motivation for self care of 'obesity'. White (1986) discusses and tacitly endorses the usefulness of a behavioural approach to weight reduction for obese clients.

In the nursing literature examined thus far there is scant evidence of any recognition that the medical discourse may be flawed and furthermore unsuitable as a basis for nursing practice. This literature largely accepts the undesirability of obesity at any level, and there is tacit support for reduction dieting and also for other more drastic means of weight control. The literature examined so far does not acknowledge gender as a contributing or modifying factor to women's concerns about body size, and to their role as feeders and nurturers of others. In summary this literature has been medically mechanistic in its approach to human beings whose body size does not conform to medically sanctioned and albeit culturally sanctioned norms.

For this reason the examination of nursing literature has revealed an almost complete absence of anything which could be characterised as a clear discourse of nursing, easily recognised as discrete and separate from medicine. The articles reviewed are characterised by an acceptance of received wisdom, most commonly through the auspices of medicine. Contrary to a review of nursing theorists' conceptions of health (Woods et al., 1988), there is visible adherence to the simplistic notion that large body size is a diseased state and health is only attainable in the absence of disease. Most crucially, the literature in this area very rarely arises from nursing research.

The next, very small, collection of literature most closely resembles what could be described as the discourse of nursing. There is more attention to holistic concepts of health and medicine is relegated to a contributing rather than overarching focus.

3.5.3 Nursing literature which is congruent with a discourse of nursing.

This section considers the work of just four nurses who have written about body size in a manner which demonstrates congruence with the broader focus of nursing. Rossi (1988) writes of feminine beauty, the impact of culture and nutritional trends on emerging images, and speculates as to the causes of the epidemic of eating disorders in women. In discussing the broad area of eating, dieting and cultural specifications for appearance, Rossi notes that studying women's experiences and perceptions, and speculating as to the meanings of these phenomena, would likely yield gender-sensitive knowledge that could be very helpful in adding to the theoretical base of nursing practice. She states categorically that reduction dieting does not work, one of very few authors to carry this information into nursing literature.

By 1991, White (whose earlier literature was reviewed in the previous section) had developed her understanding of feminism considerably and begun to critique traditional biomedical approaches to eating disorders. She now views food and size as a complex area for most women with many expressing some aspect of a continuum of distress. She suggests that demedicalisation of disordered eating and the development of symbolic interpretations of women's bodies from a feminist rather than a patriarchal perspective will mean a re-examination of women's eating and women's perceptions of shape, weight and body image.

McBride (1988) takes what seems to most closely espouse a holistic approach in a comprehensive paper which ranges across the multidimensional causes and consequences of many issues related to food, size and disordered eating. She proposes an appropriate nursing response to this area which is multifocused, and which hinges on what a person may decide to do after discussion and exploration. This, it is suggested, may often involve learning to accept the current size without intervention, or planning small lifestyle changes with aims other than the traditional one of weight loss.

In an edited text devoted to holistic nursing practice, Dossey (1995) provides a chapter entitled weight management. Unlike much other nursing literature this chapter is based on very recent research about 'eating more to weigh less' (p. 459) and acknowledges the set point theory and the value of low fat/high complex carbohydrates as a healthy eating

pattern. It does not invoke medical authority to justify weight loss, but is entirely client focused and proposes highly sensitive methods for working with people who are uncomfortable at their present weight. Not all nurses however would find the practice of guided imagery acceptable to their practice.

In summary the nursing response in this second area is seen to be very small. I find it difficult to assess whether it is indicative of an emerging discourse within nursing research and practice, but it seems more likely at this stage that, apart from the overtly holistic nursing focus, it is not.

3. 3.4. Conclusion.

The nursing literature in the area of study is, in general, supportive of medical discourse about body size. The uncritical acceptance of medical discourse without recourse to nursing research allows a level of practice which has a poor fit with our oft-repeated allegiance to holism. Some articles (Black & Mangan, 1991; Miller, 1992) adopt a response to bodily largeness which is moralistic rather than caring.

The nursing literature largely ignores available literature from other disciplines which would support a more humane and multifocused response to body size and to disordered eating. The literature reveals potential for nurses to reconsider their response to women whose bodies are large, and to avoid intensifying the social castigation which is already extended to large women. Given the inconclusive relationship between, at least, low levels of obesity and poorer health outcomes, there is clearly potential for nurses to work alongside women to maximise their health potential without focusing exclusively on reducing body size. But nurses and the women about whom they may care are further subject to the dominant popular discourses in which medicine and the discourses of femininity predominate.

3.4 Populist or dominant discourses.

By populist I mean the way in which women speak to each other about body size, and the vehicles through which women receive instruction and inspiration related to the management of their bodies. I include the word dominant because it is in effect the way in which knowledge and truth about body management is currently articulated for public consumption. Amongst the wider discourse about general bodily enhancement and improvement, there is a specific message about the desirability and the means of achievement of the smaller body for women especially. This message is embedded in

women's magazines, self-improvement health and beauty texts and the items for sale in mail order catalogues. Currently there is an interesting shift occurring in public discourse as reduction dieting is increasingly discredited, but the desirability of a small body continues to be vigorously promoted.

A populist discourse is primarily a textually mediated discourse which Bordo (1993, p. 104) notes incorporates 'an explosion of technologies aimed at bodily correction and enhancement'. Almost without exception this is aimed at women rather than men given that it is almost always a woman who models the thigh reducer, the abdominal flattener and the buttock tightener in sales catalogues, or speaks to us of her recent success in a revolutionary 'new' diet.

Bordo (1993) suggests that advertisers are aware and utilise knowledge of the ways in which women's lives are difficult or out of control. The advertisements both sell products and simultaneously teach gender- appropriate behaviour. They prey on women's deepest insecurities to create a demand for products which offer improvement, acceptance, approval and even salvation.

Since the 1970's there has been an unprecedented rise in the availability of diet clinics which will supervise reduction dieting for payment. World-wide there are several major international diet companies and the profit in America alone has, as already noted, been estimated at thirty three billion dollars annually. Statistics from such companies are not willingly released, but the failure rate of their supervised reduction dieting has been variously estimated at between 95-98% (Atrens, 1988; Kissling, 1991; Miller, 1991 and many others). By failure it is meant that the weight lost is regained within approximately two years. Of even greater concern is the knowledge that the regained weight is often 2-3kgs in excess of the pre-diet weight (Polivy & Herman 1985). In other words an extraordinary amount of money is being spent on a process and products which do not achieve the outcome for which they are designed.

The diet industry maintains an intensive advertising campaign waged through special offers, 'all new' diets, lifestyle counselling from self-designated counsellors and heartfelt advocacy from the newly, albeit temporarily, slim. Unrealistic claims do not appear to generate complaints of false advertising. A 'Six Day Bio Diet' (*Sunday Star Times*, 2 June 1996) invokes the rhetoric of 'science has proved' (Code, 1995), by inviting interested persons to call Bio Science Nutrition. It offers a five kilo weight loss in six days through a diet which: 'is a safe and effective cleansing programme ... you can clean out toxins, speed

up your metabolism and work off some fat reserves — while we ensure you get all the nutrients you need on a daily basis'.

The headline states 'Nothing comes from doing nothing' and goes on inevitably to link good health and even a healthy mind with weight loss. This six day bio diet also promises to change the bad habits of a lifetime. Given that there is clear evidence to contradict such claims this would seem to be a flagrant case of unchecked false advertising.

The link with science, and particularly medicine, is often made explicit in mail order catalogue items. Frequently, scales are designated as 'doctors scales' which suggests their greater accuracy or perhaps their added authority. A recent advertisement for an electronic diet computer (Innovations '95 mail order catalogue) offers the chance to be minutely and exactly aware of your daily caloric intake, and to assess total energy, protein, cholesterol and sodium of more than 2000 pre-programmed foods. The advertisement notes that this is 'just like having a personal dietician.'

Some medical practitioners have utilised their social authority to undertake entrepreneurial activities related to reduction dieting. Several published books have physicians as authors, and sell reduction diets by making overt links to illness fears and apparent scientific dieting advice.

In the case of Dr. Robert Linn (1980), dietary advice is also combined with a strongly negative assessment of fat women which is couched in moralistic tones and not presumably derived from his particular training as a doctor of osteopathy. Linn (1980, p. 72), asserts that fat women are 'down on men' and sees fit to warn overweight women that in being large they will be unable to be considered as 'a purely physical object'. He also makes many assertions about the gluttony and lack of self control that supposedly characterises large people.

Another good example can be found in the well known Scarsdale diet, which was prepared and marketed by Herbert Tarnower M.D. using a ghost writer. Typically this diet evokes medical authority yet the diet is faddish and nutritionally unsound. Berland (1983) in assessing a wide range of reduction diets, notes that amongst those written and marketed by medical practitioners there is no reduction in the number of claims which are either unsubstantiated or directly contradicted by the scientific knowledge of the time.

A particularly strong aspect of the populist discourse is its use of humour. Here the myths and stereotypes about fat people and their assumed eating habits abound. Here also, fat people are seen to be objects of derision rather than concern. In *Metro* (April, 1996) [a good quality magazine with wide readership and in depth journalism], the humorous and satirical gossip column made fun of Sarah Kate-Lynch, at the time the editor of the *New Zealand Woman's Weekly,* on the basis that her body size falls a little outside presumed norms. She was referred to as 'Sarah Cut-Lunch, finger food fancier and editor-in-large of that alarming organ the *New Zealand Woman's Weekly*'. The item referred humorously to her fall from a horse on a public beach and showed more concern for the horse than it did for her. In this short piece are assumptions about her predilection for food and a degree of censure for a larger woman engaging in a sporting pursuit.

The same assumptions about predilection for food are present in *Chaff*, the Massey University student newspaper (May 6th, 1996). A cartoon shows several substantial people eating in McDonalds. The caption reads 'The "It's O.K. to be fat day" parade was considered a failure when it failed to get past McDonalds'. The results of the American Consensus Development conference on obesity, discussed earlier in this chapter, were delivered to the public in a particular way. A story reporting the conference in *People* magazine showed a picture of a heavy woman lying in a coffin surrounded by a wreath of empty candy wrappers. Whatever the subtlety of the actual findings of the conference, the relatively non-discerning members of the public received an unequivocal message that fatness stems from food indulgence and results in death. It is not only death with which large women are threatened. Additionally populist discourses warn of the undesirability to men, of a women who has a large body.

Recently, one of the major diet companies ran a television advertisement which featured a woman announcing that 'the less there is of me, the more of me he wants'. Despite increasing comment, both scientific and in the populist media, that reduction dieting does not work, there is no apparent abatement in the vigorous promotion of this process by the diet industry. In the wider populist media there is, however, evidence that this particular discourse is subtly reforming to exert the same pressure in a slightly different guise. A *Kellogs* cornflake packet currently announces that 'Dieting is the worst way to keep in shape' but the words are placed over the picture of an extremely slender young woman playing on the edge of the sea in the presence of an admiring male. The packet contains a recommendation for a Special-K breakfast which has all the hallmarks of a reduction diet: measured portions, skim milk, half grapefruit and black coffee.

Similarly *Next* magazine [glossy women's magazine] concludes the article mentioned above, about the failures and problems of reduction dieting with the following comments:

> Of course the real reason diets maintain such a grip (a reason the non diet groups are careful to avoid) is that thin girls look better than fat girls.... If you're not thin, you have to rely on alternative traits. Personality? Wit? Wealth? Talent? They might be more enduring. They're also less likely to turn heads... it might take a post-apocalyptic famine to make us see fat on the female body as something beautiful (*Next*, December 1995, p. 64).

Such a statement significantly nullifies the likelihood of any reader taking seriously the carefully proffered advice on national support and pressure groups aiming to help women break the diet cycle.

Some aspects of the populist discourse manage to combine writing sympathetically about the problem while simultaneously working to increase the constraints imposed. The *Evening Standard* (July 4th 1996) carried an article entitled *"Togs need not be traumatic"*. It notes the universal anguish engendered in women who must purchase a bathing costume, and reports the enormous efforts of the industry to respond to feminine misery with remarkable engineering feats and the use of new fabrics. It notes:

> They're enhancing and minimising. They're shirring and cinching. They're underwiring, skirting, spot controlling, wrapping, moulding, reshaping and power padding ... 'Women don't feel comfortable in their own skin' opines Jay Feigenbaum, president of SwimShaper, maker of a line called Miraclesuit which claims to trim off 4.5kgs visually.

Women readers of this article may not be reassured by such effort and concern. Rather, they may gain the clear message that to appear on the beach in their comfortable old swimming costume, revealing their body as it is, may amount to serious negligence. Populist reporting of women's distress thus serves to normalise the distress. As the article falsely reassures 'The sole comfort in this misery is the chorus of moans issuing from other dressing cubicles. In this ritual of self humiliation, at least we do not suffer alone.' The ever present populist diet discourse embedded in magazines and diet industry advertising depicts each dieter as a person who is easily led into sin due to their lack of will power or moral fortitude. Diet books often talk to the reader in an understanding, sympathetic (and often accurate) way, as the woman who has tried absolutely everything and failed. But as Spitzack (1990, p. 160) points out; 'at the same time the new book offers to be the final salvation and the final rescue from the damnation

of living outside the scriptural requirement for thinness'. The inertia that the large woman feels is again compounded. Her distress and despair at failed dieting is being acknowledged, but at the same time she is being exhorted to try yet one more time.

Both dieting and small size have taken on particular meanings in both performance and discourse. Nichter and Nichter (1991) note the production of a particular ideology at the site of the body. The slim, toned body has become a form of cultural capital which is promoted expressly and intensely through the auspices of popular media. Of particular note is their reference to a process described as inoculation. An inoculation effect, according to Nichter and Nichter (1991) refers to an apologistic stance wherein one distortion or evil is admitted, permitting greater distortions to remain concealed. This is vividly demonstrated in current popular press products, where one short article on the epidemic of eating disorders is inserted between lavish fashion and dieting advertisements which show ultra thin models living the fantasy of an apparently perfect life.

3.5 Conclusion.

Dominant framings of appropriate body size for women are vigorously present in the various discourses of medicine, nursing and the popular media. This chapter has, by virtue of reviewing relevant literature, explored the dimensions of the major discourses available to women in the area of body size.

In the previous chapter I noted the work of Purvis and Hunt (1993) who comment on the degree of coherence within discourses which can be recognised as specialised or technical or grounded in seemingly authoritative research. Purvis and Hunt note that the authority of any such discourse is particularly strong. The review of literature I have undertaken has demonstrated the power of dominant medical discourse and the hegemony which ensures its infiltration into nursing and populist discourses.

This fits with the Foucaldian understanding of discourse as a particular set of constraints on writing, thinking and speaking about a given social object or practice at any particular point in history. There is very little space or opportunity to understand or speak of the large woman's body, other than as an object of pathology and concern. Such is the authority of dominant medical discourse that it overrides nursing considerations of caring and of conceptualising health in an holistic manner. Such is the exercise of power through the interplay of these particular discourses.

Reviewing the literature in this manner raises many questions about the silent voices of large women. Living largeness appears to mean living within a set of assumptions and expectations and to be compellingly interpellated into the dominant medical discourse. The choice of feminist research as introduced in the next chapter is designed to facilitate through dialogue an opportunity to speak of the experience of largeness. In that dialogue, dominant discursive views of the experience are regarded critically and their assumptions challenged.

The next chapter addresses the dimensions and implications of undertaking research from a feminist perspective. Political and epistemological assumptions will be examined, and meanings as they apply to this project will be explored. The choice of feminist research is congruent with the aim of providing a group of large women with the opportunity to both contribute to and gain from a project which explores their experience of largeness. The second, though no less important, aim is to generate knowledge of value to improved nursing practice given that the literature review has clearly demonstrated the need and potential for improvement.

CHAPTER FOUR: Feminist Research

4.1 Introduction.

The previous chapter demonstrated that body size is a personal and a political issue for women, so it is entirely appropriate that the methodological approach to this work is feminist. The choice of feminist research acknowledges that gender is at the centre of the enquiry and the area of concern is an aspect of women's lives. In choosing feminist research I am building on an increasingly rich and diverse body of work.

This chapter begins by articulating the meanings inherent in feminism. A brief description of postpositivism is provided, followed by an overview of the development of feminist research. The suitability of feminist research for nursing is argued and a range of epistemological and methodological issues is examined.

My concern has been to carry out research which will not leave participants with a sense of having been passively studied, as if their body size alone is a problem for research interest. It was important to me to convey a sense of the shared construction of knowledge which would problematise our positioning as large women in a social context which imposes rigid requirements on women's bodies. My overriding concern, however, was to do research which would generate knowledge of direct pertinence to nursing practice.

4.2 Feminisms.

Positioning feminist research occurs in a context where both feminisms and feminist research are unstable categories undergoing considerable shifts and an ongoing evolutionary process. There is no simple definition of what it means to operate from a feminist perspective; in fact as feminist theory develops, such a definition has become increasingly complex. I concur with Lather (1988) when she suggests that feminists see gender as a basic organising principle which profoundly shapes and mediates the concrete conditions of our lives. Lather describes feminism as, among other things, a way of attending or looking through a particular lens which brings particular things into focus in particular ways. Feminists generally agree, at the most simple level, that women are oppressed and disadvantaged by virtue of being women, although they have differed over the reasons for that oppression.

As feminist theory has developed, an emerging theme is that the concept of oppression goes beyond the simple oppression of women themselves and focuses increasingly on the general disprivileging of the feminine throughout the entire fabric of social life. Feminist critique which began with the structural realities of women's lives has extended to the development of an articulated critique in areas as diverse as philosophy, the natural sciences, theology, socio-biology and the history of art and literature.

Hall and Stevens (1991) suggest that there are points of useful intersection across feminisms in the sharing of three basic principles. The first of these is a valuing of women and a validation of women's experiences, ideas and needs which is followed by a recognition of the existence of ideologic, structural, and interpersonal conditions that oppress women. Finally, feminisms as seen by Hall and Stevens, involve a desire to bring about social change of oppressive constraints through critique and political action. An essential aspect of feminism is the rejection of dualism and objectification and a movement towards a more balanced understanding of everyday experiences (Parker & Mcfarlane, 1991). Feminist theory therefore, involves ontological issues that extend far beyond the oppression of women and involve a very real challenge to the deepest social structures which consign men and women to particular ways of being and living in the world.

4.3 Postpositivism.

The feminist critique in science has both coincided with and arisen out of the possibilities created by the development of a postpositivist and post modern era. There are essential differences, between what are called the positivist and the postpositivist paradigms. Differences are best explained at the axiomatic rather than the methodological level (Lincoln & Guba, 1985). In the positivist paradigm the ontology is construed as single, objective and 'out there'. The whole of reality is the sum of its discernible parts, any of which can be studied independently. Epistemologically there is a clear separation between the researcher and the researched. There is always the possibility of generalisation in that the findings from a representative sample are considered able to be applied more widely. Discovering causal relationships is a major goal of positivism and it is considered that value-free inquiry can be achieved through adherence to objective methods which are not viewed as problematic.

Conversely, the postpositivist paradigm subscribes to multiple constructed realities and a belief that the inquirer and the object of inquiry interact and are inseparable. It is

recognised that the process of observation acts upon the observed and creates change. Postpositivists argue that generalisation is unattainable and undesirable and prefer to talk of transferability meaning the degree to which information gained in one setting can be considered to have value in another setting.

Instead of the notion of causality favoured by positivists, there is a preference for *mutual simultaneous shaping* (Lincoln & Guba, 1985, p. 151). Understanding does not depend on ascertaining cause and effect, but rather on selecting out of the 'complex of mutually interactive shapers ... those that afford some meaningful perspective in relation to the purpose that the investigator has in mind' (p. 151). In this paradigm the possibility of being value free is seen as naive. Value is recognised as intruding on everything from the choice of problem to interpretation of the findings and the subsequent utilisation of those findings.

The development of postpositivist research is pertinent to this project in that so much previous research in the area has searched for a particular truth about the causes or consequences of obesity. The focus has been to look within the body and mind of so called 'obese' individuals to locate causes of triggers to an aberrant body. In this work a meaningful perspective is sought from which nursing might begin to develop improved practice.

4.4 Feminist Research.

4.4.1 A brief overview of the development of feminist research.

I have chosen to review the development of feminist research within a framework derived from Evans's (1995) concept of the three differences. Evans describes these as equality, difference, and difference within or among women. In essence these three notions represent conceptual thinking within feminism across the last thirty or so years and have, to a large extent, been mirrored in the research interests of feminists.

4.4.2 Equality.

Feminist research began with relatively straightforward concerns about the absence or invisibility of women in existing research projects. There was concern about the tendency to use male subjects only, then generalising the results to the population at large. Acker, Barry and Esseveld (1983, p. 424) speak of attempts to deal with the 'exclusion, distortion and neglect of women, as producing many useful theoretical and empirical studies'. In the 1980s research began to expose the taken-for-granted nature of women's work in areas

such as unpaid caring and housework (Oakley, 1985; Finch & Groves, 1982; Graham, 1985). Such work extended beyond the inclusion of women as subjects or participants in research to widening the range of areas of research interest to include the lives and work of women.

In this context, Mies (1983) defined feminist research as that research which tries to make women's needs, interests and experiences paramount and thereby to become instrumental in improving women's lives in one way or another. The ideological underpinning of earlier feminist research began as an acceptance that women are oppressed and that the research should work towards addressing fundamental power imbalances (Stanley & Wise, 1983). There was agreement that a major aim of the research was to carry women's multiple voices into forums where they had not previously been heard, except through the screen of objectifying or androcentric research.

The concept of women's voices was predicated on eliciting knowledge based on women's experience, and it assumed a value in getting to the 'centre' or learning the truth of previously repressed or devalued women's experience. The focus on women's experience supported feminist examination of key issues such as the sexual division of labour; the allocation of separate spheres, public and private; unequal allocation of resources; diminished political voice and, under capitalism, the commodification of women's bodies as objects. There was, in the simpler context of equality, considerable clarity about the appropriate focus or topic of feminist research. Inevitably feminist theorising around equality raised questions about the nature of men and women and the reasons why social structures had developed and were maintained in particular ways. This led to the next stage of the framework; difference.

4.4.3 Difference.

A focus on difference assumes that men and women are dichotomous categories with their own natures and perspectives. Thinking between the categories ascribed may negate the multiple differences that can arise from within the same category. Hence there arises the possibility of stereotypical notions of masculinity and femininity and all that that implies.

In this context the interpretive framework of research was rendered problematic. Gilligan's (1982) study of moral development demonstrated that girls were not stunted in their moral development, as previous frameworks, predicated on research on young boys, had suggested. Rather, Gilligan argued that girls demonstrated a pattern which was appropriate for them and revealed different ways of acting in a moral fashion.

This context supported a tendency to valorise women's ways of knowing (Belenkey, Clinchy, Goldberger & Tarule, 1986). Lewin and Olesen (1981) studied nurses' career patterns and found that female nurses viewed lateral growth which increased their degree of satisfaction as success. This was in contrast to the masculinist hierarchical growth previously assumed desirable and used as a standard against which achievement or satisfaction was measured. Fine (1992) in her work with disabled women found that previous research had imposed inappropriate frameworks which had overlooked the multiple roles or statuses of disabled women as women and focused on their disability in a manner which negated their specific context. The value of such research cannot be underestimated but a growing concern developed about the political consequences of arguing for innate difference between men and women. If such a difference existed it could be seen as a reason to retain the status quo for women's inequality.

4.4.4 Difference among women.

Earlier feminist research uncritically accepted the category 'woman' but feminism's growing alignment with postmodernist thought made the category inherently problematic. Previously uncritical usage of the term 'woman' became open to criticisms of essentialism. Essentialism refers to the attribution of a fixed essence to women. This essence is inevitably linked to biology, to naturalism and sometimes to psychological characteristics such nurturance, passivity and emotion. The existence of essentialism leads to universalism (Grosz, 1990, p. 334), which "tends to suggest the commonness of all women at all times and in all contexts".

Postmodernist thought in its rejection of metanarratives and totalising theory has called into question the usefulness of an overarching category 'woman'. Postmodernism challenges both equality and difference, and draws attention to difference among women. It therefore resists the possibility of an all inclusive social theory or a unified political practice.

For this reason a number of feminist writers have questioned the value of postmodernism. Hartsock (1990, p. 163) has asked:

> Why is it that just at the moment when so many of us who have been silenced begin to demand the right to name ourselves, to act as subjects rather than objects of history, that just then the concept of subjecthood becomes problematic?

Simultaneously there has been criticism from women of colour, disabled women, lesbians and third world feminists challenging white academic feminists' uncritical assumptions about understandings of women's place in the world. hooks (1990, p. 22) summarises the criticism as the tendency to speak for or 'to know us better than we know ourselves'.

Inherent in such criticism is the question of voice. The issue is raised as to how participants' voices are most accurately heard, through what forum and with what authority. Code (1991), in addressing who can be a knower, asked who can speak, from where and when and about what, meaning who can speak from one's knowledge. Code drew on Wittgenstein's notion that knowledge is based on acknowledgement, in asserting that knowledge is created in the presence of the expectation of being heard and taken seriously.

Theorists such as Harding, Fraser, Benhabib and Bordo have questioned postmodernism for the same reasons as Hartsock (1990). They posit the potential loss of coherency and the loss of a distinctive theoretical perspective when there can be no sense of unity in the category woman. Gatens challenges this in saying:

> To say 'woman' has no essence, that she is a constructed 'fiction', a product of social narratives and practices is not to say that she does not exist... To hanker after an *a priori* category 'woman' for the convenience of theorising, is to betray one's allegiance to the pretensions of the modernist narratives... To acknowledge the social construction of women does not entail the abandonment of critical theory or the spectre of relativism. Rather it calls for a commitment to an historical, or genealogical, approach to understanding the specificity of social, political and ethical relations as they are embodied in this or that community or culture (Gatens, 1991, p. 23-24).

Davies (1992) extends the argument further and reclaims the space as a woman by saying that when she talks of the experience of being a woman she refers to 'the experience of being assigned to the category female, of being discursively, interactively, and structurally positioned as such', (p. 54). This particular stance is relevant to this work as the concept of positioning is integral to understanding the play of discourses about bodies and body size, and to understanding the way the experiences of large women are 'constituted through and in the terms of the existing discourses', (p. 54).

Perhaps from this perspective, Bordo (1991) argued that it is possible to acknowledge that the experience of being, for example, a woman of colour in a racist culture will create

some similarities of position which will span class and gender. In the same way I have engaged in this thesis believing that the experience of being a large woman in a culture which prefers woman to be slim, and actively reviles largeness, will generate similarities of experience which are worth exploring and articulating.

There is always the risk that generalising in any category tends to call attention to similarities and to neglect or mask differences (Martin, 1994). But Bordo (1991) argues for not overlooking the profound commonalities which do exist in the experiences of different groups of women. I have carried out this research believing that the surfacing of those commonalities in the experience of women living in large bodies and an exploration of the related social patterns will be useful for those women themselves and will have the potential to generate useful information for nursing.

Nicholson and Seidman (1995) note the difficulty in focusing on the interrelation of social patterns when one is committed to avoiding totalising or essentialising analyses. Nevertheless, they argue:

> that it is possible for postmodern thinkers to focus on institutions as well as texts, to think about the interrelations of social patterns without being essentialising or totalising, and to create constructive as well as deconstructive analyses of the social (1995, p. 9).

In sum, feminist research has bridged a diversity of methods, content areas and epistemologies. Considerable impact has been made on both women's lives and the wider society by the knowledge and critique generated by such research. An important shift has occurred in that the research has moved from being *about* women to being *for* women, but there is no certainty yet as to how effective the research is *for* women. I have some concerns about the intensely theoretical nature of recent debates and their relative confinement within the academic community. This is pertinent to the next section in which I will consider the utilisation of feminist research within the nursing research community. This is both an academic community and very much an applied or practice discipline and, as such, the debate is important but the outcomes and applicability of the research for practice are paramount.

4.5 Feminist Research for Nursing.

Because of the essentially applied nature of the discipline of nursing, issues of equality, difference and postmodernist challenges to feminist research have not been overwhelmingly present in the small amount of feminist research in the nursing literature. But there is nursing interest in feminist research and in this next section I will consider why feminist research has much to offer nursing.

4.5.1 The need for more creative methodology in nursing research.

Nursing has long recognised the need for the ongoing development of a strong research culture. More recently, nurse scholars have come to consider the development and utilisation of research which offers a more comfortable fit with the ethos of nursing, and which will generate knowledge of particular interest and value to nurses.

Nursing as a practice discipline focuses on working alongside individuals in a wide range of contexts and situations. Nurses work with people to assist their transitions through normal life passages such as birth and death, and through experiences of crisis related to health and illness. Nursing also has a growing awareness of the contextually mediated choices and socio-political constraints which influence health status. For knowledge to have value to nursing it must offer explanation or illumination of the human experience in ways which allow growing reflection on the quality and applicability of our practice (Carryer, 1995).

This offers nursing the challenge of breaking new boundaries and gaining greater maturity as a discipline, in the process of experimenting to find new ways of generating knowledge free from the strictures of our past. Sandelowski (1993, p. 3) supports this in saying:

> The task for scholars in a practice oriented discipline is to find ways to apprehend and re-present these different representations to achieve the 'fuller knowing' that advances knowledge and influences practice.

Schutz (1994), in noting the credibility of qualitative research for nursing, believes the ongoing search for a more subjective and reflexive approach for nursing research will be painful but worthwhile. She suggests that by making use of an openly subjective approach there is the potential for a degree of partnership with participants which offers potential to generate valuable meaning and reconceptualise objectivity.

4.5.2 Support for feminist research in nursing.

Speedy (1991) argues that an increasing alignment with feminism by nursing will be useful for the development of the nursing discipline. She suggests this is because feminism has particular congruence with issues of concern to nursing. She particularly identifies the ethic of care, the centrality of patient or client, the reciprocity inherent in relationships between carers and cared for, and the importance of a healthy questioning of the appropriateness of traditional 'scientific' modes of thinking and research.

A natural progression of the growing alignment with feminism is increasing acceptance of and experimentation with feminist research. There is a small but growing body of feminist research from a nursing context, in published literature, such as Webb (1984); MacPherson (1985) ; Dickson (1990); Thompson (1991); Anderson (1991); Seibold, Richards & Simon (1994). Other nursing authors have published commentary on the suitability or applicability of a feminist focus in research for nursing. These include, amongst others and in addition to those already mentioned, Sampselle (1990); Speedy (1991); Morse (1991); Allen, Allman & Powers (1991); DeMarco, Campbell & Wuest (1993); King (1994) and Sigsworth (1995). Wuest (1995) and Keddy, Sims and Stern (1996) are nurse scholars who have explored the epistemological congruency of feminist research with grounded theory, a frequently used method within nursing research.

Feminist research allows for the possibility of carrying out research in a way which is ethically acceptable to the caring role of nursing. Distancing, objectification, and manipulation are at odds with the caring ethic, giving nurse researchers a high level of cognitive dissonance and placing them in an untenable position. Anderson (1991) addresses these issues, noting that as long as intervention by a researcher/clinician is seen as a dilemma and as a threat to obtaining reliably objective data, then this is not an appropriate situation for nurse researchers.

In considering feminist research, nurses need to clarify just when such research would be most appropriate. Clearly some research questions lend themselves to feminist research as the researcher comes to see that female gender issues are very central to the inquiry. The centrality of gender may not be all that feminist research entails or has to offer. It may be that the methodology itself will allow for methods of collecting information which fit comfortably with the ethos of nursing (Carryer, 1995).

Support for feminist research also comes from the slow growing mandate within nursing for a social activist role. Chopoorian (1986; 1990) has challenged nurses to go beyond dealing with health crises on a one-to-one level and to begin to address the socio-political

determinants to health status, especially issues of race, class and gender oppression. Hall and Stevens (1989) echo the call to reconceptualise the environment in nursing by incorporating the socio-political sphere. Butterfield (1990) and Kleffell (1991) describe the need to move beyond simple downstream nursing and widen our conceptual base to include a focus on what is happening to our clients upstream. Bunting & Campbell (1990) together with a growing number of nurse scholars, advocate for a synthesis of feminism and nursing in order to best meet the health needs of clients, especially women. Feminism as a relevant and powerful world view could inform nursing science in a way that might render it emancipatory as well as knowledge generative.

