Living large: the experiences of large-bodied women when accessing general practice services

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Abstract

The 'obesity epidemic' of the past two decades has resulted in numerous studies reporting higher levels of stigma and discrimination experienced by obese/overweight women, both within the health care system and society in the main. Despite general practice being the most utilised point of access for health care services, there has been very little international or national exploration of the experiences of large-bodied women accessing these services.

Utilising a qualitative, descriptive research design, this post-structuralist feminist study has enabled a group of large-bodied women to express their stories of accessing general practice services. Eight self identified large-bodied women volunteered to participate in semi-structured face-to-face interviews. Thematic analysis identified seven themes: Early experiences of body perception, Confronting social stereotypes, Contending with feminine beauty ideals, Perceptions of health, Pursuing health, Respecting the whole person and Feeling safe to access care.

The women in this study articulated broader interpretations of health and well-being than those teachings reproduced within dominant bio-medical and social discourses of obesity. When these women's personal context, beliefs and values are silenced by the health care provider, the rhetoric of health care professional claims of patient-centred care has given way to these women experiencing stigmatisation and a sense of ambiguity about general practice services. However, when space is given for multiple interpretations of obesity to exist within the patient-health care provider relationship, these women feel respected, their health needs are satisfied and they are more comfortable to engage in health screening services. Resisting the powerful socio-cultural milieu which supports the superiority of a slim female body as a signifier of both health and beauty presents a challenge for health care professionals to negotiate. I contend however, that giving consideration to the perspectives of large-bodied women and critically reflecting upon one's own personal beliefs and attitudes about the overweight/obese, presents an opportunity to ensure clinical practice for this population is truly patient-centred.

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Table of contents

Chapter 1   Introduction

1.1   Introduction

The World Health Organisation defines obesity and overweight as an abnormal or excessive fat accumulation that may impair health. The International Association for the Study of Obesity (IASO) describes obesity/overweight as a global pandemic, placing unprecedented health, social and economic burdens on societies (International Association for the Study of Obesity, 2011). Worldwide there are 1.5 billion adults deemed to be overweight, with 500 million of those classified as obese (World Health Organisation, 2011). Overweight/obesity have been implicated as major risk factors for chronic conditions such as type two diabetes, cardiovascular disease, musculoskeletal disorders and some cancers, with an approximated annual global mortality rate of approximately 2.8 million adults (World Health Organisation, 2011). In New Zealand the mortality rate is estimated to be 3200 deaths per year (Ministry of Health, 2004).

The most widely used tool for estimating an individuals' body fat ratio is the Body Mass Index (BMI). This is a calculation of dividing body weight in kilograms by height in metres squared (World Health Organisation, 2011). Current New Zealand guidelines are consistent with international cut off points set by the World Health Organisation in 2004, which classify overweight as a BMI of 25.0-29.9 and obesity as a BMI of 30.0 or higher (Ministry of Health, 2008). Using these guidelines, one in three (36.3%) adults in New Zealand are classified as overweight, whilst one in four (26.5%) adults are defined as obese (Ministry of Health, 2008). Similar to the global trend, in New Zealand the prevalence of obesity/overweight has doubled in the past thirty years, from 9% (males) and 11% (females) in 1977, to 20% (males) and 22% (females) in 2003 (Ministry of Health, 2004). Ministry of Health statistics show that men are more likely to be overweight than women (40.7% vs 29.4%), whilst women are more likely to be situated at the extremes of morbid obesity (BMI >35) at 7.1% and 11.1% respectively. One in two (50.2%) females are classified as overweight or obese (Ministry of Health, 2008).

When social determinants such as gender, ethnicity, socio-economic status and deprivation scores are applied, the resulting picture of obesity demonstrates an unequal