4.6 Epistemological issues.

In the previous section, in the exploration of the development of feminist research, epistemological issues have already been addressed. For clarity they are summarised here using terminology most usually attributed to Harding (1987, 1989). She has identified three feminist epistemologies which have been in existence concurrently. These are feminist empiricism, feminist standpoint and feminist postmodernism. These can be seen to have some degree of fit with the previous framework of 'equality', 'difference between' and 'difference within'.

Feminist empiricists seek what they see as a more objective truth by eliminating gender bias from the research process. They are less likely to be critical of research predicated on a positivist basis, but will critique the absence of women as research subjects. In feminist standpoint theory the context becomes important. Harding (1987, 1989) says that for a position to count as a standpoint it must be grounded in the objective location of women's lives. Standpoint theory, according to Harding, focuses on gender differences; on the differences between women's and men's situations which give a useful resource for generating theory about women's experience. According to Hekman (1997) the original formulations of feminist standpoint theory rest on two assumptions,

> That all knowledge is located and situated, and that one location, that of the standpoint of women, is privileged because it provides a vantage point that reveals the truth of social reality (p. 350).

Hekman (1997) goes on to suggest that an important concern of feminist standpoint theorists has been to provide a position which can simultaneously accommodate difference whilst creating space for the analytic and political force of feminist theory. In

critiquing the work of Nancy Hartsock, Sandra Harding, Dorothy Smith and Donna Harraway, Hekman illuminates the sheer complexity of feminist epistemological debates, particularly at the points where feminist standpoint and feminist postmodernist theories intersect.

Feminist and postmodernist thinking both present a challenge to the basic epistemological foundations of Western thought. They share the impetus of finding different ways to describe human knowledge and the methods of its acquisition. Postmodernism problematises existing 'truths' including accepted notions of power, knowledge, truth and gender, and challenges their role in social structures.

4.7 Methodological issues.

Feminism is not a research method but rather a philosophical stance which can be used to underpin the research. Acker, Barry and Esseveld (1991) propose three principles which underlie feminist research. They are: (a) knowledge produced by the research should be useful for the participants, (b) the research method should not be oppressive, and (c) the research method should be reflexive allowing for reflection on both the intellectual traditions and the progress of the study.

Bernhard (1984) provides a slightly more comprehensive list of criteria. These criteria state that the researcher should be a woman, and that the methodology used should be feminist, that is it should include researcher subject interaction, non-hierarchical research relationships, expressions of feelings, and concern for values. The research must have the potential to help its participants, study women and focus on their experiences, use the word feminism, cite feminist literature and avoid sexist language.

Feminist qualitative research, like interpretive work, focuses on intersubjectivity between the researcher and the participants. But feminist projects have tended to develop this aspect beyond most other qualitative researchers working with participants to develop modes for their participation, collaboration and overall contribution. This has posed particular challenges, especially in the handling of diverse views from women who challenge feminism (Hess, 1990), and the possible risk noted by Opie (1992) that the researcher might subsume participants, focus or direction to the researcher's own agenda.

4.7.1 Feminist ethical concerns as they relate to methodology.

Feminists have been critical of the traditional scientific approaches for treating the researched in ways which could be described as unsafe, unjust and oppressive. There is a long history of the manipulation, exploitation and deception of the subjects of research, (Mies, 1983; Reinharz, 1983; Fox-Keller, 1985). Doubtful research behaviour has tended to be justified on the basis of the suffering of a few benefiting many.

For feminist researchers there are complex ethical issues, including the risk of exploitation, the need for empowerment of the participants and the experience had by participants in the course of contributing to research. Issues of authorship, collegial relationship and the presentation of findings present ethical challenges which are not similarly viewed by non-feminist researchers. For knowledge to emerge which is not oppressive, it should be developed through dialogue rather than one-sided questioning (Mies, 1983). I believe this has been a particular feature and strength of this research project.

Thompson (1992) summarises ethical concerns in feminist research into two areas. She believes we should first ask if the research is either exploitative or empowering of participants and others, and then ask how oppressive objectification of participants can be avoided given that any method has the potential to be oppressive. Meeting these ethical concerns is not simple or straightforward, and feminist researchers have sometimes reported the challenges of carrying out completely ethical research on feminist terms (Maguire, 1987; Hoff, 1988).

Some of the difficulties include combining scientific with political and ethical concerns, addressing the intense needs of women in some settings within the strictures of a finite period of research, and the dilemma of raising the consciousness of women for whom no real concrete change may be guaranteed. Such concerns are highly pertinent to my particular study which is by necessity confined to a relatively limited time frame, and which has undoubtedly brought to the surface issues for the participants which are not easily addressed.

Thompson (1992) notes that feminist research should be characterised by a concern for social justice which includes both equality and freedom. Equality implies equal participation and treatment with respect for differences. Freedom means that people have the right to define themselves and their situation apart from the standards, constraints, demands and agendas of others. This was especially pertinent in terms of my

need to demonstrate respect for the participants who were enrolled in a diet programme during the study.

4.7.2 Method and analysis in the context of feminist research.

To date I have been describing a broad understanding of methodology and methodological issues. King (1994) describes this as the philosophical and value-laden underpinning of research. Now I intend to describe what is different or significant about the collection and analysis of interview or other research material when the research is feminist. The actual detail of method used will be described much more specifically in the next chapter.

No single method is seen as the most appropriate one for feminist methodology, but data collection methods have spanned quantitative methods, ethnography, narrative and life history (Shields & Dervin, 1993). The interview method has remained central but has also been the subject of debate (Oakley, 1981; Ribbens, 1989; Cotterill, 1992; Webb, 1993). Empowering methods such as reflexivity, critique and dialogue are used to promote the participant's increased awareness of power imbalances inherent in the area of interest. Value is placed on mutuality in which, as Hall and Stevens (1991) describe, participants are assumed to be truthtellers. Researcher-participant relationships, in research other than feminist, are more commonly noted for their power inequalities and these are seen as creating situations in which women are unlikely to feel comfortable when talking about what is really important to them. Mutuality is supported by researcher's behaviours which should be designed to foster a sense of give and take and receptive towards jointly working towards some understanding of and potential change to the area under study (Hall & Stevens, 1991). They also advise that there should be a sense of interest in the ability of each participant to convey something which is unique and of value to the study. Correspondingly, information about the researcher should be freely given as well as feedback on the course of the research .

It is often inevitable that the researcher will have more education and exposure to literature and may also be more articulate than many of the participants. This means that the researcher not only gains access to the immediate reality of a participant but then adds to that her deliberately informed understanding of the wider social context which constrains the participant's situation. The resulting 'text' is of course shaped by the academic discourse which the researcher brings. I experienced a persistent tension during this project, in negotiating what I saw as the requirements of research which is congruent with feminist epistemology, and the requirements of a credibly analytic doctoral thesis. I return to this tension in chapter twelve and discuss its origins.

To some extent this was resolved towards the end when I considered the potential reification of experience which has characterised interpretive work. Some feminist scholars (Scott, 1991; Allen, 1996) have argued that investigating experience may omit an examination of how that experience came to be. David Allen suggests that experience can retain a positivist notion as some type of incontestable evidence, and he advises retaining the idea that experience is in itself an interpretation and even that interpretation is open to challenge and reinterpretation. The process of analysing the participant's experience took place alongside against my growing knowledge and understanding of the context in which large women live their lives. Accordingly, the experience is not just presented as is, but framed in a potentially unstable but relevant socio-political context. The experience of embodied largeness as presented does not purport to be an incontrovertible or final truth.

The final methodological issue to be considered is that of who the research is for, or who it should benefit. Hall and Stevens (1991) note that feminist studies are designed, implemented and disseminated with the goal of providing for women explanations that they need for themselves about their own lives. This is quite different from the concept of providing answers about women for either the medical profession or a health agency, who may then use the information as they see fit. If, as in feminist research, the results are for women to both understand and perhaps transform their own lives, then generalisability is not an issue. In this study I have attempted to both offer a useful experience to the participants and give a vehicle for their voices to tell their stories, with the expressed aim of allowing nurses an insight into the participant's experience. How nurses use this information cannot be controlled by this study although I acknowledge the responsibility inherent in the fact that they may well use it as a guide.

4.7.3 Issues of reliability and validity within feminist analysis.

Addressing issues of reliability and validity in the context of feminist analysis involves a paradigmatic shift. Hekman (1990) outlines a move from redefining to reconceptualising objectivity. This argument involves challenging the objectivity/ subjectivity dichotomy. She notes that generally those who have rejected scientific authority assume that there are only two positions available: that of acceptance or of rejection; either there is objectivity or there is not. Challenging this dichotomy involves the admission of the human subject as a contributing part of the production of scientific knowledge.

There is no fit between empirico-analytical and feminist standards of rigour. To clarify this Du Bois, states that:

> dichotomous duality, linearity, and fixity are not the properties of nature nor of human life and experiencing. They are the properties of a learned mode of thought that casts reality into rigid, oppositional, and hierarchical categories (1983, p. 111).

Within the empiricist tradition, reliability means repeatability, in other words the ability to yield the same results from a repeated trial in a different setting. This negates both the unique nature of human experience and its contextual relatedness. Neither repeatability nor validity are therefore appropriate to feminist research, as the purpose is not to acquire information that will automatically have relevance to other settings. This contrasts sharply for example from a research project which might seek to ascertain the best form of wound dressing for a particular type of wound. Here the researcher may wish to recommend confidently, that an identified preparation will have the greatest usefulness for a certain wound in multiple settings.

Fleming (1994), in her own feminist research project, and drawing on Fay (1987), noted that replicability is not compatible with feminist emancipatory research. She suggests that in the process of presenting feminist research, readers are offered a surrogate experience with which they will inevitably engage and may then experience critical reflection on their own lived experience or on the conditions and quality of their practice if relevant. It may be that nurses reading this project will come to reflect on their views and attitudes towards the care of large women, and find some incongruence with their previously held views.

4.7.4 Issues of rigour.

Hall and Stevens (1991) building on the work of Lincoln and Guba (1985) consider that feminist research is best evaluated by standards of rigour that 'reflect the adequacy of the whole process of inquiry, relative to the purposes of the study, rather than by standards that focus only on the accuracy and reliability of measurements within the study' (Hall & Stevens, 1991, p. 20).

Hall and Stevens (1991) have described a series of criteria by which feminist investigators can plan rigorous studies and evaluate their own efforts. Their criteria are reflexivity, credibility, rapport, coherence, complexity, consensus and relevance. In carrying out this research I was mindful of these criteria in ensuring the validity of this piece of work. Issues of reflexivity, credibility, rapport, consensus, and relevance will be further explored in this and the following chapter.

These criteria build on the work of Lather (1986), who suggests that doing research with a reflexive approach ensures integrative thinking, an essential recognition of the relativity of truth, acknowledgement of ideology and admission of the need to make values explicit. The elimination of bias is considered both impossible and unnecessary but it should be explicit and addressed through continuous reflexivity. The quality of the interaction between the researcher and the researched is seen as contributing to the accuracy and relevance of the results by ensuring the full and open participation of the participant.

Because a feminist researcher makes no effort to remain detached or aloof from the discussion and actively dialogues with the participant, a degree of rapport is established. In my research this was particularly enhanced by the repeated interviews over a period of many months. A sense of trust, sensitivity and shared purpose developed, which Hall and Stevens (1991) following Oakley (1981) would suggest gives confidence that the research adequately reflects what is significant to the women in the study. Even so I have no illusions that all participants felt able at times to fully share their distress. There were times when the pain on a participant's face belied the relative lightness of her words.

Lather (1986, 1991) offers a reconceptualisation of validity which she deems appropriate for research that is openly committed to challenging the political order or working towards a change in the situation of the participants. She describes triangulation, construct validity, face validity and catalytic validity as components of reconceptualised validity.

Triangulation can be described as the use of multiple and diverse data sources and collection techniques, and a design which permits both description and interpretation (Staley & Shockley-Zalabak, 1988). In the next chapter I will discuss the presence of triangulation in this work.

Lather (1986, p. 67) says that: 'Emancipatory social theory requires a ceaseless confrontation with the experiences of people in their daily lives in order to stymie the tendency to theoretical imposition which is inherent in theoretically guided empirical work'. She recommends a systematized reflexivity which is able to demonstrate how *a priori* theory has been influenced or changed by the data. Construct validity is present in this work and can be shown by the self-reflexivity of many of the participants, as they begin to alter their own ideas in the face of the discussion and data. Fleming (1994), again drawing from Fay (1987), noted that it is the enhanced self understanding preceding political action that will test the construct validity of research.

If at the conclusion of the research participants are able to read the report and recognise the faithful representation and interpretation of their particular reality, then it is a valid representation of the data they provided. This fits with the third concept described as face validity by Lather (1991). A recycling of emerging analysis and written drafts through all participants led to participant comment on the accuracy of the work in giving voice to their experience.

Finally, catalytic validity refers to the degree to which the research process supports participants toward knowing their reality in order to feel energised towards transforming it. Lather explains this in saying:

> The argument for catalytic validity lies not only within recognition of the reality altering impact of the research process, but also in the desire to consciously channel this impact so that respondents gain self understanding and, ultimately self determination through research participation (1991, p. 68).

Reading the words of the participants in the relevant section of interview material in chapter eleven is the most accurate way of assessing the catalytic validity of this project.

Opie (1995) brings her own definition of rigour, noting the importance of the breadth of knowledge about the field brought by the researcher and the reflexive use of that knowledge. She also values the mode of interrogation of the data and the representational practices embedded in the writing. Opie concludes by stating that a rigorous practice depends as much on these dimensions as adherence to any particular method. I identify strongly with her comment about breadth of knowledge and reflexivity, believing these to have been particularly valuable in this work.

Hall and Stevens (1991) suggest that other feminist researchers can verify the adequacy of the literature review and provide scholarly critique of the process as it occurred. In this research I have experienced continuous involvement with other feminist scholars and presented the emerging work in feminist forums during the process. Specifically three publications during the course of the work have, in the process of editorial review, provided me with valuable and reflexive critique from more experienced scholars in the field of feminist research. Finally, one of my supervisors is an experienced feminist theoretician.

In general feminist research literature notes the value of emphasising the complexity of reality (Stanley & Wise, 1983). Exceptions are of vital importance and give full meaning to and voice to the area of research. People do not easily fit into the neat and tidy boxes of survey research, and much richness of data is accordingly lost. Feminist researchers argue that feminist research must be judged on its relevance to issues of importance in women's lives at the time of the research (Mies, 1983). The research question or questions should be judged on their applicability to serving women's interests and improving the quality of their lives. Hence the study should have clear relevance to women's lives at the time the project is carried out. I argue that this study is acutely relevant to many women's lives at the present time. During the course of this research I have been made continually aware of the relevance of the work by the warm reception it has received in seminars and discussions in several parts of New Zealand and in Adelaide, Australia. Most importantly the participants have repeatedly expressed their pleasure and relief that the matter will be exposed to a wider audience in a way that is different from the more usual discussion about body size. Finally I have also been accepted to present the work at the Eighth International Critical and Feminist Perspectives Conference in Vancouver this year. This will place the work before the international and critical feminist nursing community.

The criteria just described have a comfortable fit with both the epistemological and ontological stance of feminist research. They do not attempt so much to replace rigour, but to create an entirely new way of evaluating research in keeping with the paradigmatic shift which supports feminist research. The question of truth and especially objectivity, remains an essential area of critique for feminist researchers, if only because it was so central to the positivist view of science. There are feminist scientists who continue to see objectivity as so central to the whole business of science that rejecting it is dangerously irresponsible and even tantamount to nihilism (Hekman, 1990). Alcoff (1988) tempers such an extreme view by stressing the need to evolve a model of theory choice which avoids making a total replacement of empirical evidence with political debate. She further argues for a model which integrates values into the context of justification and shows them to be epistemologically significant, not unavoidable distorting influences.

4.8 Reflection on feminist research.

Feminist research best operates from a clear standpoint of being done by women and for women. In current social conditions for women such research remains not just important but vital. But it is possible that definitions of feminist research may need to extend to incorporate more than gender issues and it is here that feminist research could begin to have even more relevance and usefulness for nursing. Further opportunity exists for nurses to do some pioneering in this area.

Lather (1988) notes that as critical researchers focus on developing interactive approaches to research, it is possible to see some overlapping between emancipatory enquiry and liberatory pedagogy. Growing concern is expressed, particularly in feminist literature, about the dangers of researchers with emancipatory intent imposing meaning rather than constructing it through participatory dialogue (Acker, Barry & Esseveld, 1983; Lather, 1988). Opie (1992) warns of the danger of appropriating the data to the researcher's interests and thereby silencing potential disruptions. Finally it is important to note that there will always be many important areas of nursing practice in which feminist research might be quite irrelevant.

4.9 Conclusion.

In this chapter the methodological underpinnings of this research have been discussed. The need for a research methodology which generates knowledge of relevance to nursing practice is noted. Feminism as the underpinning philosophy is explored, and the means by which feminist philosophy translates into research methodology is described. It is argued that research drawn from feminist methodology must concern itself with research questions which are relevant to women and have to do with some form of political struggle in which women are engaged. In terms of the actual method, the dialogue between researcher and informant should be recognised as a resource available to informants and as one means of empowering people who are disadvantaged and oppressed. This chapter has also examined feminist ethical concerns as they relate to methodology.

There is significant congruence between the chosen methodology and the aims or goals of this research. The prolonged period of reflexive interviewing and the sharing of information between myself and participants has allowed exploration of their experience in a manner which facilitates a mutually informative process. Setting the participants' experience against a critical interrogation of the relevant discourses, including that of

nursing, provides information to enable nurses to review existing practice strategies. This project will differ from some feminist research in that, in keeping with the applied nature of nursing, some possible solutions will be offered.

In the next chapter I will focus more specifically on the method by which participants were located and interview material was collected and analysed. The choice of method will be based on its applicability to the topic in hand rather than by virtue of support or preference for a particular method. It has been noted, (Klein, 1983) that intersubjectivity and promotion of interaction are of prime importance in feminist research because they allow the researcher to continually compare her research outcomes with her own experiences as a woman and a scientist, and then to share them with those researched, who then have the opportunity to add their opinions to the research, which in turn might change it again. The series of co-structured reflexive interviews described in the next chapter, seem most congruent with the methodological requirements this chapter has outlined.

CHAPTER FIVE: The Research Method

5.1 Introduction.

Previous chapters have described my own position and involvement in this study, an outline of the research problem, the discourses which inform the area of body size for women and the feminist and associated methodologies which underpin the study. This chapter provides an introduction to the interview material by outlining methods used for its collection and analysis. The process of participant selection is also described but detailed introduction of the participants is left until the next chapter. This has enabled the presentation of each participant as an individual who has made a significant contribution to the project. Ethical issues as they relate to method are explored and a detailed description of the interviewing process and the method of analysis is provided.

5.2 Participant Selection.

An advertisement was placed in two local papers (see appendices) requesting interested women to phone me for further information. In all, eight women directly replied to the advertisement. Women who contacted me also suggested names of friends or relatives who they thought might be interested, and other acquaintances also suggested to their contacts that they could become involved. In all, six women were initially selected and three further women joined the study later.

Being aware of the previously cited literature which notes that many women overestimate their body size, I had wondered how I would deal with the dilemma of women volunteering for the study who were not significantly 'overweight'. Interestingly only one woman was impossible to categorise as even mildly overweight and when I subsequently visited her we decided mutually that we would not pursue the interview process. She was delighted when I said I wanted to work with women who were significantly overweight and that she did not fall into that criterion. She decided that she would probably stop spending fourteen dollars a week at Weight Watchers which she had joined two weeks previously.

Within ten days I rang each woman back and either accepted or declined their offer and set up a meeting time to confirm whether or not we would proceed. In some instances I decided, with the woman, not to proceed on the basis of simple structural issues such as travelling distance or potential difficulty in coinciding schedules to have interview times. I

needed to be able to interview some of the participants during the day to ensure their privacy and reduce intrusion of private time for both me and the participants.

Before declining any volunteers I made an initial information sharing visit to those who seemed most likely to meet the criteria, in order to make a mutual decision to proceed. Not all telephone volunteers were interviewed as they were able to be so open on the telephone it seemed unnecessary. I did either visit or talk at length with each person who subsequently joined the study before making a decision to proceed. At the initial interview I gave them my information sheet (see appendices) and used it as a means of imparting essential information and receiving questions from the participant. Once it seemed appropriate for the participant, the consent form was signed before proceeding with the first interview.

The nine participants eventually selected are all non-Maori New Zealanders. This was a serendipitous outcome of the selection process. In fact no Maori women volunteered to participate and therefore selection would have involved a deliberate search and personal approach. Undoubtedly the presence of a Maori woman would have added not just to the understanding of embodied largeness but also to the impact of constructions of femininity on that experience.

5.3 Relationship between the researcher and the participants.

In the process of explaining the research method to participants I noted that as a large woman myself I would feel free to share some of my experiences and perceptions, both personal and theoretical, in a way that would aim to enhance our dialogue. I described the feminist aim of avoiding the position of an impartial or objective observer in favour of the role of involved participant. At this early stage I was delighted by the immediate approval and identification that these women showed for the proposed research, one in particular commenting that it sounded much more interesting than answering a survey.

There was never any intention that my role would be that of impartial observer seeking to elicit the 'truth' of the lives of large women. As the work has progressed such an idea has become increasingly problematic and progressively remote. The concept of objectivity has been consistently challenged and found to be flawed (Stanley & Wise, 1983; Tripp, 1983; Hekman, 1990). I was aware from the outset that I entered the research process with a number of assumptions about being an overweight woman which arose from my personal

experience and my considerable involvement in the relevant literature. Some of the more major assumptions have been noted previously.

But even beyond that I accepted that my background knowledge, my previous experiences and even my personality would affect each stage of the research process. I was impressed right from the beginning how much my involvement encouraged the women either to reject a suggestion I might make or to use it to push the boundaries of their own perceptions. I also sensed that on some occasions the participant's apparent pain was too private and too personal to share even with another large woman such as myself. As I noted previously, there were times when incongruity was evident as facial signs of distress belied the lightness of their words.

There is also some sense in which the warmth and feeling present during an interview is completely lost in the starkness of transcribed words. Interruptions which seemed quite appropriate at the time appear insensitive in transcripts, and the myriad of signals from gestures, facial expression and posture are lost. Interviews have felt rich and revealing yet sometimes when reading the transcripts I have been struck by what seems to be a paucity of description. Listening to the tape again, recreates the feeling to an extent but it is still the written word which is transferred verbatim and without the accompanying qualities or nuances which are present in the interview experience. Such qualities have however played an important part in the process of analysis and are an excellent reason for manual analysis as also noted by Opie (1992, 1995). This is discussed in more detail later in this chapter.

5.3.1 Interviewing.

As noted in the previous chapter the interview process is considered critical for the success of feminist research. My interviewing technique was influenced by the work of Tripp (1983) who stated that:

> an attempt to record what someone thinks on a particular question must include an attempt to discover how that question and its relevant features is placed in the world view of the interviewee (Tripp, 1983, p 33).

Tripp describes the co-structured interview, a term which best describes the interview technique employed in this study:

> Where there is a symmetrical relationship between the interviewee and the interviewer - in that the interviewee shares equal responsibility for deciding the

> important questions to be answered, and the interviewer shares a similar responsibility for providing answers, one might term the interview co-structured (Tripp, 1983, p. 33).

My interviews thus more aptly resembled discussions, at times interspersed with the use of reflexive listening when participants were intent on trying to put their feelings into the words which they felt accurately encapsulated their experiences. Questions and assertions were made on both sides, but essentially participants in the second and third interview were free to select aspects of the broad topic which they saw as pertinent and to develop their ideas and feelings as they wished. At times, by inserting my own experience, or my own knowledge, as it seemed to me, they were perhaps encouraged to explore their own thoughts more deeply or provoked by challenges from me to reflect even more intently on what they were describing. I frequently mentioned issues raised by other participants as potential stimulus to a participant or as a means of supporting what they were saying. Sometimes I had to resist the temptation to push too hard in an area which seemed of intense interest to me but seemed of little tangible relevance to the participant.

The final interview when initial themes were taken back to the participants was the only interview that was fully structured. In this interview participants were asked to consider each theme individually and to consider their own relationship to that theme. Even so, time was still made available to take the discussion in any direction which surfaced out of the planned area.

In taking what was essentially an insider stance I had to be very careful to avoid the assumption that the participants' experiences or interpretations would match either mine or those of the other participants. I have previously referred to the assumption made by white academic feminists that all individuals in the world called women share similar ways of being in the world. Inevitably the participants may share my experiences of being a wife or mother or daughter, and that of living in a female body deemed to be overly large. But that similarity of experience is thereafter mediated by a multiplicity of factors including age, class, ethnicity, sexuality, education and many other less tangible differences.

It was therefore essential to the spirit of dialogue that I contribute to the discussion, share my knowledge as it seemed to me at the time and my experience as I currently understood it. This is essential to the equality of the relationship (at least at interview level) which creates the need for me to be open and honest about my feelings and experiences as a large woman. This meant I sometimes revealed very personal things about myself. Unlike

my participants I have no pseudonym or guaranteed anonymity and therefore the woman who transcribed the tapes and the women who supervised my doctoral research had unrestrained access to my comments. Accordingly, I have been conscious of limiting my comments which potentially makes my contribution to the participants less than open. I discussed this in a recently published article exploring some of the dilemmas of feminist research (Carryer, 1995).

Currently I can not see how this can be resolved. I believe it is in keeping with literature suggesting that earlier beliefs that feminist and critical research could eliminate power imbalances are now tempered by the view that at best they can be acknowledged and dealt with wisely (Stanley & Wise, 1983; Ribbens, 1989).

Another aspect of the power relationship between the researcher and the researched is the inclusion of the researcher's contribution to interviews in the eventual writing up of the research. This extends the exposure of the researcher even further with no illusions of anonymity. I reflected at length on my positional stance in the eventual written thesis and subsequent publications which will stem from the work.

When I speak, as I do, of 'the participants' then I am in effect distancing myself from the work. If I refer to 'us' then I place myself inside the work. If I write myself out I have a privileged state which somehow objectifies the participants, but if I leave myself in then I am very vulnerable to personal exposure. I decided that my position would be different throughout the work. It will be my voice which will review the literature and examine the theoretical contexts which underpin the work, but it will be 'our' voices which will speak of the embodied experience of largeness. Even so it is inevitable that 'our voices' will be shaped and mediated through my knowledge and language which is nevertheless significantly informed now by what the participants have shared.

I know that I have a rich contribution to make; at times I was astonished by the similarity of my experience with that of a participant, at other times fascinated and made curious by the difference. I have come to see that it would be less than honest to write my voice out of the thesis and therefore with some trepidation I have left it in. To some extent I have censored it but only in the same way as the participants who have always retained the right to delete any comment about which they felt uncomfortable (Carryer, 1995). My censoring has, I suspect, been more vigorous because of the lack of personal anonymity.

As a feminist researcher my task is to illuminate an aspect of women's lives with all their diversity and contradiction. In the process of writing a doctoral thesis it is necessary to

write a dissertation that is credibly analytic. In the process I will need to frame the participants' voices in my analytical voice. I was conscious of listening to participants and hearing what they were telling me and aware of the manner in which their experience challenged or enhanced my own perception. But simultaneously I was conscious of reframing their voices in keeping with my reading and growing knowledge in the area.

I explained the requirements of a doctoral dissertation to the participants and secured their permission and willingness to subject their voices to that analysis. This does not always seem to be an entirely satisfactory solution and given that much nursing research is still done within the context of doctoral and masters dissertations, it is an issue for many nurse researchers.

5.4 Ethical Issues.

Any research project mandates certain requirements to which the researcher will adhere in order to maintain ethical standards. Prior to commencing this study the research proposal was presented to, discussed with, amended and subsequently approved by members of the Massey University Human Ethics Committee.

When the intention of the research is essentially collaborative there must be concern for the autonomy of the individuals who participate and the onus is on the researcher to ensure respect for such autonomy. The researcher must also ensure that participants are fully informed as to the nature of the research process and the intended outcomes of the study. Ethical issues for this study then involve the reflexivity between myself and the participants, previously discussed as an integral part of feminist methodological concerns, the right of the participants to always be fully informed, and confidentiality.

5.4.1 The right to be fully informed.

An essential aspect of the introductory interview was to explain the use of the term feminist as it applies to research. I wondered what the term would mean to participants, as the popular view of feminism is often quite different from the theoretical perspective. I explained that as a feminist researcher my responsibility was to focus on an issue that is important to women and to ensure that participants felt in control of the research process. It would also be my responsibility to ensure that the outcome of the research was in some way beneficial both to participants and to other women. I said that my research was aimed at exploring and telling their story in a way that would both enhance

their own understanding and might also give nurses an opportunity to improve the health care offered to large women.

In most instances the first interview was not taped and took the form of a mutual sharing of information and an opportunity to develop rapport without the potential intrusion of the tape recorder. At this stage the degree of involvement, in time and nature, required of each participant was explained. I also explained that the participant did not cede any rights by consenting initially to participate and could at any stage withdraw or partially withdraw in terms of deleting transcribed material. At the start of each subsequent interview the participant was asked about the previous transcript and any changes in her feelings about continuing participation.

5.4.2 Confidentiality.

Confidentiality was protected in several ways. All participants chose a pseudonym which was used to identify tapes and transcripts. Identifying features were deleted or altered on transcripts. When receiving their copy of transcripts, participants were able to request any further deletion of material they felt would potentially identify them. They also had the right to request deletion of any material that, on reflection, they preferred not to include. Following this process copies of transcripts were then available to both supervisors and were also retained by the participant as a permanent record.

All participants were made aware that selected excerpts from interviews would appear verbatim under their pseudonym but their inspection of drafts would ensure they retained an overview of this process. The need for complete confidentiality was explained to the person who word processed transcripts, and she signed a contract agreeing to protect the confidentiality of participants. Tapes and signed consent forms were placed in my locked filing cabinet and then in the Massey University archives at the completion of the research.

At the conclusion of the research process I felt comfortable that the method used had allowed me to meet both the scientific and ethical requirements imposed by research. Co-structured interviews allowed participants the freedom to bring issues to the surface as they chose. The reflexive interview process also allowed me the right to hear their pain and provide comfort and support. In one instance I felt the need to ring a participant at intervals after an interview to offer support in continuing to deal with the pain she had expressed. As a nurse researcher I could not have impassively observed any participant's distress without offering support, nor could I have not acknowledged that I too experienced some similar feelings.

As the research progressed I had a clear sense of the ongoing modification of my views in response to what participants told me. Rather than having a sense of gaining answers, I had a growing sense of generating further questions. Because I continued to read and search the literature in the light of what participants were telling me there came a sense of answering some questions but equally quickly generating others. My sense is that the dialogue between myself and the participants has been mutually illuminating and the outcome is not a neat closure in the form of answers to a research question but rather the generation of new ways of understanding or perceiving the embodied experience of largeness for many women (Carryer, 1995).

5.5 Collection and analysis of interview material.

I have not, as previously mentioned, used a qualitative research analysis programme such as *nudist* or *ethnograph* in which the computer assists the data analysis. I have preferred, instead, to use manual analysis and thus retain flexibility and personal input. In reading the interview transcripts I found that the process of my own reflection generated key aspects of the interpretive work. Opie (1995) describes the process well. She said that

> reading for interpretive possibilities means attending to the positioning of the speaker and to the nuances, contradictions and recursiveness within each text and across texts, being aware of what is not said and also of the implications of brevity, and attending to the discursive and power implications informing the text (Opie, 1995, p. 38).

5.5.1 Triangulation in this study.

In the previous chapter I referred to triangulation as an aspect of rigour in qualitative research. Staley and Shokley-Zalabak (1989) noted that it requires multiple data sources and collection methods.

Data sources in this study have encompassed my own positioning as a large woman, the nine other women who have been interviewed, the literature on body size from a range of perspectives, and my own journalled reflections on peer and practitioner encounters in which the subject is debated. Formal collection of data has involved only the material derived from interview.

5.6 The interviews.

5.6.1 Interview One.

In this first interview I aimed to give participants the opportunity to feel more at ease with me and to cover some scene setting information to contextualise their experience. Participants were asked to loosely describe their family and work status and to talk about the history of their experience with body weight. This involved describing periods of weight gain, diets undertaken, the outcome of those diets, and their current ways of dealing with being overweight. Notes were taken and a written record was posted to each participant. They were asked to check the accuracy of the report in describing their story. I recorded their information and my reflections in field notes. These have sometimes been referred to in the chapters specifically allocated to interview material analysis, but they also directly inform the next chapter where each participant is introduced.

5.6.2 Interview Two.

This interview was not structured and participants were encouraged to explore the experience for them of living as a large-bodied woman. I shared some of my experiences and some of what I have learnt from several years of reading in this area. Interviews took the form of dialogue in which the participants and I worked towards articulating what is involved in negotiating life as a woman inhabiting a large body.

Each transcript was initially proofed and corrected against the sound recording, as I found my familiarity with the women's voices and the content often enabled me to hear words and nuances that the word processing operator had missed. It was also an important revisiting of the interview itself. The corrected transcripts of this interview were posted to the participants. They were asked to consider the reading of the transcripts as a catalyst for further thought and development of the ideas they had begun to express or explore.

I retained copies which, after two to three readings, I began colour coding to identify groups of ideas or concepts or similar themes as I recognised them. I did not read the transcripts with any sense of pre-set categories or themes nor any imposed framework. These began to arise as I read the women's stories and reflected on both them and the literature in which I was simultaneously dwelling. In this sense the analytic process was purely interpretive as I did not attempt to impose any theoretical framework.

5.6.3 Interview Three.

This interview remained largely co-structured in that participants were encouraged to pursue any area they chose. Simultaneously it included some focus on asking participants to comment on issues raised by other participants. In this interview I did deliberately ask participants to describe their view of femininity and then to talk about where they saw themselves in that view. I did this because of the evidence in the literature that appearance is such an important aspect of the way femininity is constructed. I wanted the participants to explore the issue of femininity and to consider how it feels to be different from the stereotypical picture. Again the full transcripts were mailed to participants with the same request for their use. At this stage I told them that I would now spend a prolonged period considering the interview material and using a process to distill out and consolidate the themes emerging from the transcripts. Within a few weeks I would post them a copy of the emergent themes and make an appointment for a final taped interview to record their responses and any further comments.

I then repeated the process of proofing then colour coding the new transcripts, looking for the development of previously recognised themes and the emergence of any new themes. Field and Morse (1985) note that the investigator, using manifest content analysis, reviews textual material for words, phrases, descriptors, and terms central to the phenomenon under study.

I used the processes of noting patterns and themes, looking for plausibility, clustering, noting relations and studying repetitions (Catanzaro, 1988) to dwell in the interview material and identify thematic groupings with a system of identification by colour. At this stage I duplicated all the transcripts again and actually cut them up so that I could begin to look at the thematic groupings more collectedly. Catanzaro (1988) refers to the use of baskets for beginning broad categorisations which may be events, processes or theoretical constructs. In my case I used labelled folders in which I could physically place or relocate transcript excerpts.

5.6.4 Interview Four.

This interview was carried out some months after the third interview and involved returning to the participants to discuss the initial themes which I had drawn out by doing a thematic analysis of the first two sets of transcripts. Participants had been posted the themes approximately ten days before the interview was scheduled and asked to reflect on their accuracy, and also to begin to think about how they now felt as a result of having participated in the interviews. I conducted a taped interview in which each participant

was asked to consider each theme individually and talk about their relationship to that theme. Finally they were asked to comment freely on their feelings at the conclusion of the research process. This involved looking for any changes in their knowledge or their feelings about themselves and making comments on the experience of participating in this type of research.

At this point I was aware of the literature suggesting that the line between qualitative data collection and subsequent analysis often becomes fuzzy. Catanzaro (1988) states that:

> Ongoing analysis of the data during data collection allows the researcher to alternate between thinking about the existing data and generating strategies for collecting new and often better data. Ongoing analysis keeps the investigator alert to what is happening with the data, stimulates creativity, and often energises the whole project (1988, p. 440).

Catanzaro also refers to the use of summary sheets as a way of planning future data collection, communicating with other researchers and reorienting to the research at the start of each new interview. As a lone researcher I found this unnecessary but did use a research journal in which, amongst other things, I commented on interviews when needed and noted plans for subsequent interviews when this was relevant. This journal, and the folder in which original unmarked transcripts and any written material from participants are stored, will be referred to as field notes.

Review of the transcripts of the fourth interview resulted in further merging reduction and regrouping of themes in redesignated folders. The outcome of this process was mailed to participants with a covering letter asking them to read, reflect and to contact me if there was anything they would like to discuss.

5.7 New Participants.

At this stage three new participants were invited to join the project as the scope of the research was to be increased. This arose because I was able to meet the criteria for transferring masters work in progress into the doctoral programme. One participant was recontacted from the first advertisement and two others joined who had expressed interest in the project as they were aware that it was in process. The same process of informed consent was adhered to and three consecutive interviews, in the same format as for the previous six participants, were carried out over the course of several months.

Analysis of these transcripts followed the same process as before. I searched for confirmation, contradiction, enhancement and development of the thematic analysis. It became clear that there would not be a major shift in my understanding of the topic of study. I did however gain a sense of having much richer interview material. This richness as described by Morse (1995) was derived from the existence now of much more detailed description. I also became aware of a degree of boredom which Morse (1995) indicates can be an indicator of saturation occurring when the researcher has now heard it all before. I have some discomfort in reporting this in this manner. It seems disrespectful to participants to suggest that their contribution was not unique or vital, but it is difficult to demonstrate how the acute sense of individuality I felt from each woman was still overridden by a growing sense that some core commonalities of the experience were now clear to me.

5.7.1 Interview Five.

For the six original participants, I conducted a fifth interview in order to discuss with them the way my analysis had been affected by the contributions of the three new participants. In fact there was little actual change but it was still valuable to have their input to the analysis as it currently stood. I felt it was also essential to maintain their ownership of the process.

5.7.2 Focus group with Professor Janice Morse and academic colleagues.

At this point I was privileged to have the opportunity to discuss my analysis with Professor Janice Morse and a group of six colleagues from my department. This two-hour meeting was tape recorded and contributed valuable insights into clarification and presentation of analysis of the interview material.

I then spent several weeks developing a representational model by listening to the tape and searching and examining each folder to determine the strength of the interview material to support each aspect of the model. This was a vital aspect of the interpretive project as it ensured that the themes and model arose from within the interview material rather than being imposed from without. The model is presented at the conclusion of the chapters containing the interview analysis.

5.7.3 Interview Four with the three later participants.

At this interview I presented the participants with the emerging model I had developed from thematic analysis and taped and then transcribed our discussion of each aspect of

the model. We held a lively dialogue aimed at and subsequently used for further refinement of the model in keeping with the interpretive nature of this research.

Much later I posted the six original participants a copy of the developed model and later rang them in order to give them an opportunity to make their comments accessible to the project. At this stage one participant was found to have shifted from her address, but the other five wrote letters describing their acceptance of the model and provided vital comment on particular aspects. These are stored and used as field notes and have been used in a similar manner to transcript excerpts.

The mechanics of analysis of interview material have been described in the immediately preceding section. They can be seen in this project to be closely woven with the method of collection and to demonstrate reflexive and prolonged input from the participants. The first aim of this research was that a group of large women would have the opportunity to explore their life battle with their body size in a manner that would increase their understanding of the experience. The prolonged contribution of participants to the point of creating a model and continuing to comment on its relevance has met that aim of the research. Furthermore it meant that I continually compared my own growing knowledge and insight with what the women were telling me thus ensuring a continually reflexive process.

5.8 Issues arising in the process of collection and analysis.

Returning the full transcripts to the participants was to me an essential part of ensuring the accuracy of this research. Transcripts were returned not only to allow participants to check their accuracy but also to stimulate reflection and further discussion in light of that reflection. Return of the transcripts also served to maintain participant ownership of the data in keeping with feminist methodology. Return of the themes after analysis ensured that participants had the opportunity to comment on their accuracy in reflecting their own experience.

I believe the return of the transcripts was an integral part of the research process, but for at least one participant it was somewhat stilting to see her words recorded and two or three times participants commented that they did not like the way they sounded. I also felt less comfortable about some of my own responses which again, without visual cues, often sounded less appropriate. Many of the participants also needed some encouragement to read and reflect as it became clear to me that this was not a process they were used to.

5.8.1 Reflection on the method.

During the phase of developing the model I noted recent work (Burnard, 1995) arguing that there is no reason why a textual document may contain particular meanings and certainly not just one set of meanings. Burnard suggests that it may be important to acknowledge this and the researcher should concentrate on the meanings that the researcher personally brings to the text.

> All meanings by virtue of there being no way of arbitrating, may be valid. In this formulation there is no consensus to be reached and it may of course be the case that the reader of the final research report might bring yet another set of meanings to bear on the work that he or she reads. Again, this second level reading may inform the reader just as the reading of the transcripts informed the researcher. Gradually and in a seemingly arbitrary way, there would be a building up of a rich and varied 'evidence' about the human condition. It would be the opposite of reductionism and the encouragement of holism (Burnard, 1995, p. 242).

Burnard's comments affirmed my growing sense of the bridge between art and science which is exemplified in qualitative research. I have no illusions that my analysis has elicited the truth about embodied largeness for these or any other women. But I do believe that I have brought my own immersion in the subject, both personal and scholarly, to bear on the contribution of these nine women and what has evolved is the presentation of what Sandelowski (1993, p. 3) describes as the apprehension and presentation of different representations 'to achieve the fuller knowing that advances knowledge and may influence practice.'

5.9 Conclusion.

This chapter has outlined the practical aspects of carrying out the research and the method of participant selection. Feminist ethical issues were discussed with particular reference to method and the process and implications of interviewing were presented. The detailed weaving together of collection and analysis of interview material congruent with interpretive work was presented with some additional reflections on that process. Background information to this study is now complete and the next chapter introduces each participant individually in order that her significant contribution to the project is fully acknowledged.

CHAPTER SIX: The Participants

6.1 Introduction.

I have chosen in this chapter to introduce each participant separately. The inevitable fragmentation of analysis can, to some extent, reduce the essential wholeness of the person who has contributed in a very personal way to the production of this thesis.

6.2 Heather.

Heather is in her late forties and lives in a rural area. She is in her second marriage and currently has children still at home. Other children have already left home. She works full time locally at skilled manual work and is completely responsible for the domestic work in her home.

Heather remembers in her childhood that she was heavier than others and looking back at photos she describes herself as a wee bit chubby. Throughout adulthood she has frequently dieted in a half-hearted manner and twice joined Weight Watchers. She has also embarked on reduction diets at the behest of general practitioners when seeking care for other issues. Heather talks eloquently of a situation she describes as the 'two me's' On the outside is a large, slow moving and low achieving person who is marking time in life and unable to grasp at opportunities and possibilities. But inside is a slim successful dynamo who is elegant and assured and fast moving and ultimately very successful. She dreams of cycling to work, of having a fit lithe body, of being on top of her life. Yet her size makes day to day housework and survival activities tiring enough and she describes drowning in her dreams.

6.3 Jo.

Jo is in her early twenties and has completed a tertiary qualification. She notes that she has been overweight as long as she can remember; she doesn't specifically weigh herself but has been aware of a steady weight gain over the years. I did not ask her exact weight but she is clearly quite substantially over current weight norms. So far she has undertaken one serious diet with Weight Watchers as a shared venture with her mother. In the course of that diet Jo lost 25 kilos which was soon regained with more besides. She describes constantly planning diets since then but not actually carrying them through. The most

significant external harassment she receives comes from both her overweight parents who worry about her job prospects as an overweight woman.

Jo eats in a reasonably relaxed manner sometimes noticing that she eats more because she is miserable or stressed. She has however noticed that many of her slim contemporaries behave quite similarly, sometimes overindulging in junk food. This year she achieves plenty of exercise using a bicycle to cover considerable distances.

Jo feels trapped in her body. She knows from her own study that reduction dieting produces temporary weight loss followed by increased weight gain. She would love to claim her right to be happy with her body size, but she knows she is actually deeply miserable. She is miserable because she finds exposing situations like the beach very traumatic, and worries because she feels outside the scope of acceptability to a potential partner. She wonders constantly about how others see her and reads pronouncements on the supposed dangers of obesity with fear and trepidation. She worries that if she starts crying she might never stop.

Jo's grief is hard to watch. It is grief because it involves loss of many things including approval, sexual availability, and full participation in the life activities of a young adult. Her parents concern and sensed criticism is extremely painful as is the nagging concern about what other people see when they look at her. Jo cannot comprehend living the rest of her life as a large woman, nor can she decide or work out what she could realistically do to change her status. She does not have the normal false comfort of overweight women which appears to be placing one's faith in the expected success of the next diet.

6.4 Sally.

Sally is in her twenties and describes herself as having always been chubby. She knows this from looking at photos but didn't really become conscious of it until she was about 10 or 11. At that stage she became aware of looking different, of not being able to run as fast and eventually of not looking quite right in the trendy clothes that others could wear. The women in Sally's mother's family are all very large with a history of rapid reductions and escalations in weight. Sally is currently about 80kgs, having been at one stage about 87kgs.

Like Jo and because of her job Sally has also read that reduction dieting is not a useful means of weight loss. She sees herself as a moderate eater and her description of a

normal day's intake is extremely restrained for an active young woman. She has been on one major diet, successfully losing about 28kgs but regaining it within a relatively short period. Sally knows that exercise causes quite rapid weight loss for her and has had several periods of sustained exercise programmes. However shift work precludes team sports and the sheer monotony of gym work is hard to endure. Furthermore a workout at the gym does not always appeal after a long shift on her feet all day at work.

A particular feature of Sally's story is her working life, where the products designed to enhance feminine beauty are marketed and sold. In some strange way the bodies and general appearance of the women selling the goods are seen to be on display along with the goods for sale. She describes it as like working in a fish bowl. Young men are known to come into the store just to view the sales staff. Much of the day to day conversation among the women revolves around an ongoing critique of each other's appearance with helpful advice and comments being exchanged. This is a tough environment for someone whose body size falls outside the stringent requirements for female thinness.

Sally is therefore very aware of what she describes as the constant appraisal of women's bodies; an appraisal which generally results in something being found to be in need of improvement. A painful feature of her life is that many people close to her seem to feel they have a right to pass continual comments on her supposed weight gain or weight loss, as if her disordered body is somehow public property.

This results in a feeling of constant pressure to improve and conform. Sally would love not to have to worry, but with her family history she believes she is facing a life which will involve a constant struggle and preoccupation with her body size and working to enhance other aspects of her appearance in order to compensate for her unacceptable size. She has reached a level of being able to say that if she could just lose some weight, (maybe a few kilos) she would accept herself but maybe that is just another version of many women's constant 'if I could just ... then I would like myself better'.

6.5 Sarah.

Sarah is approaching fifty, married to a farmer and with two teenagers both living at home. Her mother has been a large woman until quite late in life. Sarah has two avenues of part time work which occupy a small part of each week and is involved with the care of an elderly and moderately disabled mother. She describes her husband as doing the farming and herself as doing the feeding and says she is very content with her role in life.

Apart from some early signs of arthritis and a blood pressure level very slightly on the upper limits of what is currently defined as normal for her age, she describes herself as very healthy.

Prior to the study Sarah had lost a total of 60kgs over her adult life and in the course of five major diets. During the study period she has lost about twelve kilos from a pre-diet weight of 97kgs, regained most of it and begun to diet yet again.

Although she is aware that the pressures on women are increasing Sarah believes that her age confers some protection. She feels if she were twenty years younger now she would be concerned to diet really hard. Despite feeling that the problem is not so acute for her she works very hard to maintain an acceptable appearance carefully choosing colours and styles which are most flattering and least revealing of her body. She is preoccupied with making the best of what she has. It may be significant that to this day she remembers her mother saying to her as a teenager 'you're no oil painting, you must make the most of what you have got'.

Sarah has an extremely matter of fact attitude to any perceived constraints on her life as a woman and any strictures imposed by the requirements of femininity. She is philosophical about her need to diet and the structure of her life which is very much involved with the care of others. Her frequent comment is 'that's just the way it is'. Having accepted that that is just the way it is she then sets about fitting in as much as possible without making any severe adjustments to her life.

6.6 Clare.

Clare is a registered nurse in her mid thirties who has four young children. Since a year after the birth of her first child she has not worked outside the home but is busy with children, church and craftwork.

Clare vividly remembers being initially relatively unaware and unconcerned about issues of size and appearance. In her twenties she never consciously dieted but remembers feeling continuously aware of her 'large wobbly thighs.' Looking back at photos now she is very surprised to see how slim she actually was. She remembers a sort of undercurrent of awareness that every time she avoided eating she would perhaps lose more weight and in fact became increasingly slender to the point of her mother remarking about anorexia.

Clare too has shed an enormous amount of weight in the course of four sustained diets but began her current involvement with Weight Watchers again, weighing about 95kgs. Dieting as a long term solution was uppermost in Clare's mind when we began the series of interviews. She can identify with the attraction of Weight Watchers as a support towards the ultimate goal. She is encouraged by the before and after pictures and the sense that if everyone else can do it so can she. Clare shows a mixed level of awareness of the role of dieting clinics as highly profitable institutions. She knows that they make their money from the repeated enrolments of failed dieters and the sale of diet enhancing products, but at the beginning of the study she believed that this most recent diet was different and better and would work for her if she is vigilant enough for ever more.

6.7 Elizabeth.

Elizabeth is forty and is married with four children, three of whom are still at home. She also works in a retail position and has been studying part time for about three years at tertiary level.

She describes herself as having been a bonny child who did not overly stand out from the crowd until puberty when her weight increased rapidly. Puberty came early and she remembers having the body of a mature woman from very early. By thirteen Elizabeth had reached full height and weighed about thirteen stone. An incident in school changing sheds where she was teased about the maturity of her body marked the onset of shame. She took to the cubicles 'never to be seen again'.

Like Sarah and Clare, Elizabeth has spent her adult life dieting. She too has lost and regained about 50kgs and currently weighs over 90kgs. Repeated pregnancy was for her the time when her weight gain escalated, seemingly beyond her control, and clouded the joy associated with each new child. Elizabeth is a vibrant energetic woman who has particularly valued the opportunity to grapple with this aspect of her life.

6.8 Morag.

Morag is a working mother of three with extensive university education. She holds a full time highly demanding position in which she is recognised as extremely competent. As a young woman she was extremely thin and consciously worked at it existing on coffee and fruit and enjoying her thinness. She gained some weight after marriage but it was the birth of each of her children which generated significant weight gain. Breast feeding, which she did for prolonged periods, was the time of greatest gain, completely confounding conventional wisdom which usually advocates breast feeding as a natural means of post natal weight loss. She has attended Weight Watchers, Diet Clinic and has dieted on her own. Each diet has been successful in the short term but has resulted in rapid replacement of the weight and a gain over the years.

Morag is the only woman in the study whose husband actively dislikes her largeness and this compounds her distress. As a large bodied person in a slim family she feels as if she somehow detracts from the family's appearance and worries whether her growing children will come to feel shamed by her appearance.

6.9 Celia.

Celia is in her early forties and has a Masters degree. She works full time in a demanding job and has three young children. Furthermore her husband has a significant national profile and this has made enormous demands on their family and working lives.

Weight consciousness is a long-standing feature of Celia's life, beginning with her awareness of her mother's frequent dieting and her own dieting behaviour. Dieting behaviour is a useful way of describing what some of the women talk about. It means not embarking on a prolonged purposeful reduction diet but manipulating food intake downwards, missing meals, substitution, planning a diet or overeating following a period of self imposed fasting. But Celia has also vigorously dieted and been temporarily successful.

Prior to going to university Celia avoided eating for four days in order to arrive looking suitably pale and interesting. University was a period of virtual anorexia followed by a life pattern of substantial gains and dieted losses, including finding that the periods of breast feeding were a time of particular gain. She too has lost and regained at least 50kgs over her adult life.

6.10 Maggie.

Maggie remembers being described as tubby when still quite young. Unlike all other participants except Morag, her parents and siblings are slim. Weight gain intensified after marriage which her doctor attributed to inexperience leading her to cook too much and then eat it. She has in her adult life attended Weight Watchers and Jenny Craig, dieting successfully three times, but has still experienced an inexorable weight gain over her adult life.

Maggie lives with her partner, has not had children and has a clerical occupation. She works long hours but so does her partner, and she retains responsibility for domestic concerns. Her partner is entirely comfortable with her size although she is now substantially heavier than supposed norms. She too describes a feeling of inertia. Exercise is difficult and unrewarding, dieting has failed her, her partner is comfortable with her size. There seems little motivation to change, how would she do it anyway and yet being so large is miserable.

6.11 The researcher.

I share the participants' history of having battled weight since late adolescence. As a teenager I thought I was enormous and like Clare have been astonished to see photographs of myself looking comparatively slender. At seventeen I arrived to begin my nursing education at a city hospital. Entrance medicals were being done by a young medical registrar who berated me for my 'excess weight' when I weighed in at 69kgs. His actual words were 'well you are a porky young thing'. I immediately began the first of five major diets, losing and regaining increasing amounts of weight. Despite being a vigorous and determined dieter 69kgs is a distant memory and I have lived many of the experiences and feelings of the participants, including noting that two periods of particularly prolonged breast feeding were both a period of rapid weight gain despite calorie control.

As a result of the extensive reading I have done during the research, I feel angry that I too have spent so much of my adult life on a reduction diet, in effect creating a significant weight problem where previously I was only mildly 'overweight'. I am also mindful that despite having a very raised awareness of the particular constraints imposed on women to conform to a required appearance, I am still not entirely free of the impact of those constraints. I am unable to fully accept myself like this.

CHAPTER SEVEN: Body Consciousness and Battling with Food

7.1 Introduction.

In the last chapter I presented the story of each participant who contributed to the research. I now move to presenting the themes which articulate embodied largeness for women. In this chapter (and the next four) the analysed interview material will be presented. A commentary links the dialogue to the literature and to the general discursive context that impacts on the issues around women's body size.

This chapter addresses the theme of **body consciousness.** The term is used to describe an emerging awareness of physicality and a growing comparative assessment of one's own body in relation to the bodies of others and in relation to what is perceived as appropriate or desirable. Body consciousness for the participants in this study was followed quite shortly by **engaging with dieting,** which serves to intensify body consciousness as the dieter focuses on rises and falls in body weight and the necessary manipulation of food intake which dieting entails. Obsessing, monitoring and self surveillance ensue as the dieter engages in or fails a diet, or just feels critical of herself because she is not presently dieting. There is support for the literature suggesting that undertaking reduction dieting may alter eating patterns in ways which make weight gain more likely. But despite such preoccupation with food the large woman is paradoxically **alienated from the social world of food,** as will be shown in the presentation of interview material in the next chapter.

7.2 Body Consciousness.

The participants frequently described an emerging sense of body consciousness which they remembered as first occurring at the onset of adolescence and sometimes earlier. The concept of body consciousness as presented in this thesis is not new. Spitzack (1988b) noted that body consciousness was an ordinary occurrence in the lives of the women with whom she has carried out research into women's body talk. For the participants in this study the emerging awareness of body consciousness was tinged with a growing sense of difference and a specific anxiety about developing a too-large body. Consciousness then continued as a pervasive sense of discomfort as the body became obviously large and their fears were realised.

In most instances their awareness occurred within the context of having an overweight mother (or other close relative). It also included comments from others cautioning them about growing too large, or a sense that their body size prevented them from full participation in the social rituals and recreation of school, female adolescence and young adulthood. Spitzack (1988b) noted that relationships with family members contribute to a woman's experience of her body and this has been born out in this study. As Morag noted:

> **M:** I remember the last year of school, like all summer holidays before I was a student, all I ever drank was coffee, never eating anything, like I was really skinny because I was acutely aware of never wanting to be fat.
> **J:** ../.. why do you think you had that consciousness, even though you were slim, of wanting to be slimmer?
> **M:** I think my mother has always been acutely aware of body size ... I remember as a child when Mum was about 35 her grizzling because she had got to 11 stone and she had to lose weight and she was the fattest she had ever been .. /.. I remember I've always being told that I was like Dad's side of the family and his side of the family have always had this tendency, the woman in it are big women and there was always that consciousness that you could be big... (Morag, Int 1: p. 1-2).

Maggie remembers not the fear of largeness but the dawning realisation that she was bigger than her peers:

> At primary school I was referred to as tubby, and certainly at that stage I was aware that I was bigger than others ..//.. I didn't feel huge but I knew that I was bigger than everybody else ..//.. I think I always felt a bit on the outer (Maggie, Int 1: p. 1-2).

In the first untaped interview, recorded as field notes, Celia, Elizabeth and Clare all talked about the emerging sense that they were bigger and somehow wanted it to be different. Celia remembers herself as a solid child who was one of a family whose members were frequently described as bonny. As a teenager in the sixties she remembers always wanting to be pale, slim and interesting in a way which fitted with the current images of young women in teenage magazines (Field notes, Celia, p. 1). Elizabeth describes a focal point in her awareness when she recalls a dance where she danced all night with a boy and felt happy and uninhibited. Looking at photographs afterwards

produced an unpleasant shock when she saw that she had dwarfed the small boy she had danced with and she felt very uncomfortable with that realisation (Field notes, Elizabeth, p. 1).

Clare remembers being relatively unaware and unconcerned about her body size until at the age of fifteen a school teacher pulled the waist band of her skirt and told her that she could afford to eat a few less potatoes. The link to food and size fell on fertile ground as her mother had repeatedly dieted and Clare developed a continuous undercurrent of awareness that avoidance of food was good and desirable. Her body felt large and 'wobbly' and she has been astonished to review photographs of that period and find that she was still relatively small (Field notes, Clare, p. 1).

Sally describes the transition from the acceptable chubbiness of the tiny child to the socially unacceptable larger body of a young woman.

> When I was little people used to look at me and say 'Oh you are just delicious' and pinch my cheeks. Right through school I would always have been one of the bigger of the kids at primary school and intermediate, but not exceedingly fat, always one of the bigger girls... I never really took much notice of it until about standard three or four [age ten to eleven]... And then you start noticing that everyone else is slimmer and kids are getting in to the trendy clothes and they can run faster and are sporty and then the boys start getting interesting and they are interested in the girls and they are not interested in the larger ones (Sally, Int 1: p. 1).

Celia made a similar but subtly different observation in noting a specific aversion to visible sexual development in young girls. This, to some degree, illuminates Chernin's (1981) assertion that femininity is both feared and revered, valued and despised, and closely linked to the fatty deposits associated with secondary sexual development. Celia said,

> I felt when I was growing up that the girls that the boys liked were the ones who hadn't developed... Obviously older boys liked girls that developed, for different reasons, but the boys like at intermediate when those roles are being set, the girls that the boys liked were flat... (Celia, Int 2: p. 2).

At whatever age, consciousness of the large body is a painfully distressing lived experience which invades the emotional existence and affects many day-to-day activities

which others take for granted. There is a sense of existing in the world in a body which by its shape and size determines the sense of rightness or belonging felt by the person inhabiting the body. Clare describes the pervasive nature of that embodiment when she says,

> We feel quite different to other people. We feel overweight; we always think they're looking at you being overweight. You have these guilt feelings if you eat something you shouldn't. You sort of feel uncomfortable, your body just feels bulky... And if you happen to put on some weight you feel depressed and if you take it off it makes you feel good and you more or less keep taking it off to keep on having that good feeling (Clare, Int 3: p. 8).

Elizabeth remembers similar feelings,

> I've just always thought for years and years that I must be smaller I must be smaller. I don't know why. You've just got to conform to the way that the rest of the world wants you to be I suppose (Elizabeth, Int 2: p. 1).

The participants constantly demonstrated that they have internalised a social requirement, for women especially, to conform to a particular size and shape. Whilst all of them have eventually come to recognise this as an externally driven pressure and are able to critique the unfairness of that pressure they are not easily able to separate from it. Certainly, at the point they emerged into adolescence and early adulthood they did not stand back from or critique the strictures imposed. Being fat or fearful of getting fatter is a powerful source of anxiety expressed clearly by Sally,

> I must admit I get very fearful if I see an exceedingly large woman and I have made comments like if I ever get that large shoot me... but it's just drummed into you, there's such a fear of being large. It's the worst thing that could ever happen to a woman... I don't know why society does it... [in tears] (Sally, Int 2: p. 10).

From early on women's bodies are controlled by the growing realisation that they must be small and neat. The contours that develop in a maturing woman's body, growing breasts, fuller thighs and rounded hips are not viewed with pleasure and pride but rather with anxiety and distaste. In direct contrast to the manner in which a young man's expanding shoulders, deepening voice and strong hairy thighs meet approval, the parallel development in a young women engenders an entirely different reaction. As the young

woman, with a larger body than her peers, grows and looks around she at once confronts populist discourse about women's bodies and the means by which they are disciplined to conformity. In listening to these women and reflecting on my own adolescence I note the burdensome addition to the already enormous adjustment tasks of adolescence. Belonging and "fitting" is crucial and a large body neither fits nor belongs.

The escape from condemnation lies in controlling and curbing the burgeoning flesh. Popular consensus, arising from multiple discourses that thinness results from controlled food intake, ensures that a conscious belief that the body is too large will direct the sufferer to reduction dieting, or at least manipulation of what is eaten. Participants do not remember a conscious analysis of supposed causes of large body size, and my sense from the literature is that the area of decision making about eating in young women is poorly explored. This will comprise one of several areas for further study at the completion of this project.

These women as late adolescents or young adults recognised their apparent deviation from an assumed template of normality. In a discursively saturated context they saw the solution as the reduction or manipulation of food intake. They assumed that their emerging largeness was the beginning of an inexorable ballooning which had to be vigorously and vigilantly controlled by food reduction. The focus on food reduction became so commanding that other considerations like acceptance, exercise and developing healthy eating habits were inevitably overidden by the urge to diet.

In deciding to address the largeness of her body by turning to reduction dieting a woman displays both considerable agency and passive acceptance of an imposed norm. The dieting woman has processed multiple texts which impress upon her the desirability of slenderness and the means to achieving that goal. Dissatisfaction is aroused, possibilities for transformation surface and solutions offered through the textual mediations of various body size discourses. This process is well explained by Smith (1990) who says, in discussing cosmetic surgery to the breasts that:

> Discontent with the body is not just a happening of culture, it arises in the relation of text and she who finds in texts images reflecting upon the imperfections of her body. The interpenetration of text as discourse and the organisation of desire is reflexive. The text instructs that her breasts are too small/too big; she reads of a remedy; her too small breasts become remediable. She enters the discursive organisation of desire; now she has an objective where before she had only a defect (Smith, 1990, pp. 185-186).

Hence a crucial lifestyle decision with far reaching consequences is made. Women decide that their bodies do not match the arbitrary norms of the current requirements of femininity. As Smith (1990) says, there is a gap between the textual ideal of image and the actual appearance of most women. The gap is particularly wide for larger women and identification of that gap triggers a movement towards correction. From a variety of sources rectification is presented in the form of reduction dieting, or at least some degree of engagement with that process. The implications of the decision to diet will be further discussed in chapter thirteen when implications for nursing are examined. In the meantime this next section will explore the involvement with reduction dieting which shortly ensues.

7.3 Engagement with dieting.

The point in adolescence or early adulthood when the issue of size eventually surfaced for all participants was invariably the beginning of reduction dieting. Having become aware of a sense of closely related physical and personal inadequacy they then looked to a solution for change. As too large or could-be too large women, they entered into a discursively saturated and medically and socially sanctioned field in which everyone is at once an expert on the cause and solution for their 'problem'. The area of intersection or agreement for all discourses about large-bodied women is not only that having a large body is not desirable, but also that food consumption and personal behaviours are at the root of the problem.

Neither the woman herself nor her advisers ask if her eating is or has been inappropriate. At no time did participants describe their adolescence or young adulthood as characterised by excessive eating. Yet without fail they came, at some point, to see resistance to food as the only way out of inhabiting a larger than acceptable body. Rarely do diet clinics or health professionals, when consulted about body size, take an eating history to ascertain whether or not the food intake is in fact excessive for age and activity level. Either the visible evidence is seen as incontrovertible or the desire for even greater slenderness is seen as sufficient reason to begin dietary restraint. Almost without exception calorie reduction is recommended as the solution. It is a short-term solution but its long term outcome is entirely different.

For example, Sarah remembers a trip overseas in her twenties during which, despite doing a great deal of walking, she inexplicably gained about 8-10 kilos. She responded by undertaking a successful reduction diet and this was the beginning of a series of diets and

a slow but steady increase in weight (Field notes, Sarah, p. 1). She has never wanted to be large, clearly viewing largeness as extremely abnormal and has endured the constant dieting and regaining with a degree of stoical resignation.

By the end of the study Sarah was on her seventh major diet and, despite her history of regaining and increasing weight, she is still sure that this time she will be successful. Her sixth diet was initially motivated by wanting to lose some weight to control any exacerbation of her mild arthritis and her mildly elevated blood pressure. Despite having lost sufficient weight to achieve this objective half way through the study, Sarah decided to continue on towards the Weight Watchers goal weight for her, although she noted,

> My husband's not that keen, he'd rather I lost 10kgs and left it at that ../.. I decided no, I would like a bit more off ../.. It would be nice to be a size fourteen again (Sarah, Int 2: p. 4).

Sarah does vaguely know that dieting is not a permanent solution, but can not imagine any other means to prevent her body ballooning to what she feels would be an endlessly unlimited size. She appears not to comprehend her body as having its own control mechanisms, but feels she must impose them herself. It seems as if the endless involvement with dietary restraint obscures any sense that the body can signal appropriate hunger and satiety. She said,

> Somebody said to me the second time I went to Weight Watchers, I said about how I had put on weight each time, and she said yes I have too but she said if we hadn't lost that weight to start with, would we keep going up and up and up? And I said yes we probably would. So she said therefore we are doing ourselves some good because we are not just going up and up and up, we are doing something about it. (Sarah, Int 2: p. 10).

Similarly for Elizabeth, dieting has been a constant focus of her adult life. Each pregnancy after the first was viewed with a mixture of feelings: joy at the impending arrival of another child, but always tempered by worry about the weight gain which accompanied each pregnancy and the enormous effort which would be required to diet it off again (Field notes, Elizabeth, p. 1).

Morag also describes the repetitive nature of dieting and the net result of becoming heavier,

> I guess really in those teen years I was not really dieting but probably [when] working I would have dieted ..//.. I started dieting and I remember that I wanted to get to 65kgs, ideal weight, but I think I was 70kgs or something crazy and I remember getting on the scales at work all the time and dieting and really doing it hard, you know ..//.. and then of course because I got so small I could only get bigger ..//.. then as I got bigger, to 9 stone then I wasn't 8 stone anymore so I dieted and that sort of started it all I guess ..//.. I guess I would have one serious diet a year. Lose a bit and gain up again. (Morag, Int 1: p. 2).

Later Morag described the multiple traumas of continuing to diet as a mother of a young family, and alludes to the strange paradox present when a group of women with a common problem meet at a weight loss centre but talk not so much to each other but to the authority figure of the diet group leader. This person is both one of them yet not one of them because she has succeeded in a manner which they have yet to do. Morag also describes the sense of hopelessness engendered by the sheer enormity of the task which confronts the would-be dieter.

> I went to Weight Watchers, paid the ten dollars which crippled us... and just loathed it. I loathed the rigidity of the meals, I loathed their little pep talk because I used to think, there was so much that we had to talk about ..//.. I loathed lining up with a bunch of fatties. I just hated everything about it ..//.. like this is really bizarre but if I start to lose a bit of weight I am so conscious of the rest of me that I just feel awed by how fat I am, there's no point to keep losing ..//. It makes you feel fatter, and I get really nasty...the whole family's style of eating has to change because I can't suffer just making for me something different, so I become fixated on what you buy and what you've got and what you can eat and I'm a most unpleasant person to live with (Morag, Int 1: p. 3).

Morag is not only describing the traumas of supervised reduction dieting, but also identifies another paradox when planned avoidance of food generates an unprecedented preoccupation with food. Celia and I shared our recognition of the mixture of deprivation but simultaneous focus on food which dieting invokes.

> **C:** .//..You'd wake up in the morning and you wouldn't think I'm going to eat today [normally], I'd think what am I going to eat. It was like you had failed before you start. And you know there's no way you can win. And that is caused by the whole dieting thing as well because you know what you are supposed to do, you're supposed to have a piece of toast without any

> margarine and half a grapefruit and a black coffee for breakfast and you know that no way can I have that.
> **J:** I've got vivid memories of driving home from work particularly when I was a charge nurse of a cancer ward and I had worked hard during that day and got through extreme physical and emotional exertion and I'd be driving home about 5 o'clock absolutely exhausted and it would go through my mind, all I've got left of my days allowance was 60gms of skinned chicken and some boiled green vegetables (Celia, Int 3: p. 4).

Both Celia and Sally spoke of the constancy of awareness and the related monitoring of food intake in order to control their body size, not only when dieting but every other day as well. As Sally noted,

> I'd love not to worry all the time but I think because knowing that all my family are overweight and not just overweight they are enormous. I will need to fight it for evermore, I have to, its in my metabolism and I've never heard a way I can change it (Sally, Int 2: p. 8).

Celia describes the monitoring of food intake,

> It's been awful really. It's been a controlling factor, like I am worried about it all the time virtually. More so when I wasn't working. When I'm working my day is regulated. When I wasn't working outside of the home, it would be terrible because that was what my whole life revolved around anyway, producing wonderful meals for the children. (Celia, Int 2: p. 8).

Heather is the exception in that she has never successfully dieted off any significant amount of weight. She describes her life as having been fraught with stress and how her energy mostly has been focused on surviving. The focus on self and the feeling of doing something 'just for me' which prolonged successful dieting entails has not ever seemed possible or important. However even she has spent almost all her adult life planning to diet and has joined Weight Watchers twice and some other diet programmes on other occasions. She said,

> I've always dieted on and off but it's not been with a goal of success at the end of it really. I mean you always knew you were going to fail type thing, once I got beyond..there was one time when I married the first time, I'd been quite sick and I was actually 9 stone 3 and the next thing is I was about 12-13

> stone and I don't really remember what happened in between but as I say my life was a real messed up mess in those days and that was the last thing you thought about... (Heather, Int 5: p. 13).

Sally, through her own reading prior to this study, had decided that reduction dieting is not an effective procedure. A previous job in a pharmacy brought her into constant contact with women's engagement with weight loss attempts and the daily dialogue which arises out of body consciousness. She noted the constant stream of women wanting diet supplements and related diet products in the process of the endless attempt to shed pounds. She said,

> **S:** Women want to feel good and they think if they are taking something and it may lose a couple of pounds then they will feel better for it.
> **J:** Do you... I suppose it seems a bit futile to me that women need to lose two pounds to feel good.
> **S:** 'Tis really but I must admit I was sick last week and I lost four kilos and I must admit I thought that was the best thing that ever happened. I have put two back on now but not the other two. People are making comments..hey look at all the weight you have lost off your face since you have been sick and my uniform fits better and people just make so many comments.
> **J:** How does that make you feel?
> **S:** Well good because I don't like myself with chubby cheeks and a round face. I'd like a hollow jaw line so it actually does make me feel good with the women at work because we are a real family, always encouraging one another and if we know that someone or other is on a diet then we can actually see..I mean we don't lie but if we can see someone has lost weight we will say ...but we will also say hey your uniform doesn't look so good or you have put on a bit of weight (Sally, Int 2: p. 3-4).

Here Sally describes the shared preoccupation with bodily reduction which characterises her interaction with colleagues. Women's subjectivities are powerfully moulded by a plethora of texts both visual and verbal which speak of slenderness as desirable and reduction dieting as logical, advisable and inevitable. Medicine adds authority and therefore power to the will to diet. The codes, conventions and norms of dieting behaviour are widely known and well learnt by most women who can act either with or against the decision to diet, but are never entirely free from engagement on at least some level. It is very difficult for a large women to stand outside such positioning even when she is aware of the contradictions. Morag has acknowledged the short-term success of

reduction dieting, but makes a significant comment related to its dominance when she says in response to being asked if she will ever diet again:

> **M:** Yes, well I don't know if I will but I will always be tantalised by it because that is the only thing that I know that offers hope for me to change my size so [if] it's at a point where I feel I care about myself, and I don't want to change my size so it's not an issue, but the moment some other crisis creeps in and I can pinpoint that on my weight then I have to think dieting cause it's the only hope that I would have to change it
> **J:** Yes but what does that feel like, I mean because I am in about the same position in that I too have dieted and regained the same thousands of pounds and I know that dieting doesn't work but I can't guarantee that I won't diet again. I mean even here I am doing this research but because the only way I think I could ever be smaller is by dieting I can't reject it.
> **M:** No that's what I mean because it offers some hope
> **J:** But I am becoming more daunted by the transience of that hope.
> **M:** ...There are people that do succeed to keep it off but their life is a prolonged diet. And if you could be disciplined enough for the rest of your life to keep that then it's possible. So you'd have to, what I guess is the point I'm at is that I have to think to myself, am I prepared to diet for the rest of my life, whereas most of us think, can I diet to lose weight
> **J:** For Christmas or by summer or... (Morag, Int 1: p. 5).

There is evidence (and participants have already alluded to the phenomenon) that the consideration of, or constant engagement with, reduction dieting raises the awareness of eating beyond the level of simple satiation of hunger. I discussed with participants the evidence in the literature that abnormal eating patterns may be created by reduction dieting (Polivy & Herman, 1985). More recently, the work of Cowen et al. (1995) suggests that calorie deprivation alters the ability to sense hunger or satiation for a considerable period after the calorie deprivation ceases. In the interviews, this was illustrated by the following discussions:

> **J:** But you see sometimes I wonder if actually letting go of dieting would enable us to get in touch with eating a bit more normally anyway. I mean I think some of the overeating we might have done was in response to either having dieted or threatening ourselves with a diet, so when you let go of dieting and you actually know you are going to eat the next meal and the next meal there's no need to actually have a bit before it as well. Does that make sense?

E: Yes, it certainly does. I mean often you used to sort of say well I won't have breakfast. I'll skip lunch or whatever, and of course you are absolutely ravenous and before you get to the tea table you've already gone through the biscuit tins or had a rummage around and seen what you can find and just stuffed it in (Elizabeth, Int 4: p. 2).

And later Elizabeth again:

E: When you diet you tend to binge so that you can quick let's enjoy this last piece of pavlova, chocolate cake, you know it might be the last one you get, and you sort of say to yourself well it's going to have to be this way for ever and ever that you can never have chocolate and milkshakes and stuff again, you know, and yet after dieting it's amazing how, yeah, it just starts with eating normally again and you see the weight going on and you think well I may as well have that piece of whatever, so yes you do. You almost give up and think well what's the use.

J: Yes, I know. And then you think of all those weeks of deprivation and cutting up celery sticks and spooning out cottage cheese and think what was it all for.

E: Mmm, exactly, you've just wasted it and you've just proved to everybody else that yes you haven't got any discipline in your life and you're a failure once again (Elizabeth, Int 5: p. 10-11).

Here Elizabeth clearly articulates the complex relationship between dieting and eating differently as a result of dieting. The physiologically determined resumption of weight after a period of loss is perceived as a personal failing, and the attitude to food becomes fraught and far removed from the simple satiation of hunger. Elizabeth also describes how the experienced or repetitive dieter knows the strictures to follow and cannot resist prior comforting with what will become forbidden food.

By the end of the study, at her final interview, Sarah was embarking on another diet to lose the weight she had gained following a loss earlier in the study. Having listened to her determination and excitement the previous year and watched her weight loss it was illuminating to see the scenario enacted. I shared with Sarah my own experience of having been at that point but having responded to it differently.

J: I am large and I'm not the weight I would like to be at all. I mean I'd desperately like to be slim but I came to the realisation that I was not going to

> make it and I didn't want to diet for evermore. It was very scary letting go of dieting, because it had been a great part of my life and because I am a very persistent, determined, motivated kind of person and if I want something I work quite hard at it. But also what I started to see was that dieting made me eat badly when I wasn't dieting..//.. It's a bit like being let out after being shut up
> **S:** Yes let out of a cage. You go mad don't you... (Sarah, Int 5: p. 2-3).

By the fourth interview Heather had decided that in many ways her eating has always been influenced by the threat of dieting. She had discovered that her blood pressure was extremely high and was planning to 'take herself in hand' by beginning another diet. She noted at that interview that again she was eating more than usual in anticipation of the strictures that were to follow. Ogden (1992) documents related outcomes in the altered relationship to food described by dieters in her study. This included obsessing about 'forbidden food', following one dietary lapse by eating excessively to compensate for the sense of failure, feeling bad about themselves and their eating after having a high-calorie meal or eating in anticipation of impending deprivation. As Heather noted 'You know I went into a coffee bar the other day and had a cream horn because [soon] I wouldn't be able to have any more' (Heather, Int 4: p. 13).

Not only does the eating become disordered and unrelated to hunger, it also takes on a component of guilt. This was also noted by Spitzack who suggested that guilt underpins the dieter's recognition that eating to excess is always a possibility, because dieting itself 'underscores the hidden character of consumption, which the diet is designed to cure' (Spitzack, 1990, p. 18). Clare commented,

> At the weekend I had Easter eggs with the family and I shouldn't have eaten those and then I thought "why should I feel guilty about having an Easter egg?" and I was trying not to feel guilty and I never put on any weight having them anyway... you are really conscious like, oh, that's got so many calories and I better not have something later because I've had that (Clare, Int 3: p. 4).

Inevitably the guilt which Clare describes is accompanied by an apologetic remark. In chapter three I noted Spitzack's (1990) work identifying the process of confession in which women publicly apologise for eating in order to defuse the implicit criticism which they expect if a large woman is seen to indulge. If Clare displays her apparent awareness that Easter eggs are really out of bounds for her she is reassuring herself and her audience that she knows there is a problem that she must address.

Celia too could begin to recognise the impact that dieting or food control had had on her eating, and she talked about the manner in which emerging body consciousness was translated into food manipulation in order to feel better about herself and in control of her situation. She described her entire adolescence as a period of interaction with the possibility and the actuality of degrees of starvation:

> When I started I felt really good. I went through phases of feeling awful when I didn't [control eating] and I ate too much, but I wasn't really into too much flagellation but definitely a control thing ... (Celia, Int 4: p. 1).

Despite growing awareness that reduction dieting does not work, as noted in chapter three, medical advocacy for the practice continues. Failed dieting continues to be assumed, somewhat simplistically, to be due to the resumption of bad eating habits on the part of the former dieter and to the pathology of obesity. Participants in this study clearly acknowledge that at times they do eat unwisely but ironically this is as a result of attempting to cure imagined poor eating habits which may well have been non-existent at the outset.

Polivy and Herman (1985) suggest that following the severe deprivation of prolonged or repeated reduction dieting abnormal eating patterns may occur, and the overeating of some obese persons may have more to do with reduction dieting than any original eating disturbance. This information was shared with some participants, in this instance Celia, when it seemed pertinent to the dialogue. She commented,

> **C:** The damage is there but I think you can undo it. But it's a long process.
> **J:** O.K. Are you saying that you still sense that your relationship to food is impaired by the things you've been through (**C:** Yeah) but you can recognise it and you think you can challenge it a lot better.
> **C:** Yeah. I'm doing it at the moment by, I guess consciously not dieting and actually trying to eat as a person would eat who hasn't been damaged in that way... I think it means eating when maybe I don't feel like it, as a discipline, and I think that breaks it in a way. Like I think my old patterns were that I wouldn't have breakfast because I felt like I had eaten too much the night before and then I'd feel really hungry about mid morning. Lunchtime and I'd have a huge lunch or pig out, or maybe I wouldn't even eat at lunchtime, I would enjoy the feeling of hunger and then I'd go home and I'd be so low that I'd eat something that would give me a quick pick up.
> **J:** And then go on eating through the evening?

C: Yes, absolutely yes, because you never feel satisfied. (Celia, Int 4: p. 2-3).

Drawing on the profiles of these participants, as described in chapter six and the discussion in this chapter, a picture emerges of women dieting their way to obesity. Their experiences fit the description of Brownell and Wadden (1992) who noted that many of their clients by the age of forty had lost and regained approximately 50kgs moving from about 70kgs at the beginning of adulthood to often 100kgs or so by the age of forty. When this is related to the material in chapter three about body size and health outcomes it is apparent that a person weighing 70kgs does not need to diet for health reasons. Yet in the prolonged attempts to reach well below such a weight participants become inexorably heavier and move into a different category of weight where there may be medical reason for concern.

Nearly twenty years ago, based on extensive work with women, Orbach (1978) argued that dieting produces an obsession with eating and noted the secretive eating which it encourages. This finding is borne out in this study, but of more significance is the degree to which work such as Orbach's has remained marginalised and largely inaccessible. Work such as Cowen et al. (1995) now provides an explanation based in the natural sciences, which may be seen to carry more weight in reducing medical and nursing support for reduction dieting.

The images offered to women by the diet industry and condoned and supported by medicine represent unattainable levels of bodily transcendence for all but a very few women. Each woman imagines that if she just works hard enough and long enough, she will access a palpable zenith which then becomes her judge and a constant prompt against which she will forevermore confess that she has not been vigilant enough. Spitzack (1990) notes that the slender body is viewed quite literally as a heavenly-after life, a reward for virtue and starvation. There is always, as depicted in diet clinic photographs, an unacceptable, untenable 'before' and a gloriously slim 'after', invoking an earthly now and an everlasting heavenly afterwards.

Unfortunately it is the dieting which becomes everlasting and not slenderness. The consequences for women are the engagement in an endless battle with their own bodies. The battle is herculean and never satisfactorily completed, because even when the woman disengages from actual dieting she exists within a tension between herself and the possibility of dieting. Her expressed reason for dieting is often within the realms of needing to feel better about herself because that female self is so intimately bound with the physical manifestations of appropriate femininity.

Participants have described, in this chapter, the repetitive nature of their reduction dieting and their growing sense of frustration and hopelessness. Full information about reduction dieting was not known by participants, even those who had read that dieting does not work. Research-based challenges to the efficacy of reduction dieting are not present in more accessible forums, meaning that women continue to make decisions and choices based on insufficient information. As noted in chapter three, medical authority is still invoked to claim that reduction dieting is effective and there are still direct statements by medical practitioners advocating the practice.

In chapter three I noted that popular discourses utilise humour, medical authority and the power of science to inform the large woman of her deviance. She is exhorted to reform, restrain, and above all to refrain from the eating which is always assumed to be the source of her deviance. Simultaneously, women learn how very unacceptable a larger body is. Many sources assume a mantle of expertise in advising the large woman how to enact her cure and few if any acknowledge the transience of that 'cure'.

Althusser (1971) describes how subjects of discourse interpret it variously according to their social context and the variety of understandings which are possible. They are, as he noted, 'interpellated' or called into being by the ideological forces issuing from institutional superstructures, in this case medicine and popular culture through the media. He noted especially the manner in which subjectivity may be interpellated differently because of factors such as class or educational achievement, creating the possibility of fragmented subjectivity. In this study it is remarkable that despite wide class, educational and other differences the knowledge that participants held is very consistent. They have almost universally believed that they have been wilful overeaters and that thinness is a matter of personal vigilance.

The discourses of femininity are so powerful that the pursuit of slenderness runs as a central theme traversing class and educational differences. Bartky (1990) notes that the technologies of femininity, in this case reduction dieting, readily become compulsive or even ritualistic in character. She notes that the processes or disciplines that construct a 'feminine' body out of a female one appear no less prevalent across multiple localities even if their pursuit or expression may differ to some extent.

For all of the participants there is a constant relationship to reduction dieting. Even when they are not engaged in dieting there is inevitably an underlying sense that they should be. Food is a source of anxiety or guilt rather than pleasure. Deprivation is planned and then compensation occurs. Yet at the same time as their inner world involves an endless

relationship (albeit uncomfortable) to food, the participants describe their diffidence about being publicly associated with food or enjoyment or indulgence in food. The next chapter deals with the alienation from the social world of food as experienced by the body conscious and dieting women.

CHAPTER EIGHT: Alienation from the Social World of Food

8.1 Introduction.

The previous chapter examined the manner in which the woman who decides that her body size is defective turns to reduction dieting or endless manipulation of her food intake as a seeming solution. In this chapter the women describe how food and its enjoyment become forbidden and problematic as a result of the prolonged engagement with reduction dieting. I use the term 'engagement' to signify that there is always a relationship to reduction dieting, because even when active dieting is not taking place the large woman is at some level relating to the process even if she is only resisting beginning a diet until tomorrow.

8.2 Alienation from the social world of food.

Avoiding eating or eating minimally in front of others is, like reduction dieting, a way of assuring others that we are mindful of the potential or actual aberration of our bodies. It is both a demonstration that we have the matter in hand and a signal that vigilance is always needed. Spitzack (1988) notes that women's daily talk is redolent with dialogue about the need to control eating and to demonstrate both the need for and the reality of that control to others. In so doing we reassure ourselves and others that the wayward female body is in hand, and we tacitly acknowledge populist discourse which casts large women as slothful gluttons.

There is, as previously noted in chapters two and three, some degree of overlap between the various discourses which inform the area of women's body size. Much of that overlap is located in a general agreement that fatness is solely related to excessive and inappropriate consumption of food. Until comparatively recently any genetic contribution to obesity was vigorously denied. When I ventured the suggestion of genetic issues in the popular press four years ago I received an angry letter of condemnation from the medical director of the New Zealand Nutrition Foundation. As noted in chapter three, Swinburne (1995) has now estimated the genetic contribution at about 30%, but the August 1996 edition of New Scientist suggests there is growing evidence that it may be very much higher.

The intersection of the various discourses about body size, at the point of food consumption, allows for the behaviour modification focus of public and medically sanctioned diet programmes. The participants in this study demonstrated that they are highly conscious of the beliefs and ambiguities present in their portrayal as gluttons. Not only do they, as just described, engage with reduction dieting, they also alter or monitor their public eating behaviour accordingly, because they feel interpellated by public assumptions about large people's eating.

Elizabeth described vividly her horror at being 'caught' up town eating an ice-cream when she met a slim friend. Not only was she 'caught' eating, but this also raised concerns for her about her entire physical presentation and possible interpretations from others:

> But she [the friend] always looks absolutely gorgeous and of course we'd rushed out and my hair needed a wash, I wasn't really looking my sharpest and here I am standing there with this blimmen ice cream and I couldn't let it drip down my hand, so I had to stand there and eat it and I just felt really blah, I thought what are they thinking, they're thinking oh you don't need that you know. (Elizabeth, Int 2: p. 12).

And Morag makes links between self scrutiny and the assumed or supposed surveillance of others on our behalf when food is to be publicly or socially consumed:

> **M:** Oh well if we were at a family do, like we are going away to a family thing this weekend right, but you see I don't really eat, maybe I do, I don't know, but like at a meal time I would probably eat the normal sort of meal do you know what I mean but I'll be very conscious about what I put on my plate compared to what other people put on their plate
> **J:** What because someone else might watch
> **M:** In terms of the type of food. Because it would be just classic wouldn't it, it would just reinforce the stereotype if I sat down with a cream bun opposite my skinny Aunty who looks across and thinks poor Morag she is fat, no wonder look at what she is eating... (Morag, Int 4: p. 4).

And Maggie also commented,

> As in, when you go to lunch, you don't have the cream cake. You are conscious, I mean I am quite conscious if I go to a coffee bar that people sit there and watch what you take to eat... (Maggie, Int 1: p. 10).

Elizabeth and I discussed this further in an exchange which graphically demonstrates the manner in which large women both experience and inflict stereotypical views. The hegemonic power of beliefs about bodily largeness is significant. Elizabeth said:

> This is the thing, you think people look at you and think oh she doesn't need that, or no wonder she's such a bonny lass .. /.. I know I have done that myself when I've seen somebody that's really huge tucking into something really scrumptious and I think 'oh boy what are you doing to yourself'. (Elizabeth, Int 2: p. 13).

Celia and I explored this area alluding to some of its wider meanings.

> **C:** What do you eat when you go out to lunch with some of your friends. Do you watch what they put on their trays?
> **J.** I still think a bit more when I go out with skinny friends, I mean I have got to the point where I probably eat quite reasonably anyway, but yes there's still an element of consciousness there that if I was going to indulge this wouldn't be the time in case the skinny friend thought less of me as a result.
> **C.** Yeah Yeah, it's funny isn't it. There's that whole thing about enjoyment of food
> **J:** But that enjoyment is like the friend you just talked about who implied that if she started [eating] she might not stop. I think we don't dare express enjoyment because where is the boundary, the end to enjoyment. It's too big.
> **C:** Yes, But then what's wrong with that?
> **J:** Well I don't know
> **C:** Or are we showing in our bodies that we haven't been able to find the boundaries,
> **J:** I don't think that there's anything wrong with that but I think control has been so continuous that it's quite hard to let go of it (C. Right) And I still feel a little shocked when one of my larger friends says, 'there's nothing I'd like more than a cup of coffee with brandy and sugar and an inch of whipped cream on it.' I still have that shock reaction. (Celia, Int 3: p. 5).

The tendency towards public abstinence and private indulgence and the complicated relationship of denial and reward surfaces in the following story from Clare.

C: Our playgroup runs craft evenings a couple of times a year, for the mums just to get out and learn something different and us on the committee make the supper. If you make something like chocolate gateaux and things it doesn't get eaten. Last time I did crackers and cheese and they all went. Even in front of other women they won't eat the yummy things. I think the last time they did that, us committee ate up all the yummy things after they'd gone. That's good.
J: So maybe it's no wonder they have to go home and eat in secret if you're not allowed to do it in public and maybe if we did it in public like everyone else, we'd ultimately eat a lot less.
C: Probably. Because when you get home you will eat more, than if you just eat when you are out. (Int 4: p. 10-11).

And Clare also said,

> At Weight Watchers, one meeting they were saying do any of the others have secret eating? Well, we all have, and one woman said it was chocolate biscuits for her, because if she ate them, if her husband saw her eating them, he'd come and pull them out of her mouth. So of course she was going to eat twenty more when he wasn't around; fortunately my husband wouldn't do that. But like last night, he was out last night and he came in and I'd done the dishes but I'd forgotten my pudding bowl which was by the chair in the lounge and he said' oh well what did you have for pudding?' and I said 'I had ice-cream and fruit', it was allowed [Weight Watchers ice-cream], but he was just checking me. (Clare, Int 3: p. 11).

For these participants answering the question "Do you overeat?" caused confusion and uncertainty and conflict. My strong sense from listening is that participant descriptions of eating patterns are discursively constructed through the various discourses which tell us and the public at large that fat people must overeat. It requires considerable resistance to discursive constructions of large people to understand oneself as a large woman who eats normally or at least did eat normally until becoming caught up in the diet and regaining cycle. As Maggie noted,

> people do think that large people do just eat and eat and eat, that's how they got there, but I mean you've got skinny people that eat and eat and don't put weight on, so I don't agree with that (Maggie, Int 3: p. 8).

The belief that obesity is created by excess intake of calories has attained the status of a dictum. Given the usual networks of knowledge and power this belief is widely disseminated through multiple discourses pertaining to body size. The dictum was based on authoritative studies which failed to demonstrate conclusively any evidence to the contrary despite the frequent observation, as just made by Maggie, that different people do eat more or less than others but only some become fat (Hirsch, 1997). Very recent research in the area of molecular genetics is beginning to provide some new information with regard to differing rates or levels of calorie expenditure as a basis for obesity (Hirsch, 1997). Meanwhile it remains difficult for large people to understand themselves in any way other than as large eaters.

Sally, however, is certain that she eats quite sparingly in comparison with friends. She both works and lives with other people of similar age and has many opportunities for frank comparison (Sally, Int 2: p. 6). Jo believes her eating habits fluctuate according to time pressures, emotional states, and money and social life pertinent to student life. She has never really considered if this is any different from the eating habits of slim student contemporaries (Jo, Int 2: p. 3). Heather is certain that she consistently overeats but does not link this to her dieting or plans to diet. Rather she is sure that she overeats to compensate for the stresses in her life and believes that if she could resolve her emotional distress her weight would resolve as well.

Morag and I discussed her firm perception that she overeats. She makes an interesting assumption that she overeats because she eats more than her husband (Morag, Int 1: p. 11), which she later acknowledged might be a socialised belief based on childhood observation that men always received the larger portions. She also goes on to suggest that it is now hard for her to know how much food is normal, because eating is so distorted by concerns about the judgements of others.

> **M:** I know on an intellectual level that dieting [makes] you compensate and put more on, but the bottom line is that what I have eaten has made me this size.
> **J:** So do you actually think you have eaten more than you need?
> **M:** Well see I don't know because I suppose I certainly eat more than most people eat
> **J:** Do you? How do you measure that?
> **M:** By my husband, I eat as much as he does, easily and more probably
> **J:** And you are not as physically active as he is
> **M:** No and he's a guy, so if I am eating more than him I am eating too much, I mean that's the sort of thing

J: Is there a rule that says men need to eat more than women?
M: I thought there was.

Later I asked her again if she was sure she did overeat and she replied:

> Yeah I think I do. But I'm hungry if I don't. Like I don't overeat all day, I eat in the evening. I'd eat in an hour a couple of packs of chips, something like that, crackers or a sandwich or something. I would have four small meals, not three normal meals. (Morag, Int 1: p. 11-12).

Here Morag insists that her eating is excessive even though she feels physical hunger if she attempts to eat less. I have observed anecdotally that whilst comments about 'big boys' needing feeding are common, similar comments about 'big girls' are not made. Recently there has been some discussion as to whether caloric need is actually governed by body weight. Concar (1995) has suggested that larger bodied people might need more calories which would compound the large woman's certainty that she overeats and therefore has only herself to blame for her size and failure to reduce. However there is no clarity in this area and more recently Hirsch (1997) has stated that caloric requirement is not altered by larger body size.

There are other issues related to food and eating which are of significance to the participants as women. Participants, all in heterosexual relationships, could identify the particular expectation that they were held responsible not just for their own nutritional requirements but for those of their children and partners and in some instances the wider community in particular social settings.

The disciplinary project of femininity thus extends beyond the appearance of one's own body and into the care of other's bodies. Women have been designated as responsible for the feeding of others. Clare was angry about an address given by a speaker at a church family camp. During a long speech about families the speaker focused almost entirely on the men, referring once only to women and then to tell them simply that their job was to keep the biscuit tins full (Clare, Int 4: p. 6). Elizabeth noted that even when women move into a breadwinning role (as more and more have), they inevitably retain responsibility for the private sphere and for feeding the rest of the family. She said,

> You're thinking all the time. Even when I ran out the door today, I was in a rush and the last thing I thought as I locked the door was 'blast I didn't get any thing out of the freezer for dinner tonight.' I thought, 'right we are going to have to

have something that thaws fast in the microwave when I get home tonight'. (Elizabeth, Int 3: p. 8).

Feeding others both at home and often in jobs which involve food provision means that women actually handle a great deal of food, and spend a large part of their days either buying it or preparing it or cleaning up after it has been consumed. I was interested that in the final round of interviews seven participants mentioned Oprah Winfrey's [American talk show host] recent televised and widely publicised weight loss, and they were quick to pick up on how she had achieved it. Elizabeth articulates the view espoused by other participants as well,

E: ../.. if I was as wealthy as Oprah Winfrey, you know, personal trainer and personal chef, I always think if I had someone to cook for me then I'd be thin because I wouldn't be in the kitchen.
J: And someone would be saying 'here is a beautiful fresh salmon with a green salad' and faced with that why would you bother to pick [at food].
E: Yes exactly. (Elizabeth, Int 4: p. 11).

Because food is a way of caring for others then it should also be a way of caring for oneself, but for women a contradiction arises in that they must abstain from eating in order to attain the desired feminine appearance. When I asked Jo about the links between femininity and food, she said

Jo: They...um...they don't...food is at one end of the scale and femininity is at the other...you can't eat and be a size eight...you can't eat if you want to be society's ideal woman.
J: But it's woman who do all the providing of food?
Jo: Yes, we're expected to cook it and bake it and deliver it on the table at 6 p.m. every night but not expected to enjoy it ourselves. (Jo, Int 2: p. 6).

Clare talked about women's role as food providers, noting how much of her life as a full time mother and church member is devoted to the nourishment of others, especially men and children. And she recognises the aspect of pleasing and caring for others that is bound into the feeding. She says 'I often will cook my husband a really nice meal because you want to do something really nice for them and you want to do it with food' (Clare, Int 2: p. 9). But she was also aware that as a dieting woman any thought of caring for herself with food is problematic. She says,

> When you are in the work force you do something really well, people will say well done, you get that sort of praise and feed back, at home your husband is working, he's not going to see what you are doing. Nobody says "you cleaned that bath great' You don't get that feedback, even when he's home, he's too busy with his own things to notice the mundane things you do every day. Maybe we are rewarding ourselves with food. You think, oh well once I have cleaned up the lounge and done all those windows I will sit down and have a cup of tea and a piece of cake. (Clare, Int 2: p. 10).

Sarah is the oldest participant and, as previously noted, feels very comfortable about the naturalness of her role in her family setting. She describes her husband as doing the farming and herself as doing the feeding of her husband and two boys (Sarah, Int 2: p. 1). And whilst Sarah seems entirely comfortable providing love and caring for her family she is perhaps less sure of her own needs or rights for recognition as a person separate from the caring through food. She comments,

> I think I probably still am taken for granted, but it doesn't worry me, it never has done.... My husband used to call me Mrs. In fact my son didn't know my name until he was probably nearly five../.. my son didn't know for years what my name was. because we asked him one day and he said 'Mummy' and I said 'No, what's my real name?' and he said 'Mrs' and he was nearly five. (Sarah, Int 3: p. 7).

Heather who works full time outside the home cannot relinquish any responsibility for the domestic sphere and battles both the physical tie of doing both and emotional uncertainty about what is 'right'. She says 'It's funny I can't find a balance for myself between the mother and the person who's going out to work' (Heather, Int 3: p. 6).

Despite enormous changes in labour force participation women still, as noted in chapter one, carry the bulk of domestic responsibility, and are associated in media imagery with the preparation and presentation of food alongside other domestic work. In real terms they handle food constantly, yet as shown these participants describe having trouble eating publicly and are aware that femininity has to do with being small and fragile and not displaying or publicly satisfying hunger. Caring work on behalf of others is a big part of many women's daily lives, yet there is considerable confusion about caring for self especially with food.

MacBride (1988) notes that feminine giving of self has often been equated with the giving of food; a candlelit dinner for a lover, soup for the sick, biscuits and a drink for the homecoming child, home made delicacies as gifts and the daily routine of shopping, cooking and feeding the immediate family. Yet Chaiken and Pliner (1987) found that women who eat smaller meals are assumed to possess stereotypically and therefore desirable feminine traits. This places self denial of food as an important component of femininity and makes feeding self as compared to feeding others, fraught with contradiction.

The disciplinary project of femininity has thus far provided a lens through which the first phase of the experience of embodied largeness is explored. The development of body consciousness and growing awareness of the body being larger than desirable is followed almost immediately by manipulation of food intake and eventual engagement with the process of reduction dieting. Reduction dieting is seen to facilitate a situation whereby food becomes overidingly important and the focus of constant monitoring. In the process the dieting woman is subjected to a continuous surveillance from within and without, as she comes to understand herself as the subject of various intersecting discourses about the eating habits of large people. Accordingly she imposes an alienation from the social world of food as a means of assuring both herself and society that she knows she must not eat without careful restraint.

Foucault's (1979) description of normalising disciplinary practices explains how these women have become the subjects of what Foucault calls disciplinary power. Women may discuss various means for the achievement of slenderness and compare notes on procedures as to their effectiveness, but they rarely if ever challenge the discourse itself. They have regulated their lives according to the requirements of the dominant discourses about body size which, as shown, are heavily pervaded or penetrated by medicine.

In this chapter I have focused on the confusions and contradictions which exist for a large woman who must negotiate the fraught area of public and private eating. She is the subject of a cogent disciplinary power that assumes an authoritative stance in terms of the 'truth' about the nature and source of large bodies. Having first learnt that her body is too big or in danger of becoming too big, she then learns that it is her inappropriate and undisciplined eating which is at fault. Once caught in the dieting and regaining cycle her distress arises not only from the failure to become thin but also the intensely public nature of her transgression.

The next chapter moves on from the issues of eating and dieting and begins to explore aspects of living as a fat woman. Constructions of femininity remain as a central thread which informs the experience.

CHAPTER NINE: Interpreting and Internalising the Meaning of Fatness

9.1 Introduction.

This chapter elucidates the phenomenon of **interpreting and internalising the meaning of fatness**. A key aspect of this is **suffering**. I argue that living as a fat woman is seen to involve a process of identity as other, and the disciplinary project of femininity (as introduced in chapter two) by defining what is central, plays a significant role in the construction of that other.

Here the participants have, in a variety of ways, expressed the complexity of embodying largeness while living in a world which vilifies largeness. In other words the social meanings ascribed to fatness are embodied in the way they experience their lives. They are literally trapped in a body which has been designated as one of the several 'Others' which characterise Western discourses of the body (Davis, 1995).

As Davis (1995) explains, dominant discourses of the body within Western culture enable certain groups to become the ones who determine and measure the standards which come to be seen as 'normal', central and somehow desirable. Davis notes that those identified by the dominant culture as 'other' include the old, the disabled and the fat, and as such these groups are imprisoned in the body which defines them. She says that 'beauty standards set up dichotomies of Otherness and power hierarchies between women' (Davis, 1995, p. 51).

Put most simply this means that the shape, size, and appearance of some women meets approval and reward, whereas the same aspects of differently-structured women meet particular social disapproval. For large women there is added stress, because Western society also subscribes to the notion that physical appearance is closely linked to character traits. As noted in chapter one, large people are stereotyped as possessing various character traits including laziness, poor self discipline and personal responsibility for their unacceptable appearance.

Dominant framings of femininity first create the circumstances in which women are intimately involved with food and feeding, then simultaneously demand that women's bodies remain untainted by the impact of excess flesh or unsightly fatness. The bodies of

women who have borne and fed children may not relax into the softened, more blurred outlines of the maturing female body, but should at all times remain firm, slim and taut.

The textual mediation of discourses of femininity simultaneously demonstrates both the problem and the solution. The very texts and social contexts which create body discontent also offer a multitude of complex solutions. Women are offered an apparent choice: they can actively resist depictions of female perfection and choose to live outside bodily boundaries with all the consequences that entails. Alternatively they can accept the authority of such images and look to populist discourses in which, as previously discussed, everyone is a self appointed expert who can tell them how to achieve the supposed 'nirvana' of feminine beauty.

Being overweight is described by the participants as a state of constant concern and preoccupation. Embodied largeness becomes the filter through which life is screened in a preoccupied way. This ranges from efforts to disguise and flatter their large bodies with appropriate clothing, to despair and disgust with a body that acquires object status as they confront its unruly and unwanted largeness. The large woman is not comforted or cheered by the sight of other large women. Rather she imposes the same standards of condemnation as she would if slim. This generates confusion and shame because they have condemned a fellow sufferer. Celia commented on her response to seeing another large woman,

> When I look at a woman like that I think surely they could do something about that, you know the parts that hang down and they waddle along, surely they could do something about that it would be easy... (Celia, Int 4: p. 8).

Sarah not only worries about hiding her own large body but is also offended by the sight of other women's bodies when they are large. In this instance she is describing an acquaintance.

> Mind you sometimes in the summer time she does tend to wear big sunfrocks and things with these huge arms sticking out, it really puts you off. (Sarah, Int 2: p. 7).

And Morag,

> ... and then I'd think about weight when I see another overweight person and think crumbs I'm as big as they are..//.. And then I think, that's really awful. I wish I didn't look like that. (Morag, Int 1: p. 7).

Jo, Heather and Clare also expressed their feelings about other large women, noting uniformly that they found the sight of such women unpleasant and off-putting but then felt confused and ashamed when they immediately realised that they are not dissimilar. Most painful was the realisation that they were engaging in the same stigmatising processes of which they are victims. As Heather said:

> And then you do a double take when you see yourself in a shop window and you think my God I am as big as that and you feel yeah, a little bit disgusted-really disgusted. (Heather, Int 5: p. 1).

Large women, then, think and speak from within the discourses of criticism, blaming and revulsion towards large bodies, their own included. Some of them are also aware that the strictures are particularly intense for women who are large, as compared to men who are large. For example, Elizabeth commented:

> Men even though they're huge don't have to justify their whole existence...it's definitely the women who get hung up on this weight thing...it's their duty to be slim and attractive for their man you know (Elizabeth, Int 5: p. 14).

The participants identify their shock and even disgust when suddenly confronted with the sight of their own bodies in a shop window or shop mirror. They convey a sense of being able to forget the reality of largeness until it is reflected back, at which stage the realisation of largeness causes considerable distress or loss of confidence. Elizabeth remembers going out one evening feeling attractive and confident that she presented well until she caught her reflection in a mirror

> ... it just sort of waived my confidence again and I thought ooh, I'm a blob, so all those feelings that I'd felt of looking confident and good, yeah they went out the window again (Elizabeth, Int 5: p. 14).

Although this is themselves they see when looking in the mirror, they sometimes use the word **that** when describing the reflected view of their body. Millman (1980, p. 180)

suggested in her study of large women that they experience the body as 'an unwanted appendage', somewhat distanced and dissociated from the person. Smith (1990) argues that in considering the reflection the subject is displaced from the body. She says that 'the mirror provides the standpoint of the text looking back on her reality in relation to the textual images of fashion' (p. 189). Smith goes on to explain that it is the disparity between what she sees in the mirror and what she so constantly sees as images of perfection and desirability elsewhere, that locates her imperfection for her. She says,

> The mirror offers a simulacrum of the text; a woman can look in the area and see herself framed as if by the margins of a page and raised thus to the level of the text; the relation between herself as text and the ideality of the image is the measure of the gap (Smith, 1990, p. 189).

Both Sarah and Jo articulate this when they comment,

> **S:** No, and I don't like what I see in the shop window, I see the reflection in the shop window and think oh, I don't like that. (Sarah, Int 2: p. 5).
> **J:** I have a great day at work and everything's going fine until I catch myself in a mirror or something and I think God...you know, look at **that**. (Jo, Int 3: p. 9).

Large woman inhabit a body which is constantly reflected back to them in particular ways. Public depictions of large people are frequently the subject of humour or revulsion, and they are portrayed as the physical manifestation of greed, sloth, overindulgence and general slovenliness on the part of the woman who inhabits the large body. Because they are rarely visibly associated with positions of power or authority, and frequently associated with gluttony and self-destructive behaviour there is the added tendency to associate largeness with low intelligence. Millman suggests that 'the obese' elicit blinding rage and disgust in our culture. They are often, she says, 'viewed in terms that suggest an infant sucking hungrily, unconsciously at its mother's breast in a way that is greedy, self absorbed, lazy and without self control or willpower' (Millman, 1980, p. 65). Lockford (1996, p. 295) drawing on Millman's earlier work suggests that the overweight woman is 'marked as engaging in an *intentional, threatening,* yet *out of control act of rebellion* ' which places her at odds with her own femininity. It also makes her subject to a variety of judgements which are sometimes implicit, sometimes explicit.

Morag in describing her husband's response noted:

> Yes he hates fat people. To him it represents slothfulness. If you are fat you are lazy (Morag, Int 1: p. 7).

Internalising this meaning of fatness generates responses which include compensation, denial of feelings, and constant fear of others' assumptions. For Celia as an academically successful woman it is the assumption of low intelligence which most bothers her.

> I think I'm conscious of the image that my body portrays that it's maybe somebody who's not very intelligent because how did she get herself into this situation in the first place. There must be something wrong with her and therefore I am at pains to present myself as an intelligent, reasonable not emotional person. (Celia, Int 3: p. 1).

The assumption of lack of intelligence in large people is demonstrated in the nursing literature by Black and Mangan (1991), who stated that the morbidly obese tend to be of below-average intelligence to the degree that they may be unable to understand dietary advice. Positive role models of large women are extremely rare in media presentations and it is difficult for many large woman to feel any pride in identifying with someone such as the character Roseanne in an American television situation comedy. Roseanne is large, noisy, somewhat crude in mannerisms and not notably intelligent. There are aspects of 'otherness' here as well and interesting links to historical tendencies to depict people of colour as similarly lacking in intelligence. Compensation may involve trying to counteract the social expectation of laziness and lack of motivation or willpower. As Elizabeth notes,

> they see overweight people as people who don't have any self control you know.. /.. I suppose you sort of have to justify yourself in other ways to either be smarter, work harder, I never get caught sitting down, you , you know if someone comes to the house and you happen to be lying down reading a book and having a cup of coffee, quick leap up, get the broom, clean the windows ../.. I don't want to be a slob. (Elizabeth, Int 2: p. 11).

I told Jo that some of the other women had talked of trying to compensate for how other people might think of them because they are fat. She said,

> I really identify with that. It's like in the last couple of years, especially with work, I want to be super organised, and everything just so... so people can't say ...you know... (Jo, Int 4: p. 6).

Morag was very aware of the impact of stereotypical portrayals of large women such as 'Roseanne' on television. Interestingly she too utilises a populist discourse of 'fatness equals slovenliness' in noting that 'she [Roseanne] is a fat slob with a big mouth and a bossy rude attitude' (Morag, Int 4: p. 6). From that she reflected on her own response as an organised and hard working person to imagining she might be considered lazy or slovenly. Celia too commented on the presentation of Roseanne 'who is excessive in every way and we don't want to be seen like that, or Mama Cass [large woman singer] who died over a ham sandwich'. (Celia, Int 3: p. 1). Additionally, Morag noted:

> **M:** We can always be hard working, this could be our redemption to be seen to be hard working
> **J:** What does that compensate for?
> **M:** The fact that large people are slovenly and lazy...And yet I've met women quarter the size of us who haven't got the energy to lift up a chair and move it from one table to the next. And nobody accuses them of being slovenly when they sit all day
> **J:** Do you know I have a very strong memory of being nine months pregnant one January in Auckland when the humidity was about 95% and I was too embarrassed to go for an afternoon rest because I thought people would think I was lazy. (Morag, Int 4: p. 8).

There is the sense that the large body defines the nature of the person who inhabits that body. Characteristics of the large person's nature are built from populist depictions of large people as those who overeat, underexercise and are generally lazy and undisciplined. There is little overt acknowledgement of the somewhat serendipitous allocation of smaller bodies. After all it is not the case that all small people exercise vigilantly, and nor do they always make sensible food choices.

There are also other aspects to the assumed nature of the large person, in particular the association of fatness with 'jolly' good naturedness and a general ability to absorb criticism. Sally revealed a great deal of pain talking about her friends' assumptions that she could cope with comments and criticisms as if they somehow perceived her as not having real feelings. She said,

> They try the nastiest tricks to make you feel like the biggest dick in the room and you'll laugh because you're fat and jolly, yes we do because, I mean I'll hop in the car and drive home crying. (Sally, Int 2: p. 7).

Throughout the period of interviews, Elizabeth reflected on her tendency to tolerate the remarks people may make to her, even when she disagrees with these remarks.

> That was something that really struck me when I read through the transcripts, especially the bit about tolerating other people saying and doing things. I'm having some problems with that too , I'm just not being assertive enough and sort of letting people get away with saying things.. ....you do tend to be more of a doormat I think. (Elizabeth, Int 4: p. 7).

There was a period during the study in which Jo received the frightening news that she might have a malignancy and was waiting for elective surgery. At that time we were discussing and trying to clarify a possible theme that being fat somehow prevented people from seeing our vulnerability. Jo noted the difficulty her friends had had in perceiving her neediness. She observed that they continued to come to her for support and solace in a way which made her feel both large and available and simultaneously invisible (Jo, Int 4: p. 7).

Throughout the interviews the participants and I grappled with the notion that largeness was variously equated with jolliness and lack of sensibilities. Morag saw these as related:

> What you build up is a profile, if you think about it, you've got, in a large body, you have to develop a mechanism for dealing with the hurt so you laugh or joke or make a joke or whatever, OK, so for a start there will be that element where people know that you can handle ridicule or whatever... So therefore you're seen as somebody who can take the hurt. The next thing you do in a fat body is you don't want to be seen as slovenly so you're busy and you're efficient, OK, so you've got this profile of a very content, happy, able to cope with the traumas of life, proficient and busy person. So you're the very sort that attracts everybody with their woes and troubles which in turn makes you feel worthwhile cause if your opinion is sought and your counsel is sought and on you go. (Morag, Int 4: p. 16).

I described to Maggie other participants' sense that they fight hard to have other people recognise their need or their distress and to deal with the sense that large people have got broad shoulders and cope with others' problems. She responded

> **M:** I think people would make comments about large people where they wouldn't make comments about disabled people... I think it comes from the fact that large people are perceived to be makers of their own destiny and disabled people are not and so therefore you can't, you don't joke about something people don't have control over and being a large person we all know how hard it is to have any control what size you are really, it takes so much control if you want to do something, but people seem to think it's O.K. to make large jokes.
> **J:** We had a dinner party the other night with older cousins of mine, funnily enough we were talking about things like funeral costs and his wife said to me 'well I don't mind, I'll probably go before you and you can have my coffin', and he said 'oh no that's no good she wouldn't fit it' and he said it very unkindly and I thought then, you know if I wouldn't fit in the coffin because I had a disabled leg that stuck out sideways he would never have said a word, not a word (Maggie, Int 3: p. 9).

The meanings available for large women to interpret and then internalise are drawn largely from populist discourse which is, as previously discussed, given authority by the incorporation of medical discourse. Because medical and populist discourses depict largeness as the avoidable outcome of wilful gluttony and insufficient self control and discipline, personality attributes are extrapolated and applied to, then embodied by, large people. Because 'obesity' has been particularly resistant to an enormous investment of human and financial resource by medical science it is perhaps inevitable that some frustration is directed toward the inhabitants of large bodies, who are asked to accept a significant degree of culpability for their 'diseased' state. This culpability is the basis for the suffering which is the next part of the experience to be explored.

9.2 Suffering.

This seems the best word to describe the ongoing and constant engagement with embodied largeness and the degree to which it pervasively impacts on far-reaching corners of the large woman's existence. There is something about the concept of suffering which incorporates the dignity with which the participants endure somewhat stoically and

usually silently their particular lived experience. What follows is an excerpt from one of Morag's transcripts in which she describes her experiences with surgical sterilisation:

> I was apprehensive about having surgery because I had heard from a friend who was a student nurse who told me that a surgeon made comment about a woman who was having a sterilisation operation [who] was very large, and they cut through the fat and made comment about what on earth would this woman be wanting to have a sterilisation op for when she was so fat anyway who would be wanting to get her pregnant...

Morag described her fears of getting an infection and of being spoken of in the above manner. She described enduring an obvious wound infection at home until her temperature was nearly 40 degrees and eventually being readmitted to the public hospital having had the initial surgery done privately. She continues,

> Anyway this nurse, she was really young and she took the stitches out and it was so tender (**J:** yes) I can't begin to tell you how sore it was. Anyway she took the stitches out and they were quite deep (**J:** yes) and I swore at her which is really uncharacteristic of me and I said a really rude word to her (**J:** cause you were in so much pain) and she was really miffed with me and I apologised and said 'look it just hurt so much I'm sorry I didn't mean to be rude to you but be really careful please I am really sore', but I could tell she was really angry and I could tell she was thinking if you weren't so fat you would never have had this happen (**J:** so you felt blamed) so I felt fat and dirty and sick all at once you know and I didn't feel like she was very compassionate at all, I expected a nurse to be more compassionate, to be far more tolerant.

And later after a burst wound and a very traumatic night with fairly cursory care and attention she noted:

> the coup de gras of the whole thing was that the specialist who had done the operation came round with the registrar and the nurses and the sister and stood at the end of my bed, the very end while I was lying flat with my stomach exposed, and said if you hadn't had that ridge of fat above the suture line this would never have happened. (Morag, Int 3: p. 2-3).

Morag later heard that the particular theatre in the private hospital where she had the initial surgery had had a series of wound infections. (Morag, Int 3: p. 4). Celia too described an experience which also speaks vividly of silent suffering

> **C:** When I was at a family gathering of my husband's and my daughter knocked over a cup of boiling hot tea on my leg, and I had trousers on and I just sat there and I didn't do anything about it although it was burning me, actually all my skin came off, because I was so self conscious...whereas if I'd been skinny I probably would have whipped my trousers off...borrowed a pair, but whose could I borrow - they were all skinny. It would have been fine...
> **J:** So you sat there with your leg frying, and you smiled and said, no, it's fine?
> **C:** I said I'm alright. I actually went into shock I think. Then I wandered around and started crying. I felt very sorry for myself.

Later Celia revealed that the skin had actually come off her legs in sheets (Celia, Int 2: p. 17). Maggie and I shared experiences where supposed recreation became a private nightmare of the kind that ensures large woman are continually vigilant in anticipating situations where their size may cause them embarrassment. Maggie described taking a trip in a float plane and learning en route that the method of disembarkation was to be piggy backed through the water by the pilot.

> **M:** I just broke down. I said I can't do it. I can't get off this. My partner said, it's alright, you'll be O.K., and I said no I can't. He won't be able to carry me...he [the pilot] piggy backed me and it was just awful. I was so embarrassed. It really upset me...that dreadful moment when you realise that that's what is going to happen. And it came on so quickly...[and later] when we got on the plane the seatbelt didn't fit me...had to get out the extra bit.
> **J:** Did you laugh about it or did you try and hide it?
> **M:** I think I probably laughed about it. So that outwardly it gave the appearance that it didn't worry me. But certainly at the other end [disembarking] I wasn't laughing about it. (Maggie, Int 1: p. 23).

In response I shared a similar experience with Maggie which occurred during a holiday in Bali, where I had made a conscious decision to swim and to snorkel regardless of the exposure and potential embarrassment.

> **J:** I went snorkelling on the reef and it was like magic. It was like a wonderland, I had never seen anything like that in my life, snorkelling with my

children and husband and I really enjoyed it. But what I hadn't anticipated was that the funny little boats we went out in, I had no way of getting back in...I couldn't climb in from the sea back into the boat, and the little Balinese man, who would have weighed about 30 kilos, had to lift me over the side of the boat.... And his eyes nearly popped out of his head! [laughter] I can laugh now but it was terrible. It was just terrible.

M: Any chance of swimming to the shore?

J: We were miles out I would have died. But you see it totally ruined the trip. And it meant I will never do that again. Because I can't set myself up for that embarrassment. (Maggie, Int 1: p. 24-25).

These last experiences derive from fear of ridicule arising from placing the large body in territory which is designed for, or anticipates only an appropriately small body. The large person desires not to stand out any further than she already does and does not wish to draw attention to her difference. But because she must frequently broach territory that is unsuitable for her body size her invisibility may at any time be catapulted into an unwanted visibility.

Inhabiting a large body is a lived experience which incorporates much suffering. Importantly the suffering derives not from the large body itself but from the social context. Most situations are easily managed by all but the very largest of people; difficulty arises because any awkwardness or diminished speed or capability is not viewed with empathy. Society will applaud the efforts of a one legged person who climbs a mountain but bestow no such recognition on a large person despite the fact that they will have overcome considerable discomfort to achieve such a goal. Bodily largeness is not only a highly stigmatised condition but one which is especially discredited because it is continually visible, aesthetically distasteful and perceived as a choice made by the large person.

The suffering expressed by participants is thus most usefully understood in the context of stigmatisation. Stigmatisation according to Hall, Stevens and Meleis (1994) refers to the marking of 'outsiders' as outside the socially defined boundaries of normality. The stigmatisation incorporates a sense of negative evaluation based on the notion that fatness is both socially undesirable and simultaneously self inflicted. In chapter twelve I will further discuss the links between stigmatisation and marginalisation as important aspects to equable promotion of health in the context of nursing.

Stigmatisation in itself has consequences for health and health seeking behaviours. In the next chapter I will focus on aspects of the participants' experience of negotiating health in its most direct or readily understood sense. In essence this concerns attempts to maintain health promotion and to cope with exposure to health care delivery when it is needed.

CHAPTER TEN: Negotiating Health

10.1 Introduction.

This chapter builds on the material in the previous chapter. Within the framework of interpreting and internalising the meaning of fatness, the specific issues relating to negotiating health and health care are considered. In particular the notion of withdrawal is considered as an aspect of embodied largeness which has significant implications for health. I have previously argued that the suffering of large women arises from their bodily dwelling in a milieu which stigmatises large body size. In this chapter I focus specifically on the context in which health care is delivered and received.

As identified in chapter two, a dominant aspect of medical discourse about body size is to simplistically link larger body sizes with poorer health status or health outcomes. When a large woman enters the realm of health care services she is immediately identified as having a significant health problem. It will be shown by some of the participants' comments that the immediately obvious nature of their transgression dominates medical consultations and nursing interactions in a way which negatively influences the experience of receiving care.

At the conclusion of this chapter I will argue that embodied largeness is a socially constructed disability with very important consequences for health. The intersections of power and knowledge which see a medical discourse pervading nursing and popular discourses, leave almost no space for the large woman to understand herself in any way other than as physically compromised and socially undesirable. There is literally no other location in which she may stand.

10.2 Negotiating Health.

Defining the concept 'health' has engaged the thoughts and writing of nurse scholars for many years. Consensus has been reached that for nursing at least, health is considerably more than the absence of disease. It has been defined variously as a state, an entity, a process a goal or an equilibrium (Tripp-Reimer, 1984). Jones and Meleis (1993) comment that while many people face enormous obstacles to achieving their health potential, nursing cannot afford to focus too much longer on attempts to develop definitions. They are concerned that constructing academic definitions of health will not assist nursing to work productively towards making good health more accessible to more people.

It is not my intention, therefore, in addressing the theme "negotiating health" to attempt to define health. Rather I am maintaining its broad possibilities as involving both physical well-being and emotional comfort derived from self esteem, a sense of social belonging and good quality relationships. I would emphasise that a further essential dimension which goes beyond the personal, is the social, cultural and political constraints on individual and community access to health, to health practitioners, to health information and to control over what it means to be healthy.

10.2.1 Access to health care.

After surveying large women, Bovey (1989) suggested that they might delay consulting doctors because they fear the potential criticism of their large bodies. Smith (1989) states that the equation of fat with disease denies fat women access to adequate health care. Doctors, she suggests, 'perpetuate the myth that fat is a question of personal choice and control by their automatic linking of size with food consumption and recommending starvation as a passport to good health ' (1989, p. 37).

Obesity has rated high among 'medical conditions' perceived negatively by health professionals and particularly by medical practitioners (Adams, Smith, Wilbur & Grady, 1993). The same study demonstrated reluctance, on the part of women who perceived their bodies as unacceptable, to request pelvic examinations. This is of particular interest as endometrial carcinoma has been clearly linked to obesity (Ernsberger & Haskew, 1987). The research underpinning this dissertation showed that of the group of women who participated, some displayed a very matter of fact attitude toward seeking essential consultation and routine screening such as a cervical smear. Whilst finding the exposure of their bodies difficult, some of them made a clear decision that their sensibilities were less important than risking neglect of a health issue. This is demonstrated by Sarah, but was also noted by Elizabeth, Celia, and to some extent by Clare who was comforted by the fact that her doctor had never mentioned her weight. Sarah noted, when asked about cervical screening,

> Oh well I do that every three years and I just front up to it - back up to it - grin and bear it...Get on with the job and get it done. (Sarah, Int 2: p. 9).

But there was also evidence of considerable inhibition in seeking medical consultation. Both Morag, Heather and myself find the potential body exposure and imagined criticism difficult. Morag comments followed by Heather:

M: I suppose I was thinking about my reluctance in getting a breast examination or smear, I don't think it's got to do with the fact that those parts are private, it's got to do with that I'm large.
J: Oh I think so too because I don't, God at my age I couldn't care less having a smear if I was thin.
M: No it's just the size of me. Just me thinking that the Dr's going to go 'oh look at this huge woman I've got to try and...',
J: Find her cervix. Mmmm.
M: Yeah, exactly (Morag, Int 4: p. 12).

H: At the moment I have been putting off a cervical smear until I am slimmer, it's something I know it's bad but the new Dr. I went to, made a crack to a girlfriend of mine she was pregnant, not madly overweight but a little bit but he made a crack about her being overweight and what was she going to do about it when the baby was born. (Heather, Int 5: p. 11).

There was an awareness in most participants that their fatness was of considerable concern and preoccupation to medical practitioners, sometimes because it is relevant but often when it has no relevance. Elizabeth shared an experience which she says confirmed her expectation that her size will cause her to be held personally responsible for any ill health.

E: Once going into A&E with suspected appendicitis, I was feeling really miserable and they left me there and then poked and prodded around of course and this doctor came in and he said of course you are overweight, and I thought well that was a brilliant deduction, I said 'so it can't possibly be appendicitis then, you know it's just fat?'
J: Did you say that ?
E: Yes I did! Yes I was really angry and its sort of not like me. How pathetic as if I didn't know that. I thought I really came here to find out something I didn't know, have I got appendicitis or what?
J: Was he suitably chastised?
E: Well he was a young guy, I don't know if I would've done it to someone more authoritative or anything, but I was just so blah because if it's one thing we know more than anyone else does it is that we are overweight, we think about it constantly, do we need people to tell us? (Elizabeth, Int 4: p. 4-5).

Clare as a registered nurse offered an inside view, from her past nursing practice, of the contempt accorded to women when their large bodies are exposed in some medical settings. The following occurred in an operating theatre where the woman was anaesthetised. It is interesting to note the manner in which the large stomach of a woman, once considered a form of great beauty and sexual appeal, has become an object of derision and disrespect even to health professionals. Clare said,

> And some of the rude comments the doctors make about some of those overweight women and I think 'why don't we stick up for them or say something?' but you didn't and I didn't ../.. Probably because you were scared of the surgeon and it was probably better to keep your mouth shut .. /.. you know one of them was shaking this huge woman's stomach- it was huge and making a rude comment about it which was not needed, and we should have said something. (Clare, Int 3: p. 9).

Maggie sensed this entirely differently, feeling that the judgement she feels toward her own size is more likely to be present in the perspective of another female rather than a male.

> Just a month ago I had to go to [gynaecologist] and I had to have this internal examination. The worst part about it was the fact that the bloody nurse was there. You know I would have felt much happier if she wasn't there .. /.. I think it was the fact it was another female. Somehow I felt that he as a doctor would not sort of look at me as the size I was, but she as a female would. I don't know whether it's because I tend to criticise women, look at women and criticise them but [I] don't do that to men. I don't know where it comes from (Maggie, Int 2: p. 11-12).

Jo, who is a nurse, discussed with me how she thinks large people are treated in hospital. Like Clare she has experienced both being large and participating in care towards large people. I asked her about the attitude of staff towards large people.

> **Jo:** I think they are being critical... It's like this person has made no effort to be any other way or, you know I mean it's like oh this person being large is just more work for me, I have to find another nurse to roll her over... I've been thinking a lot about how you said [to] think about nursing larger women and how we do it...
>
> **J:** Do you think large people in hospital get cared for as well as small people?

> **Jo:** I think that depends entirely on the perspective or values of the nurses and medical staff who are dealing with them. But on the whole I think they're subjected to a judgmental, a critical judgement against them because of their size. (Jo, Int 4: p. 11).

Heather who began nursing education many years ago but did not complete it, wrote to me of her reflections of that period. She noted,

> The women I have in mind were both older women, both very much overweight...one had a very advanced case of multiple sclerosis and was helpless. I do know all of us were guilty of not treating her as gently as one would a slimmer person. Perhaps slim means brittle? More easily damaged, fragile. Heavy seemed to mean lumpy, sack of spuds, no need to take care, solid. I do know that she must have suffered a great deal of pain and distress all the time we took care of her, as nobody really cared to make her comfortable or to take time with her, and she couldn't speak to let us know anyway... I must admit to not feeling to good about it all now, but then I think my attitudes were reasonably universal in that time. (Letter from Heather, after reading an initial draft, filed as field notes).

Heather herself has received overt criticism about her weight from her General Practitioner, and believes he sees her as a person who does not care for herself, therefore is not worth caring for. In this sense she is receiving and internalising the view that largeness is wilful and negligent.

> But it has sort of got to the point with me now that because I haven't been a good little girl and not a great help to myself therefore he cannot be bothered ../.. when I go back to him and say hey look mate I tried to lose weight and my weight went up, the wipe out is oh you're not really trying so what the hell ../.. I think perhaps he should listen to the fact that I am unhappy with where I'm at size wise and perhaps he could listen, that I did try and sure I've been quite discouraged quite often. (Heather, Int 2: p. 8).

Now in her late forties with seriously elevated blood pressure and a painfully infected eczema on one leg, she feels blamed and judged by her doctor because he sees her as wilfully remaining large. During the study she had decided not to visit him again despite feeling extremely unwell and frightened about the potential consequences of her high blood pressure levels. She is caught in the bind of needing effective medical care but feeling

unable to ask because the situation is clouded by the perception that she chooses not to take good care of herself.

> **H:** Well I can't be bothered to pursue it because the last two doctors have been the same so I can't be bothered even trying out another one...
> **J:** Does that frighten you?
> **H:** It's beginning to yes. I don't really want to finish my life early now I'm just finding a life that I'm almost happy with ../.. I certainly don't want to finish my life before I have a chance to do things ../.. Well I sometimes just get frightened that perhaps my life's going to finish early, you sometimes just feel numb in your arm and you think my God is this going to be the beginning of something and then you've got to shut that off you'd be just so paranoid you wouldn't move, wouldn't do anything and so you shut it off and keep going. (Heather, Int 2: p. 9).

Celia had the experience of visiting a medical practitioner and complaining of chest pain which really concerned her. Her public profile became the almost exclusive focus of the consultation to the detriment of any assessment of the problem with which she presented. When she subsequently complained to the Medical Council she found that the medical practitioner's reply to the Council made much of her weight and fabricated a clinical examination which did not occur.

> He said [in the letter] that he asked me to undress and that he examined me which was totally untrue, he didn't, I mean you remember if you have to undress for a doctor...and then he went on about how I was grossly obese...and apple shaped and that that was the danger. (Celia, Int 3: p. 9-10).

During the consultation in question she was prescribed an antacid (for indigestion) and was subsequently found by her own general medical practitioner to have overstretched a chest muscle in the gym. This incident encapsulates many contradictions which large people negotiate. In this instance, medical concern about the cardiac risks of large body size did not translate into a careful and considered clinical examination of a woman supposedly at risk. Given medical expectation that obesity is closely related to heart disease it would be expected that a forty year old, large woman presenting with chest pain would be cautiously evaluated. Yet paradoxically her weight and body shape became the focus of the written response to her complaint at which point they were neither pertinent nor relevant. Such comments however did ensure that Celia felt

sufficiently discredited and too embarrassed to pursue the complaint any further (Celia, Int 3: p. 10).

Elizabeth, along with Clare and Jo, talked about their awareness of the medical belief that their size would predispose them at a later stage to many life threatening illnesses, especially heart disease, diabetes and stroke. Knowing this might be assumed to be motivating but this again is predicated on the assumption that their weight is the result of laziness, lack of knowledge and motivation. Such knowing for women whose lives are already a constant battle with their weight may just add another dimension of fear and distress which is more paralysing than motivating.

10.3 Withdrawal.

When introducing the theme of negotiating health I noted the much broader definitions of health to which nursing subscribes. The theme of **withdrawing** is an essential aspect of being healthy or not being healthy. Various ways of withdrawal, precipitated by feeling that the body in which they live is unacceptable, were part of the stories and dialogue of all the women in the study. The withdrawal constitutes a kind of protection of the self from real or anticipated ridicule and it has a profound effect on participation in many aspects of life: social, physical sexual and recreational. It is involved, as previously mentioned, with fear of territory violation which precipitates a sense of isolation or stigmatisation as present in the following excerpts. So many seemingly everyday experiences have hidden dangers or embarrassment. From Heather:

> I certainly prefer to make my own clothes because every time I go into a shop I can never really find anything that's going to fit and then I feel ashamed and very small and inadequate and almost dirty sort of, just feel small somehow... I know lately I have stopped going out socially rather than have to go and be the big person or the joke. Many people know you've tried to lose weight and you haven't and so it sort of becomes a laugh. (Heather, Int 3: p. 6).

For Jo the withdrawal is deliberately not overt and she makes a real effort to look happy and involved and laid back as appropriate to her age and recent student status. She comments:

> It's sort of a withdrawal but for me its more of an internal withdrawal rather than sure I'm still seen going out, but inside I'm sort of going 'I know I look really

> fat today' or 'I know I look really awful in this but "Oh hi'... you know smile, smile, yes how's it going' I think that's how it is for me. ..//.. you go to bed and think why the hell am I exhausted today? ..//.. And it's because you've tried so hard to make yourself feel good rather than saying O.K. I feel awful. (Jo, Int 4: p. 2).

I argue that the dominant framing of large body size as a product of over-indulgence and wilful failure to control food intake or exercise, leaves no platform from which a large woman may express misery or grief about her size. Any recipient of her distress will be similarly interpellated into the discursive context of body size and may well offer well meaning suggestions for bodily reduction. Withdrawal involves containing the feelings of anger and despair and covering them with smiling good humour. It also means for Jo that she never admits how she really feels.

> I think with me I'm scared it's not going to stop and then the tears will come and the crying will start and you know I just think well once I start am I ever going to stop crying. Am I ever going to stop feeling like a social misfit, why not just ignore that, just close that door and run away. (Jo, Int 4: p. 2).

The withdrawal was not just a feature of social and everyday activities. In addition, withdrawal from participation in recreational and sporting activities was a dominant theme of all the interviews. Most prominent was making excuses to avoid activities which risked body exposure or might show up lack of athletic prowess. Inherent in these examples again is the theme of territory violation; withdrawal occurs because the space or the equipment or the clothing is perceived as not accommodating to a large body. As Elizabeth commented,

> You tend not to put yourself in situations where you think you are going to make yourself the centre of attention, like I was just thinking when the family was away at Christmas time and everybody was out canoeing, which I would quite like to have a go at. But I thought if I have any trouble getting into or out of that canoe or I tip it over..(Elizabeth, Int 2: p. 6-7).

As another example she described declining a bungy jumping experience on holiday. I asked her why she withdrew,

> Because I knew that I had to step on the scales and get weighed first and I could just imagine all these young guys there doing it and I could just imagine

them reeling the cord up metres and metres so that I wouldn't hit my head on the water you know. (Elizabeth, Int 5: p. 6).

Celia and I too, discussed withdrawal or the ways in which we limit our lives, particularly involvement in recreation.

C: I think if I was slim then I would learn to ride a horse (**J:** me too) and I would learn to play tennis (**J:** Yeah me too) but I don't at the moment and I probably would do all these things
J: I would love to have more of an outdoor life
C: Doing a lot of skiing
J: ...I absolutely love it up the mountain, I love the air, the snow the sensation of skiing and all I could think of [is] what would I wear cause I've got nothing that will fit me on the ski field and if I fall over and break my leg, how humiliating to be carried off the mountain by two zippy ski instructors
C: Or four (laughs) that's what I think. (Celia, Int 3: p. 8).

Morag was anticipating a large extended family gathering in summer at a resort with a swimming pool. I asked her how she would deal with that and her answer reveals the careful preparatory monitoring of even the most seemingly simple occasion:

M: Well I probably won't go swimming. I mean I have been deliberating over this and you see this is the sort of energy fat people have got to deal with because why do I have to bloody well think about it even and here am I thinking am I going to risk the ridicule and [be] strong enough not to feel like I'm letting [husband] down by his fat wife going swimming with him. Be strong enough not to think that I'm going to embarrass the children who say Mum why don't you go on a diet all the time..//..
J: And if you don't swim this weekend how will that feel?
M: That will feel like a fat lady too embarrassed to swim. So I'm caught between a rock and a hard place. (Morag, Int 4: p. 10-11).

Jo echoed this same dilemma describing a forthcoming weekend with friends at a motel complex.

I really want to go and we thought it would be just a chance for our friends, to get together and have a few bottles of wine and it would be really good and it's just like it comes into my head, Oh God they'll all be swimming and if I'm sitting

> on the side of the pool I will look even more of a Wally [than] if I'm not swimming. (Jo, Int 5: p. 15).

There is a sense here that nothing can occur without a cautious monitoring or preplanning, in much the same way a disabled person must anticipate probable difficulties or embarrassment. Even when the guard is lowered the consequences may just be delayed. Elizabeth described a situation when a family video captured her when she didn't withdraw and rode a water slide in her bathing suit. She described watching the video later,

> I felt humiliated I suppose but you've got to try and pretend, you know spend a lot of time pretending that it doesn't really hurt your feelings ../.. (Elizabeth, Int 2: p. 7).

I shared with Elizabeth a painful time when I too forgot to withdraw. During a day at a river we discovered a large area of extremely sticky grey mud and both children and adults had a prolonged mud fight which I really enjoyed. It involved enormous hilarity and a big swim to wash off the full length mud coating. Unfortunately someone took photos and when I viewed what appeared to be a large wrinkly grey elephant at the rivers edge, I too felt humiliated and wished I had withdrawn (Elizabeth, Int 2: p. 7). Both situations are similar in that they involve an unwelcome visual reflection and replay of the situation after the event. And they link back to participant descriptions of sometimes forgetting one is large or different until it is visually reflected back. Such visual replays work to ensure reduced chance of carefree involvement the next time the opportunity arises.

Clare describes pretending on a hot summer holiday that she didn't feel like swimming, whereas in reality she was longing to join the others in the cool water. But she could not face the walk to the water exposed in a bathing suit. Clare recognises that exercise has a very low priority in her life now that she is at home with small children. As a younger woman she swam, played tennis and walked as a natural part of her lifestyle. She was also on her feet as a nurse. Now tennis is abandoned because her youngest child won't stay off the court and swimming is avoided because of her discomfort at appearing in a bathing suit (Clare, Int 2: p. 2).

Midway through the study Clare had lost a little weight through her attendance at Weight Watchers but still had some reservations about exercise, partially due to the sense that exercise settings carry some requirement for a suitable appearance and style of dress.

> I didn't [when heavier] participate in hardly any recreation, or swimming and those things. You know probably at that stage I wouldn't have gone to a gym even wearing a track suit because I would feel so large compared to all those skinny people in leotards, whether I want to go later on, I'm actually not really into gym stuff anyway, but that's something I think I'd be embarrassed to go, feeling big beside all these skinny people. (Clare, Int 4: p. 2).

Sally is the exception, although it must be noted that she is also the least heavy participant. She is involved in skiing and surfing and wears appropriate clothing to do so. She is aware that she makes a conscious effort to resist the temptation to withdraw and is encouraged by two or three friends who support her.

> I try and think, 'Oh well that's their problem'...not mine now only because I have got tough with myself. I just think, well I can't sit home and do nothing why waste your life...but its only...I probably wouldn't run round in a bikini and I do swim and not often with a tee shirt over my togs. I've got a boogie board and a surf board and I just think stuff it I'll go and do it. (Sally, Int 2: p. 9).

10.4 Withdrawal in the context of sexuality.

The women in this study are crucially aware that women who resemble them are not portrayed as desirable sexually attractive women. This creates yet another withdrawal from the mainstream and confusion about how others see them in a sexual sense. As Heather notes,

> I sometimes wonder what my husband sees in me. I really do... And yes sometimes I just don't feel I sexually attract him too, I often wonder how on earth there's any attraction for him (Heather, Int 4: p. 3).

Jo, as a much younger woman, experiences mixing in work situations with young men who attract her, but feels there is no possibility that they might be similarly attracted to her. She wonders how they do see her.

> I just can't help thinking you know, that there are these really nice guys where I work and I sort of think what do they really think of me because I mean we give each other cheek all the time and my God what are they really thinking ../.. it's just you know this stunning young man doesn't want to be seen with me what

> a put down to his image ../.. I realise that, that I'm making these decisions and I'm imagining these things that they are thinking and that they couldn't possibly be thinking anything else, but I don't know...it's me that is saying that but how could they possibly be thinking anything else. (Jo, Int 2: p. 3).

Morag is the one participant whose husband is openly distressed by her largeness and she is acutely aware of this. Her sense of isolation and stigmatisation is present in the following comments:

> He doesn't hassle me but I feel that I'm, I, what can I say, we're walking down the street and there's this woman you know a very, very large woman, and ...she had [a] quite short skirt and she had incredibly balloon shaped calves on her legs and my husband said to me' are your legs going to end up like that?' I knew he immediately thought am I just going to get bigger and bigger or maybe he thought if I said this to her this would shock her into thinking I look like that [and a little later remembering a conversation] I said you know sometimes I think things would be absolutely perfect if I was skinny. The kids are skinny and athletic, you're athletic looking, everybody is reasonably good looking and here's this fat woman, and I don't fit the picture.....and instead of him saying, Oh what rubbish, we're a family, who cares, he said I know what you say I often think it myself. (Morag, Int 1: p. 8).

This is in direct contradiction to the other partners or husbands, most of whom are actively and overtly comfortable about their partner's large body. Prevalent advertising regularly suggests that a dominant reason for maintaining a slender body is the attraction and securing of a man. But the partners of these participants (with one exception) demonstrate, through the women's comments, that an appropriate body size is not crucial to the maintenance of a satisfying and enduring relationship. Notwithstanding, Elizabeth finds it impossible to believe that any man other than her husband, who knows and loves her and met her when she was slim, could possibly find her attractive.

> I've had the odd occasion people, men have liked large women which is really neat. But strange ../.. the first time it ever happened to me I thought oh this guy's a bit sick. (Elizabeth, Int. 2: p. 10).

Clare too comments on this, revealing that even her partner's degree of acceptance is not completely reassuring to her:

> I think it is [acceptable] if you are in a stable marriage with a good partner that accepts you as you are, I think you can feel sexually attractive, but you do, I know I do feel fat, I wish I was thinner for him but he sort of accepts me for what I am, but I know he does, he would prefer me to be thinner ../.. I sort of feel unattractive. When I'm dressed fine- but bedtime you sort of think I've got this fat stomach, I feel very conscious of my fat stomach. (Clare, Int 4: p. 2).

Heather sees the withdrawal more as being caught in a trap or self-perpetuating cycle.

> You see it seems to me that being overweight is like a trap, because being overweight makes it harder and more painful to exercise, it makes it more difficult to get involved to get out and do things and it makes it more difficult to be taken seriously in terms of health care and yet all of those things, not taking your health care seriously, not enjoying your life and getting out and not exercising are quite detrimental to health in themselves, it's like a vicious circle that we get trapped in, that all large women get trapped in. (Heather, Int 2: p. 10).

This last comment from Heather provides an effective summary of the complexity for large women negotiating health. Body consciousness, eating consciousness and awareness of stigmatised difference intrude into all aspects of life, and create situations such as activity avoidance or feelings of alienation in a huge range of life experiences, which then become fraught with difficulty and difference. Respect for the needs of individuals and a broad definition of health should prompt nurses to listen carefully to the voices of these women, who are articulating far greater constraints to health than the distant prospect of disease. Feelings of alienation and stigmatisation are not conducive to health. Despite a strong public health discourse articulating the need for exercise, recreation and involvement, this very group who might benefit most are excluded by rigid social constructions of acceptability and non-acceptability.

The outcome for these women is closely akin to a socially constructed disability. I am acknowledging a more recent concept of disability which, according to Asch (1984), reflects the reclamation of environmental and social issues in definitions of disability. Social models of disability remove the attention from the individual and consider the socio-political and cultural environment as a source of disablement for some persons.

Asch (1984) identifies discrimination, stigmatisation, inequality and the denial of human rights as contributing most powerfully to the experience of disability. This is in direct

contradiction to more traditional views of disability which located the source of the problem in the biology of the individual perceived as disabled. The source of the problem was also identified as the impairment, or what the disabled person could not do rather than what the particular environment precluded them from doing (Fine & Asch, 1988).

There are powerful parallels here for embodied largeness. Withdrawing from sport, recreation, social involvement and feeling ugly and isolated occur not through any physical inability to participate. Rather, they occur because the environment in which they are set is overtly or covertly hostile to large-bodied women. Even when they are in settings which are encouraging to women in their diversity, it takes considerable time for a woman to overcome the legacy of stigmatisation, which is born of past experience and arises from their interpretations of dominant framings of suitable women's bodies.

This chapter has examined the health experiences of women who are living in large bodies. It has taken the concept of health beyond the mere absence of disease and considered the multiplicity of ways in which bodily largeness compromises opportunities for health. Embodied largeness as a socially constructed disability raises significant implications for improved nursing practice which will be discussed in chapter twelve. The next chapter is the final section of interview material and explores the experience of women who have dieted extensively, begun to sense that it is not a solution, and now contemplate their lives permanently inhabiting large bodies.

CHAPTER ELEVEN: Between a Rock and a Hard Place

11.1 Introduction.

I have shown embodied largeness thus far to encompass body consciousness and engagement with dieting within the disciplinary project of femininity. Living as a fat woman means existing within that disciplinary project, and has been shown to involve interpreting and internalising the meaning of fatness. This, as I have shown, generates suffering and also impacts upon the way health and health care are negotiated or accessed. The body consciousness, the constant engagement with reduction dieting and the suffering, mean that the large woman always intends that her body will be different in the future. She means this either actively as she plans to diet, or inactively at a deeper level as she finds herself unable to contemplate a future in a body that is permanently too large.

She is supported in this state of endless impermanence by the discursive environment in which she exists. Wherever she looks she is bombarded with messages of unacceptability and, as previously discussed, a barrage of solutions to her 'problem'. Fat acceptance, if it exists at all, is a very marginal position and many women may never come in contact with any aspects of such a viewpoint. Even when they do, it may not hold great appeal as it asks them to take up a permanent position on the margins of female existence.

Accordingly I have identified this part of the experience as **inertia**. This captures the sense of 'stuckness' which is felt as the woman comes to realise that reduction dieting does not offer a permanent solution but nor does remaining large offer any sense of comfort or resolution. I then consider the issue for large women of **finding a voice** outside dominant discursive constructions of largeness in order to **envisage a future** less constrained than that offered by the occupation of a position of silence outside existing discourse.

11.2 Inertia.

I have used the term, inertia, because in the process of imagining or planning thinness there is a diminished ability to focus on living in the here and now. Simultaneously there is growing awareness that there is no obvious guaranteed or satisfactory solution for change.

Smith (1990) has argued that participation in the discourses of femininity is a condition of membership in heterosexual sociality. Abandoning active work towards bodily reduction incorporates the potential abandonment of a great deal more. Consequently the large woman occupies a see-saw position of acceptance and rejection of her current embodiment. Elizabeth and Heather both expressed this particularly clearly,

> I don't even really expect to get thin any more but I still think that way, I still think when I'm slim you know, I'm going to learn to ski and I'm going to have this beautiful wardrobe and I'm going to travel and I'll be full of confidence. (Elizabeth, Int 5: p. 14).

> I am still inclined to say, Oh when I'm slim, this will happen, that will happen or by next Christmas they're not going to know me because I am going to be slim. (Heather, Int 5: p. 3).

Diet clinics, as noted when discussing populist discourse, usually sell their product on the promise of the 'new improved you' which will emerge after a successful diet has been completed. As previously discussed in chapter seven a would be dieter is frequently exposed to 'before and after' pictures which constantly remind the large woman of the possibility of slimness. Spitzack (1990) describes this as offering a kind of heavenly afterlife on earth in which one is now satisfyingly, miraculously and most rewardingly slim. The consequence is a sense of transience or impermanence in which the current existence is literally wished away in the longing for slenderness.

The assumed benefits of weight loss are so well and widely known that it is almost unheard of to question them. These benefits have acquired the state of a hegemonically maintained given which is seldom questioned or challenged. Both the dieter and the purveyors of diets demonstrate repeated willingness to place their faith in a process which began to be challenged at least twenty years ago, and is now consistently disputed in a very wide range of research based literature. But this knowledge is normally not a part of the daily reality of large women who respond to the promises of the diet industry which speaks compellingly to her overwhelming need. Elizabeth comments,

> I suppose, every time I look at Jenny Craig on the T.V. or in the paper I think, Mmm...yes...It's always if I just lose X amount of weight, or, I could diet and I could look like this; we're constantly wishing to be what we are not. (Elizabeth, Int 3: p. 3).

Heather takes it a little further and demonstrates the sense of inertia by seeing the achievement of slimness as a prerequisite to real life beginning. She comments, 'I'm inclined to see the thin as the beginning of the doing everything else' (Heather, Int 3: p. 14). And yet weight loss is also important enough to be a goal in and of itself. Heather comments that when she is thin:

> I might like myself a bit better, I would feel I've actually achieved something for once. I don't think if I do anything else I don't think that would matter half as much as getting the weight down... If I'd lost the weight I would really feel I'd got somewhere and that I had really achieved something, and I don't think anything else would be that important. (Heather, Int 3: p. 7).

The extent to which imagining a slim future preoccupies Elizabeth is epitomised in the following comment which demonstrates the degree to which body consciousness permeates every aspect of a large woman's life. She says,

> I think if something happens to me, if I ended up with cancer at least when I died I'd be thin and when they carry out the coffin they're not going to be all straining and puffing and blowing... I've actually said to my husband, ' Oh well, if I did get the big C at least I'd be thin and then you'd be pleased.' (Elizabeth, Int 3: p. 13).

Jo describes how feelings of resignation and total despair occur interchangeably:

> There's a real mixture of feelings, sometimes I will get up and think, Yeah- it's O.K. I can cope with today - being a size 24... other days I walk out and think Oh God I just really can't cope with being like this today (Jo, Int 1: p. 7-8).

Another basis for distress is fear of ill health as a result of being large. The risk factors inherent in many other situations are often kept quiet in order not to unnecessarily alarm potential sufferers. But the assumed risks of bodily largeness are, like those of smoking, made prominent and public. This is directly related to the perceived degree of personal culpability in generating the risk factors. Morag, in acknowledging the fears which many large people hold, believes that she is probably a candidate for high blood pressure and cerebral haemorrhage. But her anxiety about that too is resolved by seeing the largeness as a temporary state which will one day be resolved or cured. When I asked her how she felt about fearing weight-induced illness she typically replied:

> Well hopefully I will have lost weight by then.. I am not going to be like this for ever...in my mind's eye I hope this glorious day will dawn and I will lose weight and it will stay off for the rest of my natural life. (Morag, Int 1: p. 6).

Elizabeth too talked about the impact of fear of ill health on decisions of whether or not to diet. She said,

> you wait for the day when the chickens come home to roost and you've got a bad heart and high blood pressure and you're sitting there waiting for a stroke to hit you. (Elizabeth, Int 5: p. 11).

We discussed how one would respond to rising blood pressure, given that it still raised the issue of to diet or not to diet. Elizabeth acknowledged that she often wonders how she would respond if her doctor told her to lose three stone or be dead in six months, given that the only known option to create at least temporary weight loss is reduction dieting and exercise, both of which have already been shown to be problematic for large women. In addition it is interesting to note the power she accords to a medical practitioner, in according him or her the authority to make such a pronouncement.

In chapter three I reviewed the considerable evidence suggesting that reduction dieting would not provide permanent weight loss. For these participants, most have already demonstrated that reduction dieting has not been a solution for them. Therefore the vision of 'one day I will be slim' may not be realistic and leaves them grappling with negotiating life in a body which is both stigmatised and perceived as endangering their life. The available choice is not really a choice at all. Continuing to diet offers a sense of hope but one which is frequently defeated. Ceasing to diet and accepting a larger body means living outside the bounds of acceptability and enduring a degree of stigmatisation in very many settings, some of which were described in the previous chapter. Moving backwards and forwards between dieting and not dieting is a frequent outcome, and one which supports poor eating habits and inevitable continuing weight gain (Carryer, 1997).

The outcome for participants is, therefore, the sense of inertia. They live poised between being able to fully integrate an acceptance of oneself as a large woman and yet grasping at the increasingly elusive possibility of achieving and maintaining a thin body. The sense of inertia also underpins the theme of withdrawal noted in the last chapter. Rather than deciding where one can safely exercise as a large woman, some participants noted that they tell themselves that when they have lost a certain amount of weight then they will join a gym or a sports facility or return to swimming. As Elizabeth noted,

> You feel like you're always holding back, you're always waiting for something else to happen....and life's going to start when you get thin...It's in a state of flux, always waiting for the day that life's going to start...and in the meantime it's just filling in. (Elizabeth, Int 5: p. 4-5).

And Celia also commented:

> I'd like to go to the gym, [but I would] like to lose more weight first... I've said if I get to 80 kilos I'll go. (Celia, Int 2: p. 15)."

Living inertia clearly has considerable consequence for the experience of large women. The inability to achieve and maintain the desired thinness is a state of continually emphasised and serious loss. But it is a loss that can never be grieved for or resolved in the normal manner of other losses, because of the enduring sense of 'one day' or 'if I could just' which are the internalised consequences of living in a cultural milieu which consistently insists that slenderness is universally possible. As Sally notes,

> Accepting the fact of not being able to successfully lose weight/diet is a hard thing to do, a total feeling of inadequacy. The description of inertia is great. Stuck between a rock and a hard place. I don't want to stay like this but it is so hard to diet successfully. A big vicious circle. Diet or stay like this. I've resigned myself to being a larger woman but I will always feel that people watch exactly how much I eat, and how often and when. (Sally, in letter, filed as field notes).

Jo too, writes poignantly of her feelings at the end of the research.

> Lately I have been thinking a lot about being stuck between a rock and a hard place, and as you put it inertia ..//.. Sometimes I am fast to remind myself that this is not me [referring to dreams of thinness] and will never be. Other times, I let the thoughts linger. I also know that it is no good living with these fantasies, for I believe that if I don't face the truth, I will only set myself up for more pain and hurt in the future .. /.. I believe that incorporating our body size into the future is the hardest part of the realisation that this is what will be. Often the future brings change, but with our bodies, they will be the same large size. (Jo, in letter, filed as field notes).

And Elizabeth captures a sense of relief and achievement whilst demonstrating that it is, as always, tempered by the underlying need to conform to 'normality'. She says,

> Your research and my participation in it has been very empowering to me. Generally I feel great and I believe I look fine too, but deep down those 'what if I were slim!?' thoughts are still there. (Elizabeth, in letter, filed as field notes).

Inertia means that these women are, as Jo and Sally so aptly put it, stuck between a rock and a hard place. Fighting to become slim has lost its attraction as a source of real hope but accepting largeness is only transiently possible and has the accompanying sequelae of stigmatisation and fear. At this point it is pertinent to explore what involvement in this feminist research project has meant to the women concerned.

11.3 Emancipatory outcomes or finding a voice.

I have, earlier in this thesis, discussed my disinterest in studying the experience of large women unless the research would have some direct benefit for the women who contributed to the study. I stated that the research had an emancipatory intent in that it was hoped that in the process of dialogue and co-structured interviews the participants would experience some lessening of the constraints of living their lives in bodies considered unacceptable. At the outset I did not anticipate an enormous level of emancipation, as I believed the requirement for women to have slim bodies to be very powerful and very pervasive. I was also mindful of how the constraints have persisted for me despite a supposed degree of enlightenment. In addition as I began the interviewing process I was almost overwhelmed by the sense of audacity generated by commencing research with an overtly liberatory intent.

In the process of working with this group of women I learnt of the elusive nature of so-called fat acceptance. Working with these women taught me much about diversity, even though we shared a strong commonality. As I began to understand and accept that degrees of emancipation were possible within the gap between fatness or thinness I began to see some useful consequences of participation for these women.

Towards the end of the study I found all but one of the women were expressing a sense of relief from at least some pressure as a result of participating in the research. I believe some level of emancipation did occur as evidenced in the following transcript excerpts, and in excerpts derived from letters participants wrote to me towards the conclusion of

the study. Possibilities emerge for different ways of envisaging the future and for finding a voice out of the silence.

To some degree, just talking in a relatively unrestricted way about their experience has been therapeutic for participants, but also there is a sense that the process has even more value than just talking about it, because it has a collaborative feeling and the participants' voices will be heard by others. Sally and Clare commented:

> **S:** To go through this process, its actually been like, I had actually thought that I was going crazy and that maybe I should go and see a psychiatrist and it's been a little bit like that I've got things a bit sorted out, that someone actually cares that they want to do this and find out how women are feeling, not just me but how other women are feeling, ../.. I think all of this points out to our society and it just makes it easier to be able to speak out and I think well some people are going to read this thesis and know exactly how it feels and hopefully it will strike a chord somewhere and something will be done, people will start thinking and feeling differently. (Sally, Int 3: p. 10).

> **C:** I've found it's been good for me, I mean before I started doing the study, well you don't quite know what to expect, you think you are just going to talk about being overweight just like any survey where you have to tick boxes, but I feel more comfortable about myself now, I'm not worried about what people think of my size, they can accept me as I am or too bad. I think I've learned a lot and my attitude towards diet has maybe matured and changed. (Clare, Int 4: p. 12).

As a result of taking part in the study some participants also shared what they felt or had learned with friends or close family members. This was a considerable difference as they had more commonly been quite silent and even secretive about their real feelings about being large. In effect they were able to give their own experience a different voice, without simply saying what they believed others wanted or expected them to say. To a small extent they have managed to move outside dominant discourse about body size and reposition themselves in a new space. Elizabeth said,

> I've been talking so much about it, I suppose I have been thinking a lot more about it and thinking well why am I letting this conditioning rule my life, you know, why aren't I doing the things that I really want to do and I suppose I've been a bit more open about it too (Int 4: p. 1). I was, yes, ruling my life by my

> body shape. I guess I've decided that I'm not going to do that....I've found I can sort of talk about it a bit more and just, yes, think well, is it really so much my problem as being other peoples' problem ../.. if they feel so disgusted at watching me eat something then I think that's their problem. (Int 4: p. 12).

For some participants a sense of how they might do things differently was beginning to emerge towards the end of the study. Clare had been attending Weight Watchers for the duration of the interviews. During the final interview she had left Weight Watchers, having gained a clearer picture of the repetitive and unsuccessful nature of repeated reduction dieting. At the end of the study Clare wrote to me of her current feelings and her experience of her fourth pregnancy. During the research she had spoken of pregnancy as a time of particularly rapid weight gain.

> After our session of interviews I really changed my view of diets and dieting and how they have affected my body especially the rebound effect that I experienced after every diet. I decided to banish the word diet from my vocab and try not to be so thought conscious about food ..//.. During my pregnancy I put on about 12kgs. Which quickly dropped off after baby was born..//.. I found that with not thinking 'diet' I ate whatever the family was eating, even the puddings and chocolates. I did not feel the desire to binge on food that my body was deprived of. (Clare, in letter, filed as field notes).

Jo is trying with enormous difficulty to see if she can focus on other aspects of her life and achieve, despite her largeness. She is not reconciled at all to being large but simply cannot work out how she could feasibly be slimmer. Over the course of the study she had progressed from having virtually no exercise to bicycling considerable distances on a daily basis, but she has not noticed any change in weight. She is working on moving the focus away from her appearance.

> **Jo:** I think I can be successful being large. And I think it is turning into I will be successful, just because this is happening to me, just because I am this person, I'm not going to let it stop me...
> **J:** So how are you going to negotiate being successful as a large woman, what's that going to involve? What's being successful for a start?
> **Jo:** For me? Having the career I want. Having the life that I want and being able to function in society and say, get stuffed, I don't care what you think, I'm happy, this is my life, this is my career, this is my house, my car, my life and I mean sure, people may frown upon...look at that fat woman...it's not going to

> be look at that fat woman it's going to be look at that successful woman, isn't she brilliant, hasn't she done marvellously and she's done this while being fat, you know I think that's it. (Jo, Int 4: p. 10).

Heather came to feel that she had been allowing her weight to be an excuse for many things that could in reality be difficult at whatever weight. But in view of her significant health problems, she had decided her current high weight was not acceptable. She said,

> I've finally taken the bull by the horns and I have changed my doctor... And as I say I am beginning to feel that now I really could make the effort and start walking and yes, think for myself again. ../.. I guess, yes, I don't think I'll ever come to accepting my overweightness, I think I'll always have a battle that I want to be--it's almost like a suffocating struggle of something trying to break out because I wanted to be slim. (Heather, Int. 4 : p.16-17).

In reflecting on the meaning that participation in the research had had for her, Sally noted how very therapeutic it had been and how much her involvement had come at a crucial time for her. She said,

> I just found it really, really interesting and really beneficial for me...it's been sort of being like at a counselling session as well. I had never had the chance to talk about how bad I felt. When I first talked to you I was really unhappy. I'd actually been, like taking the car out and thinking - well I'll just end it all - you know just drive off the edge - I'd gone out a couple of times and just you know - come home. I was really, really unhappy. (Sally, Int 5: p. 4).

In a letter written after she had read an early provisional draft of this work, Jo wrote of her experience of participating in research conducted in the manner of this project:

> The experience has made me more aware of not only my own issues but that many other women (who are overweight) share them with me. I no longer feel like an isolated being. To know that other women are sharing my feelings, emotions and face the day to day struggles with me is reassuring. (Jo, in letter, filed as field notes).

In a letter written in the same circumstances Elizabeth states,

> If I am naturally large, which I am, why, **why** should I spend all of this wonderful short lifetime wishing to be someone else. Your research has **empowered** me. [emphasis in the original] (Elizabeth, in letter, filed as field notes).

Elizabeth with characteristic energy shared a story which doesn't just envisage a new future for her but perhaps has wider possibilities.

> I found this neat little cartoon, about this woman, she's lying in the bath and she's reading a true romance novel or something and she's imagining it in her mind and she's lying there and she says ' and Nigel swept tiny Brenda into his arms' and then he says ' my God woman, you're a bag of bones - put on ten stone immediately or I'll leave you' and she says ' I was only dreaming of course' at the end of it and I thought that was great so I've doctored it up you see, and I took it home and put it on the fridge, and put our names on it. Just about everyone says 'I really like that'. (Elizabeth, Int 3: p. 4).

It is not my impression that these participants have entirely come to accept or be at peace with their bodies. I believe they have to some degree shifted from a sense of total personal culpability to incorporating or including a wider social critique of the particular constraints on women negotiating femininity and maintaining an approved body size. They have come to see some of the wider socio-cultural issues which are embedded in their quest for slenderness, and to understand that their situation is shared by many others. They have also begun, to some extent, to envisage ways of living around the largeness by moving it aside from its position of centrality to all their concerns.

In three years of talking with the nine participants in my research project, I have searched intently for signs of their resistance to being positioned as passive victims of dominant framings of the meaning of their body size and shape. On one level I can see one participant who is using her considerable talent to write a work of fiction about embodied largeness. Another has gone to work in an up-market shop selling designer clothes for large women; from which point she comments 'My job has made me appreciate that most 16+'s [the size at which the large clothes range begins] need all the assurance and confidence they can muster to take on the 'normal' sized women of the world'(field notes). Yet another participant utilises every commercial trapping of feminine beauty and works as a dispenser of beauty advice and products. These woman have positioned

themselves in locations of resistance, just as I have in the very act of carrying out and writing about this research. Most of us have, with trepidation but growing conviction, relinquished the dieting and regaining cycle in favour of rediscovering the use of food for the simple sustenance of hunger (Carryer, 1997).

But I cannot escape the overwhelming impression I have of having listened to a great deal of pain. It is the pain of having a stigmatising disability, and uniquely, a disability which is perceived to have been wilfully self inflicted through insufficient self care and self control. It is, as noted previously, a disability which is not inherent in the biology of the person but constructed from the manner in which it offends socio-cultural and gender-specific requirements for women's bodies.

The need to conform to imposed requirements for women's bodies is combined with limited opportunities to talk about that experience in a voice free from the discursive shapings of the experience. There is a rhetoric of autonomy which suggests that women choose to agonise over their appearance and choose to diet constantly. This rhetoric negates the difficulty of standing outside powerful intersecting discourses. For large women this is isolating and marginalising, and supports the ongoing sense of a very personal and private battle with the body.

When these women talk about a possible future they speak still of dieting or not dieting. They very rarely speak of more creative options for maximising their health, such as healthier eating not focussed on caloric restraint, or searching for safe exercise settings or combining with other large women to generate recreational experiences which feel safe. Such is the dominance or hegemony of dieting discourse that it leaves little space for repositioning.

11.4 Conclusion and presentation of a model.

To complete presentation of the interview material I have created a model, a schematic representation of the experience of embodied largeness. Arranging the material in an orderly and accessible manner necessitated that it be unfolded in an essentially linear fashion, which does not always do justice to the actual circularity of the experience. Once the material is presented in this linear manner it becomes to a large degree, static. The fluidity of nuances such as the dimensions of time and age and variations of the moment are not easily present in an orderly presentation. It was clear as I worked with the women

over the years that they move backwards and forwards through different aspects of the experience.

Sometimes the battle with the body is abandoned, only to be taken up again when the sense of stigmatisation or a perceived health issue make the battle seem imperative once more. Towards the end of the project some of the women were moving out of the inertia and into pragmatic ways of incorporating their largeness into meaningful ways of living and working. Almost all had moved from isolation to a sense of shared positioning or experience.

The model, visually reflects the circularity of the experience but it does not easily represent the changes in different participants which are contingent upon age. For example, the two youngest participants had become much more aware of the problems with reduction dieting at a younger age. This is because they are young at a time when such information is much more readily accessible than it was to those participants who were twenty years older. Some experience for these two participants is, in this respect, qualitatively different from the seven older participants in that they have not endured such a prologued history of reduction dieting.

The model aims to clarify the circularity of the experience. Body consciousness leads to the engagement with dieting which is the beginning of the battle with the body. Living that battle means constantly being focused on food and body size, while maintaining a public persona of disinterest and non-participation in food enjoyment and consumption. Public alienation from the social world of food intensifies the private obsession.

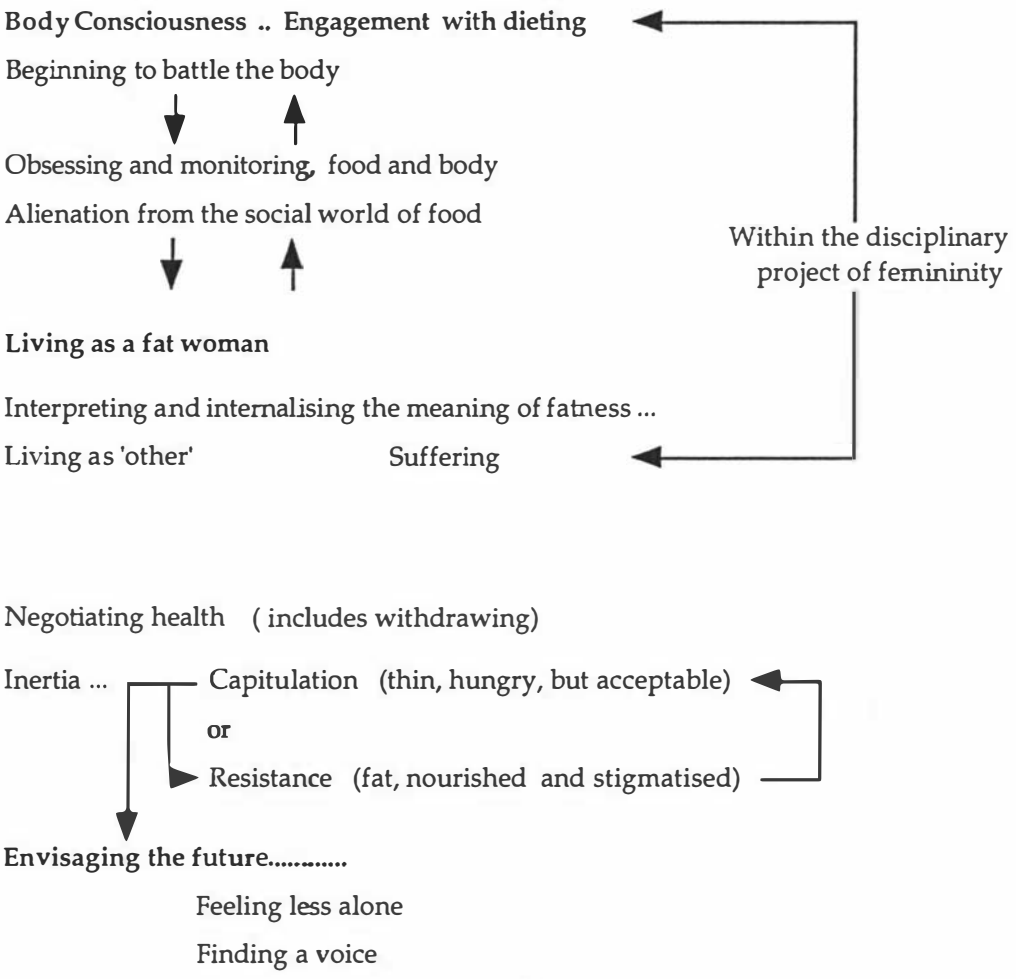
As diets succeed and fail the woman comes to live as a fat woman, not necessarily having relinquished the battle with her body, and her body consciousness. She takes into her own self-concept the public meanings and perceptions of fatness, and from that context negotiates health and health care as a large woman and experiences suffering.

Both sets of experiences are frequently overidden by a sense of inertia. The battle seems futile, it isn't working but giving up means living out a stigmatised existence and all that that means. Continuing to battle the body offers the chance of acceptability at the cost of loss of energy and constant food and bodily surveillance.

Other possibilities exist, some opened up by participation in the research, some because there are fractures appearing in the hegemonic support for the belief that thinness is just a matter of vigilance and hard work. Some of the women are beginning to work within that

gap, although their sense of belonging there is fragile and offers considerable potential for improved nursing practice.

11.5 Schematic representation of embodied largeness



This completes exploration of the interview material. This chapter has concluded by presenting the interview material in the form of a model which explains embodied largeness. The participants have provided a rich tapestry of insight, for themselves and for readers of the research, into the experience of embodied largeness. In so doing the first aim of the research has been met. In keeping with the feminist nature of the project the experience has been investigated within the political context of women's lives.

This leaves the second aim of the research which was to use the knowledge generated to consider how nursing practice in relevant areas might be improved. The appropriate

areas for improvement in nursing practice have been identified. Firstly it will involve working alongside women in the gap between the choice to diet or not to diet. Secondly it will involve disruption of the dominant discourse which locates the cause of 'obesity' in the mind of the women who fails to exert sufficient control over her eating and exercise habits. Improved nursing practice will be addressed in chapter thirteen, the final chapter.

In the penultimate chapter of this thesis I will discuss the relevance of embodied largeness in the context of health care delivery. With this goal in mind the next chapter considers the relevance of medicalisation, marginalisation and consciousness raising as they relate to this work. The final chapter deals explicitly with the relevance of this work to nursing practice as it stands now and as it could be.

CHAPTER TWELVE: Research as Social Change

12.1 Introduction.

The final two chapters of this thesis constitute a discussion of the findings. This chapter discusses the experience of largeness, as elucidated by the research process, from the perspectives, of medicalisation and marginalisation and considers the potential of this research to initiate change, either personally for participants or politically for a wider group of women. At this point I provide some criticism of the relevance of postmodernism for nursing based on the tensions I have experienced in the production of this thesis. The next and final chapter will discuss the specific implications for nursing practice which have been raised by this work.

In exploring the embodied experience of largeness, I have come to view women as subject to a variety of competing discourses which attempt to explain or theorise and inevitably pathologise multiple aspects of body size. At the very least it has become a taken-for-granted assumption that there *is* such a thing as normal body size. Furthermore values of good and bad have been ascribed to variations in body size and reasons are postulated for those variations. In order to explain or even understand their experience, large women are subject to such discourses, some more than others. From these they come to understand the meaning of their experience, its cause and its consequence and they assess their own behaviour accordingly.

The research does not provide definitive answers to the problems which have surfaced. But it does present a compelling challenge to the hegemonic assumptions which underpin the dominant management of body size from a variety of sources. Most critically, whereas medicine can be seen to at least adhere to its own reductionist model of health and illness, there is no rational explanation for nursing's participation in the processes of surveillance and normalisation to which large women are subjected.

The answer may lie in the production of subjectivity, not just of large women but of nurses as well. Why else would nursing literature so profoundly take up the discourse of medicine into its own literature, and advocate management of large bodies in a manner which is antithetical to its own espoused holism. Clearly the political practices of health care delivery exert considerable surveillance from which nurses are not yet free. The process by which such surveillance occurs is best understood as medicalisation.

12.2 Medicalisation.

Medicalisation refers to the process whereby western medicine turns its gaze toward aspects of women's lives and bodies, renders them problematic and focuses attention on treatment to achieve a cure. There is also the hegemonic centrality of medicine, referred to in chapter three, in which a medical perspective has come to dominate all ways of understanding matters of the body. The current focus on normal and abnormal body sizes can be read as involving a significant degree of medicalisation.

Ever since slimness became an integral part of current concepts of beauty, medicine, according to Walden (1985), has taken a deep and sustained interest in so-called obesity. An in-depth reading of the vast medical literature about obesity has revealed a degree of contradictory information. I noted at the outset of this work that, as a nurse and in dialogue with both nurses and medical practitioners, I had previously felt very certain that any excess body weight was detrimental to health. Reading medical research literature has shown that there is information which significantly modifies conventional medical wisdom and this has remained as a marginal discourse in the midst of what is presented as an apparently neutral scientific endeavour. I consider it marginal in that as a nurse and nurse academic with a particular interest in this area, I had not heard such literature discussed or debated, and had not seen such information until I carried out a concerted literature search. Poorer health outcomes, especially for women, cannot be conclusively demonstrated to be related to increased weight, over a much wider range of weight levels than is popularly understood to be desirable. Yet medicine does not intervene in the public discourse which suggests that striving for a universally very low body weight is meritorious (Carryer, 1997).

According to Walden (1985) medicine has, in this particular area, represented an application of current aesthetics to the functioning of the body, and medicine has taken a deep and censorious interest in so-called obesity ever since slimness evolved into an ideal of beauty. Walden notes that,

> medicine turns to what has been judged to be naturally ugly or deviant and then develops aetiological accounts in order to explain and treat in a coherent fashion a manifold of displeasing signs and symptoms (Walden, 1985: 367).

I have identified, in chapter one, that there is a continuum of distress for women in issues relating to food and body size, and that this research explores just one small aspect of that continuum. Bordo (1993) comments extensively about the medicalisation of eating

disorders but less so about the medicalisation implicit in labelling a range of larger body sizes as diseased with obesity.

Bordo (1993) notes that in the medical model, the body of the subject is the passive tablet on which disorder is inscribed. She notes that,

> deciphering that inscription is usually seen as a matter of determining the 'cause' of the disorder... But always the process requires a trained- that is to say highly specialised- professional whose expertise alone can unlock the secrets of the disordered body (Bordo, 1993, p. 67).

Medical science focuses on the elaboration of pathology as the driving force behind research. As Bordo (1993) notes, the aetiological significance of the cultural context, if acknowledged at all, is noted as contributory or facilitative but never as central. The almost exclusive gender specificity of both eating disorders and concern about body size has not been a feature of attempts to explain such problems. There is a sense that gender is all too messy a variable in the pure rationality of objective medical science.

The hegemony of medicalisation or pathologisation is never more present than in comments by Strober referring to anorexia nervosa as a disease state. He suggests that,

> the intensifying preoccupation with body shape and dieting so common in non clinical adolescent populations may be indicative of a symptomatically milder or partial expression of the illness (1986, p. 24).

In a staggeringly sweeping comment, he pathologises all young women in an attempt to preserve the medical ownership of eating disorders. Taking a different perspective, Polivy and Herman (1987) note that reduction dieting has become a normative state, for North American women at least, and there is little evidence to suggest any significant difference is present in New Zealand. Instead of noting and addressing the intense pressures on women particularly, to eat and look certain ways such behaviours are more likely to be labelled as normal feminine preoccupations.

The medical gaze, not surprisingly, is always focused within the body of the sufferer or the subject of that gaze. In keeping with the reductionist nature of medicine, women especially are asked to look within themselves for the source of their problems, effectively obscuring a wider scan of the environment in which they negotiate health. Cultural, social and political contribution to health status or health experience is thus negated; each

individual feels a sense of personal culpability for her disease state as so clearly demonstrated by the participants in this project.

Women, as we have seen in this project, talk not to each other but to the apparent authority of diet counsellors, medical practitioners and others who appear vested with the power to pronounce about body size. Each is somehow qualified to assess a woman's performance in complying with the hegemonic ideal to which she continuously aspires. There is intense cultural pressure on women to be small as confirmed by the women in this study. The process of medicalisation, through the power embedded in medicine, acts to obscure the cultural misogyny which asks women to be warm nurturant social caregivers, while inhabiting a stringently disciplined and increasingly androgynous body. Medicalisation is thus the process, but for the woman whose body is consequently labelled deviant the result is marginalisation.

12.3 Marginalisation.

In introducing the aspect of the model which describes the experience of living as a fat woman, I noted the comments of Davis (1995) in including fat people amongst groups of individuals who are stigmatised as 'other'. This research has shown that large women both interpret and internalise the meaning of fatness as it is socially perceived. Hall, Stevens and Meleis (1994) have explicated the concept of marginalisation as a means of understanding the experience of people who are vulnerable through being perceived in a particular way within the society they inhabit.

Hall, Stevens and Meleis (1994, p. 25), define marginalisation as 'the process by which people are pushed to the social peripheries on the basis of their identities, associations, experiences and environments'. They suggest that some persons are viewed as different in some way from the norm or removed for some reason from the societal 'centre' to its periphery. In this instance thinness is identified as both central and normal and even virtuous.

Participants, in describing their distaste for the bodies of other large or larger women, confirm another aspect of marginalisation. Hall, Stevens and Meleis (1994) suggest that marginalised persons internalise their own identities as well as the negative, stereotypic mainstream images of members of their categories: 'if they do not come to develop knowledge of the heterogeneity within their category, they retain a sense of self uniqueness that compounds their sense of isolation'(p. 31).

Participants described the shock experienced when they encountered visual feedback which confirmed their largeness. When a woman identifies herself as large she confirms her affiliation with other overweight women and immediately takes up the full range of cultural prejudice ascribed to that status. She cannot separate from her own cultural assumptions about large bodied people but finds that she herself embodies that stigmatised way of being. She perceives then that her body size and shape say something about her which is strongly in conflict with what she would like her body to say about her.

When the participants read early drafts of this work, their frequent comment was that they had no idea that other women felt most of the feelings that they themselves experienced. This again reinforces earlier comments that the operations of power in the discursive explosion around body improvement ensure that the large woman does not speak to other large women, but looks to the centre for normality and decides that she fails to measure up. That centre is clearly articulated through the auspices of medicine, which acts as the often unseen arbiter of the regime of normality.

Participation in this research has meant that a group of large women have spoken through the recycling of transcripts and through review of the developing model, to me and, to some extent, to each other. In this sense the research has represented a disruption to the normal operations of power in the context of bodily management.

Opie (1992) writes of the private dimensions of research in which participants may be individually empowered through participation. Writing of her research with elderly spousal caregivers she noted:

> By taking part in the research they lifted the veil of invisibility surrounding carers' everyday lives and the experience of marginality from their existence (by becoming 'centre' even if briefly) thus opening what is generally a socially obscured experience to a more public gaze (Opie, 1992, p. 64).

Participants in this project expressed a sense of satisfaction in knowing that they were lifting the veil on the experience of largeness, and creating the potential for change or disruption of the status quo. The experience of participants in this project can well be described as consciousness raising, in that they came to see that their previously personal and lonely struggle was an appropriate site of political challenge. In the process of contributing to this research the participants and I have created the possibility for change, not only in our own lives but we may have produced a catalyst for social change.

12.4 Consciousness raising / Research as social change.

The second wave of feminism and the emergence of the women's health movement in the 1960s was characterised by the development of women's consciousness-raising groups. As epitomised by the Boston Women's Health Collective's *Our Bodies Ourselves*, consciousness raising was about the reclaiming of knowledge generated by women about issues of concern to themselves and their lives. Writers such as Ehrenreich and English (1979) pointed out the manner in which the rise of medicine had allowed the appropriation of knowledge from women to medical 'experts'.

In this research project, consciousness raising has both underpinned the methodology and characterised the experience of the researcher and the participants. It is a far more accurate description of participant outcomes than to describe their experience as emancipatory. None of them are freed from the constraints of embodied largeness, but most of them has come to see their experience in different ways. For some this has constituted a move from seeing it as an entirely personal failing to perceiving the wider socio-political context in which women are required to inhabit smaller bodies.

As noted in chapter eleven, some participants did gain the courage to speak more openly of their silent experience and to speak of it in a manner which potentially disrupts dominant discourses about body size. Nearly all of the women have reduced some degree of their sense of personal culpability. For this reason I consider that my aim to do research that would be of direct benefit to the participants has been met.

My own experience of involvement in the research also requires comment. This has, for me, been a period of considerable exposure which is not yet over. Applying for research funding for this project necessitated a formal interview with male scientists from within the University. I felt acutely aware of their possible thoughts as they considered the value of funding a large woman to research the experience of largeness. Whenever I answer the question as to what my research is about I see the questions that arise but are often unspoken. I have been overtly and covertly questioned about bias particularly by those more used to researching in a different paradigm. But such questions have also arisen from those who are well acquainted with the notion of openly ideological research (Lather, 1986). Most painful has been the occasional assertion that I am using this research to come to terms with my own problems, whatever they may be. I have yet to face receiving a doctorate while my topic is read out to the assembled audience.

In addition I have had to spend several years dwelling in a subject area in which I am most vitally yet not pleasantly involved. Each medical treatise on the dangers of obesity generated fear and even sometimes the (short-lived) resolve to accept my foolishness and begin another diet. I am still startled by slender colleagues who bemoan their apparent weight gain in my presence and note anew how much a frequent dialogue about food and body size graces even the most enlightened female circles.

Towards the end of writing this thesis I read the work of Henderson (1995), and came to see that the process she was describing closely resembled the process inherent in this research. She notes:

> Consciousness raising in participatory research is the meeting ground of theory and practice; it is both the method of achieving a goal and the goal itself. The research process becomes a consciousness-raising experience in which researched and researchers engage in critical dialogue. This act leads to new understandings of self and new understandings of each other and to the creation of new theories to explain phenomena (Henderson, 1995, p. 67).

Participants in this study certainly engaged in a mutual sharing of information. They talked relatively freely of themselves, heard of my discoveries as the research progressed, and learnt something about each other in reading drafts of the work in early stages. The voice of large women is conspicuously silent in the discourses which inform women's body size. The experience and daily reality of large women is discounted in daily practices constructed from and through the discourses which speak of largeness in particular ways. Their dieting vigilance and eating confusion is silenced by the vigorous and vociferous discourses of science, medicine and the diet industry in which the scientific and populist discourses are embedded.

In the process of consciousness raising there is a sense of what Drevdahl (1995, p. 13) has called 'coming to voice'. A group of large women have had the opportunity to move from a position of silence to a position where their voice is heard articulating a model which describes their experience of embodied largeness in a reflexive manner. Both they and the readers of this work can now perceive this experience within the socio-political constraints so critical to the experience. Furthermore the nature of the interviewing process enabled individual differences to be addressed and supported a therapeutic process for several participants.

In terms of the political project which is feminism it is has been important that the women who have participated in this research should benefit to some degree. But it is even more desirable that the challenge to hegemonic constraints on women's lives should be addressed at a community level. In this respect the second aim of the research was to create the potential for improvement in the quality and applicability of nursing practice.

Before addressing the arena of nursing practice I turn to the tensions engendered in negotiating the postmodern context as a feminist nurse scholar. I began this project with a clear understanding of the political project which is feminism and feeling an impetus to do research which would make a difference to women's lives. In the course of years of reading and thinking I have inevitably dwelt in the rich scholarship which is current feminist theorising in the postmodern context. I have both advanced into and retreated from postmodernist ideas.

Foucault's notions of discourse and power were useful analytic tools. They assisted in understanding the networks of power in the beliefs, ideas and practices relevant to body size and health as espoused by medicine, nursing and within the popular domain. Foucault argues that, 'power is not an institution, and not a structure; neither is it a certain strength we are endowed with; it is the name that one attributes to a complex strategical situation in a particular society' (Foucault, 1980, p. 93).

This was particularly relevant in considering nursing's persistent locatedness within medicine. Nurses are attracted by the seeming power of medicine and they unwittingly propagate a power that has a base elsewhere. In so doing they strengthen the power inherent in medicine by masking its operations because they are both of it and yet separate from it.

My attempts to apply similar analytic tools to the interview material after the interpretive process of thematic analysis, held little meaning in terms of my desire to problematise large women's experience and place it vividly before the nursing and wider community. It is already evident that in discussing marginalisation and even medicalisation I have referred to the binary notions of a centre and margins which is problematic within a Foucauldian use of discourse. Hall, Stevens and Meleis (1994, p. 27) argue, with great relevance to this research project, that,

> Postmodernism is still predominantly the product of male European theorists; its rhetoric does not nullify the real existence of a powerful group at the centre that continues to enforce policies from a central cultural and political position.

At the conclusion of this project I have a strong sense of standing between two poles. One is the intellectual challenge, even thrill, of grappling with the complexity of postmodern ideas in all their myriad uncertainty. The other is the sheer concrete reality of large women's lives which demand from me, as a nurse, some very focused attention from a platform of connectedness and shared purpose. Brodribb (1992) warns of the potential for postmodernism to support female oblivion and disconnection whereas a feminism that is not exclusively caught in the postmodern context offers the potential for so much more. Most compellingly Brodribb suggests that postmodernism is 'the cultural capital of late patriarchy' (Brodribb, 1992, p. 20-21).

This speaks to another tension I experienced. Claiming to operate in a postmodern context renders the notions of patriarchy and capitalism almost unmentionable. Yet my strong sense at this point is that embodied largeness is an aspect of women's lives which is supported by their capture in the web formed by the intersection between capitalism and patriarchy so clearly articulated by socialist feminists. At the very simplest level dieters are fertile ground for the enormous consumption of goods which supports capitalist economies. Diet foods, exercise machines, and changed clothing sizes are just a small part of the weight loss industry (Schwartz, 1986).

Given that I have used a Foucauldian notion of discourse to frame the context of embodied largeness it could be expected that I would have considered the resistance and displacements or disruptions to dominant discourse present or possible in the words of participants. In chapter eleven I discussed some aspects of resistance demonstrated by participants but mostly they have consistently and very clearly demonstrated their difficulty in taking up any other subject position than the one offered through the most dominant framings of acceptable female form. Even at the point that they can articulate the unfairness and the limitations of being so constrained, they express their difficulty in standing outside the powerful discourses of medicine and femininity.

To this end I claim the vital need to address an improvement in nursing practice and to develop greater clarity around nursing's contribution to the socio-political domain of health service decision making. This in itself may offer the potential for a reconstituted discourse about women and body size in a way that does not currently exist. The final chapter deals with this need, considering women as patients and as clients of primary health care. Reflections on the research and implications for further study will also be addressed.

CHAPTER THIRTEEN: Improving Nursing Practice

13.1 Introduction.

The previous chapter discussed the research from the perspectives of medicalisation, marginalisation and consciousness raising or research for social change. This chapter provides a closer discussion of the research findings as they relate to women's health experience and nursing practice decisions. As I have noted earlier, nursing, as a practice discipline, is critically concerned with the responsibility to act and must, therefore, move beyond discussion and critique to provide appropriate care. I begin first by revisiting the aims of the research, provide a critique of reduction dieting as the conventional response to 'obesity' and place the participants' experience within the context of health seeking behaviours. Living embodied largeness is then examined for its implications for nursing practice and the potential for any further research.

13.2 Revisiting the aims of the research.

The aims of this study were two-fold. Firstly, a group of women would have the opportunity to explore their experience of living in a large body and might come to perceive that experience differently. Secondly, it was intended to generate knowledge from that exploration, which would provide insight to nurses relevant to supporting large women in their pursuit of good health.

The generation of the model of embodied largeness is indicative of the extent to which participants have freely explored their life battle with body weight. Acceptance of the model by participants confirms its usefulness as a means of illuminating their experience. That they have come to see the experience differently is demonstrated by the extent to which almost all of the women have found the research participation at least enlightening, in some instances empowering or therapeutic and occasionally even liberating. Evidence of this has previously been presented in the final chapter of interview material. In keeping with the second aim of the research this chapter discusses the nursing practice implications of the model of embodied largeness as developed in participation with nine women medically designated as obese.

13.3 A critique of reduction dieting

The women in this study have constantly striven, and one continues to strive actively, for the liberation of a slim acceptable body as a passport to all that is important in life. But that quest for slimness has in effect produced increasing confinement in an ever-burgeoning body, thereby becoming less acceptable and feeling unable to fully participate in life until the largeness is transcended either physically or at least mentally.

The assumption promulgated by medicine is that excess weight is universally unhealthy and must be reduced in all circumstances. But as discussed in chapter three there is no such absolute certainty about the benefits of substantial weight loss for all people and there is clear evidence of the detrimental consequences and apparent ineffectiveness of reduction dieting.

There is no certain or absolutely reliable means by which a person may guarantee the loss of a significant amount of weight followed by the maintenance of that loss. There is at the least growing confusion within the medical literature about the best health outcomes related to body size and weight loss on an individual basis. The women in this study had undertaken a number of reduction diets which, due to their own determination and vigilance, were successful in the short term. In good faith most repeatedly undertook a process which they believed to be both desirable and effective if they only worked hard enough. But there was a degree of inevitability about the manner in which the weight returned following each period of dieting.

It is thought that the body responds to the sensed starvation of a reduction diet by conserving fat and slowing metabolism. As this response comes into effect the initial rapid loss of weight is slowed and the dieter experiences a plateau effect with minimal weight loss and increasing hunger. Extremely determined people prepared to endure the fatigue, irritability and hunger will persist with a slow weight loss. The majority understandably succumb to the body's craving for sustenance and break their diet. Information relating to the problematic nature of reduction dieting has been explored, documented and described over a considerable period of time (Bennett & Gurin, 1982; Atrens, 1988; Wooley & Garner, 1991; Leibel, Rosenbaum & Hirsch, 1995; and many others).

The participants described the repetitive nature of their reduction dieting and their growing sense of frustration and hopelessness. Some of them have, as previously noted, lost and regained up to fifty kilos of weight. Only Sarah, at last contact, was still dieting,

buoyed yet again by the initial success of her seventh or eighth diet and certain once more that this time it would work. Clare was still dieting during the study, but by the end of the study had made an unequivocal decision to stop. Heather is still determined to lose weight but believes she will do so by resolving some of her emotional concerns. The remainder have abandoned dieting but cannot relinquish the hope for slenderness.

Clearly many women do lose significant amounts of weight, if only in the short term. Wolf (1990) notes that during the use of concentration camps in Germany in World War Two, 900 calories was scientifically determined to be a minimum level necessary to sustain human functioning. Comparing such figures with the 800-1200 calorie level typical of apparently reasonable reduction diets, it can be seen that persistently dieting women are indeed enduring chronic semi- starvation.

The cost to women in terms of loss of energy, irritability and nutritional deprivation appears to be neither acknowledged nor researched to any degree. That women, especially young or pregnant women, have particular nutritional needs has been documented by Kirkley and Burge (1989). They note, especially, the need for calcium and iron intake. Whilst such detail falls outside the scope of this study it is of note that a recent New Zealand study (LINZ, 1995) has reported consistently low iron levels in women compared with levels in the normal range for men. There is also growing awareness of the problem of calcium related diminished bone density in women, leading to osteoporosis in older women and the sequelae of life-limiting hip and other fractures.

Ogden (1992) has documented some of the effects of reduction dieting. She reports that a 1988 Cambridge study found that after two weeks of reduction dieting, subjects experienced an increase in feelings of loss of control, demonstrated unnecessary eating and reported increased preoccupation with food. Ogden's own study of twenty-three women also showed increasing preoccupation with food as the diet progressed. As discussed in chapter three, there is growing awareness that reduction dieting in itself creates disordered and even binge eating (Polivy & Herman, 1985, 1987).

The women in this study report a degree of eating consciousness which is present whether they are dieting or not. Whilst constantly handling food in the process of caring for others they are also aware of its forbidden nature for themselves. Ogden (1992) documents the altered relationship to food described by dieters in her study. This included obsessing about 'forbidden food', following one dietary lapse by eating excessively to compensate for the sense of failure and feeling bad about themselves and their eating after consuming a high calorie meal.

All of this has been born out by the women in this study who have described the manner in which their alienation from the social world of food is concurrent with a disordered private relationship with food. They live in a discursively saturated environment which tells them that they are greedy and eat inappropriately. Simultaneously they grapple with the physiological and psychological consequences of dieting, and it is virtually impossible for them to know how, or even what it is, to eat normally.

I contend that there is sufficient evidence to suggest that nurses should cease to support reduction dieting as a method of weight control, and actively work to prevent young women from embarking on a life-time involvement with reduction dieting. I also contend that it is inappropriate to encourage large women to engage in reduction dieting. In so doing we enforce the binary opposition of, to diet or not to diet and avoid looking for the healthier practices which may arise in the gap between these two poles. Nursing needs to address the support that could be offered to women such as those in this study, who have dieted extensively and are now overweight, some to the point of possibly having altered mortality and morbidity statistics.

I use the word possibly because, as discussed in chapter three, there is considerable uncertainty with regard to the links between women's body size, body weight, mortality and morbidity. It is however clear, that a much wider range of weight is healthy, and that a good deal of reduction dieting occurs for aesthetic rather than health concerns.

There is a further dimension, in that MacBride (1988) notes that fat women who eat nutritiously and have regular exercise have never been studied separately from those who do not. Nor is it likely that fat women who do not feel considerable stigmatisation have ever been located in sufficient numbers to study. Health statistics about large women are based on studies of a population who have inevitably experienced considerable swings in body weight, eaten poorly in tension with dieting, and felt chronically stigmatised.

The issue of body size and health, for women at least, is intricately clouded by socio-cultural and political dimensions. This creates a complex area which is difficult for both women themselves and health professionals to negotiate with any clarity.

13.4 Being healthy as a large woman.

The participants' experiences include body consciousness, eating in tension with reduction dieting, withdrawing, feeling stigmatised and being unable to accept their largeness. The

outcome of these aspects of living in a large body is a decrease in what we might call healthy behaviours. Elizabeth has finally taken up regular exercise with the advent of an all-women's gym but it has taken her until her late thirties to feel both comfortable and allowed to do this for herself. Sally makes a very conscious effort and manages to stifle feelings of shame to participate in recreational activity. The other participants, for reasons of lack of interest, discomfort or embarrassment, do not have any exercise. In Clare's case pre-school children remove her freedom to exercise which compounds the other issues.

Fear of injury, shame and ridicule are significant deterrents to exercise (Packer, 1989), especially participation in public recreation such as skiing and swimming. Celia actively longs to ski and ride horses but feels precluded as a large woman from becoming involved. Exercise which is fun, competitive and varied is perhaps more likely to endure as a way of life than solitary grinding in a gym or on a home exercise machine of some description. Knowing how one is viewed and thought of by others serves to confine large women to lonely encounters with a rebounder or skipping rope rather than the more motivating participation in recreational sports.

Exercise is almost invariably promoted to women as an activity aimed exclusively at the loss of weight. For example a recent advertisement for a women-only gym *Evening Standard* (August 28th,1996) invites members to 'burn fat fast'. The advertisements of gyms aimed at women often offer a reduced joining fee in order to achieve weight loss before summer. Women-only gyms advertise the presence of 'tummy trimmers' and 'butt blasters', thus employing graphic language to offer the eradication of the demonstrably female portions of a woman's body.

Exercise therefore becomes linked to the choice between to diet or not to diet and does not stand alone as a means of feeling fit and active regardless of body size. The female models used to promote gym membership denote a level of perfection which acts to exclude the woman whose body is full and soft and more comfortable in tee shirt and track pants than lycra leotard and g-string. Exercise is therefore frequently abandoned along with the failed diet, as it holds no identity of its own.

The constraints of socially constructed femininities also play a part in limiting women's exercise participation. Participants described their emerging body consciousness and the awareness that their larger body was somehow defective. As girls begin to consider their bodies are defective they may begin to avoid revealing themselves in exercise participation. This was intimated although not fully explored in this project but it has

been a frequent comment at seminars where I have discussed the work. Later on as pregnant women and mothers of small children, opportunities for exercise are frequently diminished. As Clare noted, her husband just goes to the gym after work and does not have to worry about the preparation of dinner or minding the children. Sarah noted that her husband's life as a farmer is naturally very active, whereas her own in the domestic sphere is much less active. These women are typifying some of the situations which exist for significant numbers of women.

Participants also talked about their difficulties in seeing themselves as fitting the conventional stereotypes of approved feminine appearance. In some instances they expressed their difficulty in considering themselves as sexually attractive or desirable. Images and sexuality are inextricably linked. Smith (1989) suggests that flesh has been eroticised in rigid and exclusive ways in western cultures, and women whose bodies have been defined as 'defective' are pushed to the erotic margins of society. Fat women see few if any positive images of their bodies let alone in sexual settings. It is beyond the limits of this study to describe the impact on self esteem but it is probable as previously mentioned in chapter nine that the experience of feeling outside mainstream acceptability because of body size and appearance is closely akin to chronic stigmatisation.

Wooley and Garner (1991) argue that the purported benefits of weight loss are simply assumptions as so few people have lost and maintained a clinically significant amount of weight. Polivy and Herman (1985) have noted that prolonged and periodic calorie restriction results in personality changes consistent with passiveness, anxiety and emotionality. Wolf (1990) suggests that reduction dieting is a potent political sedative rendering women quietly mad and usefully tractable. Certainly women in this study reported the weariness and physical fatigue associated with chronic dieting especially when combined with work and domestic responsibilities.

A further theme surfaced by participants related to concern about being seen as a fat woman in a social context which holds negative views about fat women. Ross (1994, p. 63) says that being overweight is distressing mostly because it is viewed negatively in our society. She argues that 'negative evaluations are internalised as self-rejection because we view ourselves as others see us'. It was notable that participants in this study reported particular distress when their image was reflected back to them either in a mirror or through family videos or photographs.

Ross (1994) cites numerous studies demonstrating that the overweight person is considered lazy, sloppy, mean and stupid by both adults and children and that women

who are very overweight are especially stigmatised. On the surface the misery expressed by overweight women and the sense of stigmatisation and alienation would seem to be good reasons to support weight loss attempts for large women and certainly the nursing literature frequently justified reduction dieting on these grounds amongst others.

Ross's (1994) study however found that trying to fit norms of attractiveness by dieting is more stressful than not fitting them because of a strong relationship between dieting and depression. Participants in my study noted that a major reason for dieting was to feel better about oneself but given the transient nature of any success no permanent benefit was achieved. On the contrary the repeated trying and failing served to focus participants even more intently on issues of body consciousness and eating awareness. Feeling good about oneself is largely accepted as an important component of health and wellness and chronic dieting does not engender feelings of self worth beyond the initial excitement of early weight losses.

Conventional or bio medical views of health have more commonly taken the view that health is the absence of disease. This view impacts strongly on the area of body size. Health has been assumed to exist in the presence of thinness and to be absent in the presence of largeness which is then defined as illness. Accordingly the assumption is made that striving to be thin is the single most health promoting activity that a large woman can undertake.

Conversely health can be defined as a multi faceted multi leveled state of wellness which incorporates physical and emotional well-being achieved through satisfying engagement with work, relationships and leisure or relaxation. Participants described how they constrain a large number of lifestyle and other choices because they perceive their large bodies to be either unsuited or unacceptable for many settings. In particular they withdraw from exercise participation, sit on the sidelines in recreational pursuits and feel hesitant in many areas because of real or imagined stigmatisation.

No large woman can fail to be aware of the widespread repugnance with which an out of control female body is viewed. Evidence for the universality of distaste was previously provided in chapter one and again in this chapter (Ross, 1994). In the process of interpreting and internalising the meaning of fatness they are taking a deeply stigmatised way of living in the world into their own self concept.

In summary, the experience of embodied largeness is a health threatening experience. But it is made so by rigid socially and medically sanctioned requirements for women to

inhabit particularly small and artificially restrained bodies. Suggested treatments, diet triggered disordered eating and prolonged stigmatisation combine to produce a lived experience which on balance may be far more detrimental to health than simply having a larger body than the body currently and somewhat arbitrarily deemed to be normal. As I have argued, nurses have, in the main, colluded with the unhelpful responses offered to large women. I want to turn now to considering how nursing might practice differently in this area.

13.5 The Nursing response.

As noted in chapter three, there has been a degree of uniformity about existing nursing responses to women whose body size falls outside accepted norms for height. Nurses have accepted the premise that this bodily state of largeness is a disease and a disease with such unacceptable consequences that weight must at all costs be reduced. Some literature, for example Miller (1992), spoke of 'the obese woman' in terms which at times entirely precluded a caring focus and assumed their culpability for their unfortunate state. A behaviourist focus was present in the majority of literature aimed at improving the bad eating habits which are assumed to occur due to lack of willpower, insufficient knowledge or poor motivation. A notable lack of focus on assessment allows the assumptions of disordered eating and a complete lack of awareness of socio-cultural or political analysis exists. There are notable exceptions, (White, 1991; Rossi, 1988 and MacBride 1988; Dossey, 1995) but they are few and far between.

Nursing has, in the last twenty years, come to pride itself on the possession of a separate body of knowledge unique to nursing and entirely separate to medicine. That separateness is articulated in saying that what makes nursing unique is that we nurse persons, not parts of people or diseases or even isolated events in peoples lives. We have also prided ourselves on a growing realisation that people cannot be effectively nursed without reference to their environment. This may be their family, their wider social sphere or more ambitiously the socio-political context in which each individual negotiates their health.

Wicks (1995) carried out an ethnographic study within a hospital ward and found that nurses operate with a duality of focus. She says that nurses practice within a central contradiction between servicing scientific medicine at the same time as they try to provide holistic care for their patients. She goes on to argue that there is 'a fundamental schism in nursing knowledge and nursing practice' (Wicks, 1995, p. 134).

In relation to this study, comparing the response in related nursing literature (Chapter Three) with the need made manifest by the participants in this study (Chapters Seven to Eleven) also reveals a similarly profound schism. The women in this study have clearly articulated their suffering and their very real difficulties in reaching their full potential to enjoy life and to be as fully healthy as is possible for them personally. Supervised reduction dieting, referral to diet clinics (professional or entrepreneurial) and complicity with marginalising stereotypes do not fit comfortably with any ethos of nursing we could currently explicate.

13.5.1 Improving the nursing response.

I now move to considering how nursing could best match theory with practice in the area of embodied largeness. I contend that the attention will need to focus on two different levels. One is an altered response to large women on a one to one basis in the way that we provide care physically and psychologically to patients or provide primary health care to clients. But I will also argue for the development of what has been called the radical critique (Kermode & Brown, 1995), in suggesting that nursing must focus more of its energy beyond the immediacy of the client and into the socio-political context.

13.5.2 Caring for large women as patients.

Throughout the course of this study I have inevitably discussed the work with post graduate students and with registered nurses in seminars. I have received many spontaneous comments about the degree of censure which is expressed privately, and sometimes not so privately, about large woman as patients. It is noted that such comment is made by both medical practitioners and registered nurses. Furthermore two of the participants are registered nurses and one had been a student nurse for just over a year. They too endorsed such comments. During the course of this study I considered conducting a focus group to discuss attitudes to large patients but decided against it on the basis that my own positioning as a large woman might preclude any real honesty of response.

It is clear from this that the social stigmatisation and the perception that fatness is wilful and distasteful may well be present in the attitude of many health professionals. There is some literature available from the 1970's which demonstrated negative perceptions by medical practitioners and active distaste for caring for large patients (Wooley and Garner, 1991). One nursing study (Peternelj-Taylor, 1989) has identified that nurses hold negative attitudes to fatness and also notes that no previous work has been done in this area.

Such negative perceptions must cloud the caring and concern for a patient's well being and reduce sensitivity to her distress and embarrassment in situations which inevitably include high levels of bodily exposure to strangers. Morag described very poignantly how her experience of feeling ill and vulnerable in hospital was compounded by the obvious condemnation of her fat body.

Most nurses have been and continue to be socialised as women even before they are socialised as nurses. Connors (1985), notes that women have been socialised to focus on their bodies as sexual or medical objects and to turn themselves over to the experts at the expense of their sense of bodily integrity and inviolability. Nurses and women alike engage in endless self monitoring of their bodies' compliance and they jointly look to medicine as an authority on the acceptable body (Connors, 1985). It is asking an enormous amount of nurses to stand outside their socialisation as women and to practice nursing free from marginalising behaviours but it is also a requirement that needs to be addressed vigorously.

13.5.3 Women as clients of primary health care.

The equation of obesity with ill health and the assumption that weight loss must be pursued at all costs is clearly an extremely simplistic response to a problem which is multi faceted. Nursing has a commitment to nursing whole people, mindful of their individuality and mindful of the diverse pathways toward good health.

Nurses generally adhere to the principle of prevention as a key to the achievement of health. In the area of women and body size it is extremely important. Prevention of negative health consequences in this context would mean encouraging the acceptance of a much wider range of body sizes as normal and healthy and avoidance of the dieting regaining cycle of reduction dieting. It could also mean refocussing on healthier eating patterns and coming to see good nutrition as an act of self caring far more positive than the deprivation cycles imposed by focusing on reduction dieting.

There is a particular need to work with young women to support them to critique the social pressures which make them so unhappy with their body image. Creating situations where young women and adolescent girls may articulate their distress to each other would reduce the feelings which young women describe of bearing this burden alone and reduce the sense that their own peers are sitting in judgment on their 'out of control' bodies. Nurses need to exhibit a caring approach to each other and to their young women clients as they struggle to cast off the strictures which have been so rigidly imposed (Carryer, 1992).

There is a rich area here for nursing support of appropriate exercise for large people (Gillett, 1988). Gyms, swimming pools and tennis courts with periods reserved for the significantly heavy woman, with privacy guaranteed, would do much to create a habit of pleasurable exercise. Arrangements for transport, child-minding and cost containment would represent a realistic appraisal of many women's needs.

Any attempt to increase women's exercise participation cannot occur without consideration of the particular status of women. Because many women do the 'double shift' of careers and domestic work they have significant time constraints. Fear of lone walking or running in certain places is an issue for many women especially if they do not feel fit and able to run away or defend themselves from sexual assault. The feminisation of poverty means many women cannot afford expensive gym fees or many of the trappings of exercise experience in commercial but safer settings. Participants were quick to note the much publicised weight loss of Oprah Winfrey, a process which involved the enormous cost of a personal trainer for a prolonged period.

A recreation of pleasure and pride in women's bodies in all their diversity, and a reaffirmation of their obvious femaleness when not pencil thin would represent highly health promoting behaviour. This combined with the creation of a safe climate where large woman could request health care without fear of humiliation would further promote the health of all women. Nurses looking for the opportunities created by health reform could well consider providing leadership in this area.

Celia commented on her experience of attending a general practitioner who was so focused on her largeness that he overlooked basic requirements for an appropriate clinical assessment (chapter Ten). Elizabeth noted a house surgeon in an accident and emergency setting who felt her body size was a factor in explaining her acute abdominal pain (chapter Ten). Both Heather and Morag noted their reluctance to request screening procedures because of the bodily exposure required (chapter Ten). There is a risk here of limited health promotion and diminished early detection.

There is enormous and unrecognised potential for effective health promotion for girls and women. It will not be found in nursing's current acceptance of the oppressive requirements for women to conform to rigid specifications for body size and limiting definitions and practices of femininity. It will not occur while excessive anxiety about food and appearance are deemed to be normal feminine behaviour. It is not health promoting for nurses to comply with behavioural programmes which require some women

to gain weight and others to lose it, both based on arbitrarily imposed norms and in most cases without cognisance of the issues which make body size so problematic for women.

MacBride (1988) and Dossey (1995) are nurses who argue for an approach to large women which does not equate with the traditional practice of supported weight loss. They suggest that genuinely holistic care means having multiple criteria for success and this would seem to fit comfortably with the multi faceted nature of the problem as identified earlier in this chapter. Their approach begins, as should all nursing approaches, with a careful and entirely individualised assessment of each woman which attempts to identify what that person wants.

I contend that this would need to be underpinned by a feminist analysis of how woman come to want what they say they want in terms of bodily appearance. Neither nurse author mentioned above problematises the particular socio-political climate in which women negotiate body size. Dossey (1995) asks clients to look within themselves for the source of their difficult relationship to food although at the same time she strongly advocates the need to abandon reduction dieting. Given the hegemonic nature of discursive constructions of femininity, it is difficult for any women to take up a subject position which stands outside conventional feminine attractiveness with its close links to slenderness. More challenging for nurses who do view women's health through a feminist lens is the art of choosing to what degree and exactly how this will be utilised.

The nursing assessment may surface a range of aesthetic or physical health reasons for wanting to be smaller. Fears of ill health from excess weight may be both realistic or unrealistic depending on each individuals particular circumstances. There may be considerable pressure from relatives and partners which will need to be examined and dealt with. There may well be inaccurate expectations about reduction dieting and a high sense of personal culpability to explore.

There are a variety of possible interventions for a woman who is realistically concerned about her weight. In the New Zealand context, alteration of the diet may involve closer adherence to national Heart Foundation guidelines in terms of increasing complex carbohydrates, fibre, calcium and iron and reducing processed foods, salt, simple sugars and fats. Searching for an appropriate exercise modality which is not too boring, too expensive or impossible to combine with other commitments may be useful for some women. Support for such a process is offered by Abernathy and Black (1996) who suggest that,

> Indexes associated with high risk in obese persons often return to normal with appropriate physical activities, dietary habits and a small weight loss even when body weight and percentage body fat remain above recommended standards (p. 448S).

Learning to disengage from reduction dieting may eventually allow healthier eating patterns. Ogden (1992) and Hirschmann and Munter (1995) suggest that as the specter of dieting fades the former dieter may be able to resume eating in response to hunger and need rather than less appropriate cues. Participants in this study described eating in anticipation of dieting or as a result of the deprivation of dieting (chapter seven). Regaining a relaxed attitude to satisfying hunger and relinquishing eating consciousness may or may not cause weight loss but it may well prevent further gain. Even more importantly it will eventually relieve a source of constant anxiety and preoccupation.

There is one further issue of importance to nursing practice and that is the nature of the therapeutic relationship between nurse and client. The essence of such a relationship in nursing is that the client experiences the encounter as a valued and respected person. In a situation where the nurse holds negative evaluations of the client and unrealistic expectations it is likely that the nature of the relationship will be compromised. Wooley and Garner (1991) note the anger which arises out of repeated experiences of helplessness and failure and suggest that this is a high risk for professional encounters aimed at weight reduction. They note from their experience that when obese patients sense that it is safe to express their real feelings, they say that they have felt deeply humiliated in therapeutic relationships.

Improved nursing practice in the area of large body size has covered both the care of large women as patients and the primary care of all women. I have suggested that in order to provide a high standard of practice, nurses must acknowledge and deal with their personal positioning within the dominant discourses about so called obesity and those pertaining to femininity. As befits the standards of a profession, care must be based on research derived knowledge about the client group tempered with an approach which is in the true sense of the word holistic. In the delivery of effective primary care the challenges to nursing fall within the next section where I will address the radical critique within nursing scholarship.

13.6 The radical critique.

Butterfield (1990) notes that descriptions of one to one relationships dominate much of the nursing literature. This focus emphasises the nurse client relationship and has minimal if any attention to forces outside that relationship which may have affected the clients status or behaviour. Butterfield argues that:

> Examination of nursing problems from a "think small" perspective fosters inadequate consideration of these social, environmental, and political determinants of health. This perspective results not only in a restricted range of intervention possibilities for the nurse, but also in a distorted impression of clients' behaviours. An understanding of the complex social, political and economic forces that shape people's lives is necessary for nurses to promote health in individuals and groups (Butterfield, 1990, p. 1-2).

There has been a small but persistent call within nursing literature of the last five to six years to expand the focus of nursing to include the socio-political context in which health care is given and received (Chopoorian, 1986; Stevens 1989; Kleffel 1991; and Kermode & Brown, 1995).

Kermode and Brown (1995) argue for attention to the radical critique in nursing. They challenge nursing by asking if we are so preoccupied with our own victim discourse that any discourse on our potential contribution to other oppressive structures and processes is not possible. Delaney (1994) provides a pertinent critique of the nursing notion of health promotion. She notes nursing's tendency to ignore the social structures which engender ill health whilst focusing on individual 'lifestyle' issues. Similarly Caraher (1994) contends that nursing attitudes to health promotion decontextualise social problems.

The nursing response to body size management fits very closely with the critique of Delaney (1994); Caraher (1994) and Kermode & Brown (1995). Despite professing to reject reductionist concepts of health and illness, nursing has proceeded to adhere to them somewhat blindly. In the process of proselytising holism nursing has according to Kermode & Brown (1995) also subverted that from its initial global and population focus to an individual focus in which it has an uncomfortable fit. The consequent philosophical and practical confusion is clearly borne out in the area of this study.

To work effectively in the setting explored in this thesis it seems that nurses will need to move outside their traditional employment settings. Work in new settings will need to be underpinned by further participatory research (Drevdahl,1995; Henderson, 1995) in this area, to develop a nursing response untrammeled by the dictates of medicine. This would be tantamount to what Kleffel (1991) describes as a revolution of consciousness and a move to perceiving nursing in an entirely different way and perhaps in entirely new settings.

Whilst not revealed in the transcripts I noted several times in my diary [field notes] how little exposure these women had had to nurses, apart from during birth and early child raising. Even if nurses were superbly prepared to support these women in negotiating health in some of the above ways, these women and most others would not have had ready access to an autonomously practicing nurse to consult for help, support or advice other than in the context of supported reduction dieting available through some general practice settings.

Given the medical viewpoint on obesity and reduction dieting it would be difficult for nurses employed by doctors, as they frequently are in the community, to provide more appropriate support. Dr. John Birkbeck, the medical director of the New Zealand nutrition foundation is certain 'that to suggest that reduction dieting does not work is ridiculous' [Letter to the editor of the *New Zealand Listener*, June 1993] and he has stated categorically [*New Zealand Listener*, September 1994] that the obese die young. Such statements presented for widespread public consumption are overly simplistic and contain some truth and much untruth. They serve however to support the diet industry and the general belief that reduction dieting is a useful and essential practice. They reinforce the hegemony of medical belief and secure nursing obedience.

13.7 Reflections on the study.

It is inevitable that throughout the long period of dwelling with this topic and listening to and reading the words of participants, I have come to a different understanding of the topic than that with which I began.

If I were to commence this project now, with the same emancipatory intent, I would probably engage even more actively in the process of sharing resources and information with participants and in seeking their input more deliberately in determining the development of improved nursing care. Towards the end of the project when I began to

understand how much some of the participants had felt alone with this problem, I began to see that a focus group session between all participants could have generated interesting material but also may have offered increased participation benefits to at least some of the participants.

Recent publications by Hirschmann and Munter (1995) and Erdman (1996) suggest possibilities for self and body acceptance which would be worthy of shared participatory work by nurses with large women. I retain the sense however that the issue of nursing's lingering allegiance to medicine needs addressing first.

There is a sense of constraint on the work that could have been done, due to the need to meet the requirements of doctoral study and to complete the work in a particular period of time. Towards the end of the study, as I read recent work on participatory research by other nurses, I came to see that although this study has been reflexive and open ended it has not been as participatory as is possible.

In the context of epistemological concerns, it has become increasingly apparent to me that this research fits most comfortably into the category of feminist standpoint. In researching the experience of largeness for women I have made claims to special insight because the participants share an identity as women. Feminist research is a vehicle for exploration of multiple sites of oppression, in particular those created specifically by gender. The experience of inhabiting a large body has particularities which arise from the prescriptive nature of femininity which is the way of being in the world ascribed to women.

One can argue interminably about the sources, origins and agendas of the disciplinary project of femininity, as indeed many feminist scholars do, but undeniably the lives of most women are connected at some level to that project. Undoubtedly the connection is mediated by variables such as ethnicity, class, education and other locations; but the connection exists. Even the woman who states that she will not fight to maintain a suitably small body is connected to the project by virtue of her overt rejection of it.

In evaluating this project I note that being large is an experience of considerable interest and concern to women as well as to nurses and nursing practice. Bodily largeness has been explored in a way that renders it both vivid and revealing and the exploration has been juxtaposed against the complex context in which the experience occurs. Analysing the networks of power in the various discourses about body size has revealed nursing to be inappropriately located within a discourse more suited to medicine. Listening to the

voices of women living the experience of largeness provides critical insights which have been utilised to suggest a realignment of the theory and practice of nursing.

As I noted in chapter four this research cannot control how nurses use the information presented by this thesis. At its conclusion however, I have a sense of having presented a vehicle for the voices of a group of large women in a manner lent greater meaning by its location within a critical analysis of the discursive context of body size and health care delivery. Nurses who have read the work will undoubtedly reflect more critically on their practice, may develop research interests of their own or participate in a more informed way in decision making which impacts on the care of large women.

13.8 Implications for further research.

There is unlimited scope for nursing research in this area particularly given the paucity currently available. As I came to the end of this study I sensed an emergent change in medical discourse related to body weight management. For example Abernathy and Black (1996) now contend that a very minor weight loss, alteration of the balance of dietary intake and some increase in physical activity may offer the best health outcomes to obese persons. This argues for just the gap I identified between the binary opposite of dieting or not dieting.

Potential nursing research here would include assessing the decision making processes of young women related to nutritional intake and learning how they choose whether or not to diet. Gender sensitive assessments of the impact of current health promotion packages related to obesity prevention would yield a good basis for nursing leadership in this area. Finally I believe there is more work to be done to learn how to best support optimal health for women such as those who have generated this research. Similar work with other groups of women such as Maori or lesbian women may well enhance the knowledge base on which new practice must be built.

13.9 Concluding statement.

The constraints on women's health highlighted by this study are ingrained in the fabric of society and stem from much which is considered natural and even desirable. The intersection of patriarchy and capitalism is a powerful web in which women's embodied experience is enacted. Most nurses share the embodied experience of all women and as previously noted will not easily stand outside it .

Health educators are naturally concerned with prevention of disease, longevity and enhanced quality of life. But health professionals as health educators are also members of the consumer culture of late capitalism where health and beauty have become inextricably linked. Featherstone, (1982, p. 25) argued that 'concern with the cost of health care makes it easy and tempting to castigate those who do not attend to the new messages as self indulgent 'slobs'. Since he wrote that in 1982, the issue of cost containment in health care has inexorably become an overarching concern in health care provision. Health is increasingly presented as something which calls for individual hard work, instead of more difficult but ultimately more meaningful social solutions. In the area of women's battle with their bodies this is clearly being enacted in a manner which is impacting significantly on an important area for women's health. If nursing fails to heed the radical critique it can only fail the chronically dieting woman.

Nursing needs to include a critique of the fundamental structures of society which construct femininity and masculinity so oppressively and thereby perpetuate women's distress. This is not to negate the areas of stress for men perpetuated by the hegemony of masculinity but they fall outside the scope of this thesis. Despite the authoritative feminist scholarship present in many other disciplines, the feminist voice in nursing remains limited to a very few nurse scholars. This is extraordinary in a profession which is more than predominantly female and concerned with health, wholeness and caring. Nursing at large continues to marginalise feminism thus limiting the potential for a politicised health professional who works collectively and alongside the public it serves.

I have a clear sense at the completion of this project that I have not arrived at the truth about women's experience of being overweight. More than ever I understand that there are multiple truths embedded in the experience. Such truths are however closely linked to the particularities which arise from the prescriptive nature of femininity.

The process of feminist praxis has produced vital knowledge and insights about the lived experience of large women. It has been presented in a manner which is intended to make such knowledge transparent and above all accessible and therefore able to address the conditions of some women's lives.

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APPENDIX I: Advertisement

NURSING RESEARCH

I am a registered nurse carrying out research for my Masters degree in nursing. My area of interest is women's experience of being overweight, in a social setting where it is considered unhealthy and self inflicted. I believe this may create many difficulties for women. I would like to explore this topic in a series of three to four unstructured interviews.

If you would like more information about this or might be interested in participating, please ring me at the number below.

Jenny Carryer (06) 357 0559 (evenings)

APPENDIX II: Information for Intending Participants.

My name is Jenny Carryer and I am a registered nurse doing research in order to complete my Doctoral thesis. For several years I have been aware of the growing requirement for women to be increasingly slender. At the same time I have read and evaluated a considerable amount of medical research which demonstrates that there is a high level of variation in natural body size and that reduction dieting is more likely in the long term to cause weight gain than weight loss.

Clearly many women experience considerable worry about the size of their body, and their eating. For large women these concerns are especially severe. It is possible that this alters some women's approach to health behaviours and health care. In this research I want to explore what it is like to live in a body that is larger than society currently deems as normal.

My intention is to have a series of interviews with each participant in which you will be free to tell me what you think is important. Sometimes we will exchange our ideas and concerns. The number of interviews is negotiable with you but is not likely to exceed four. With your permission the interviews will be taped and then typed up. Also with your approval selected excerpts may be printed in the final document as they were said. Any taped or typed recording which you want deleted will be wiped or destroyed without being used. You will be asked to read each transcript to comment further on their accuracy in reflecting your experience. Should you decide at any time to withdraw from the study, tapes and transcripts will be given to you to treat as you wish. In any event your anonymity will be completely protected by the removal of any means of identification by name place or personal detail.

During the course of the research all tapes, discs, transcripts and signed consent forms will be kept in a secure place. Their content will be seen by myself, the typist, who will have signed a confidentiality form and the two Massey University staff who are supervising this research. Supervisors are Dr. Julie Boddy and Dr. Lynne Alice. No person other than myself will see the signed consent forms thus protecting your identity. A copy of each transcript will be given to you to check, amend and retain. At the conclusion of the research they will be retained securely in the Social Science Archives at Massey University for at least five years.

I plan to share the results of this research with you, with other women and with nurses in order to raise our awareness of this complex issue.

Jenny Carryer *Home Phone:* (06) 357 0559
Massey Phone: (06) 350 4320

Supervisor — Professor Julie Boddy, Massey University (06) 356 9099

APPENDIX III: Consent Form.

A feminist exploration of women's embodied experience of large body size.

I have read the information sheet for this study and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I also understand that I have the right to withdraw from the study at any time, or to decline to answer any particular question. I agree to the use of a tape recorder but I have the right to ask at any time to have it turned off or to have any or all of the tape deleted if after further thought I am not happy. I agree to provide information to the researcher on the grounds that it is completely confidential. The means of protecting my confidentiality has been explained to me.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signed: .....

Name: .....

Date: .....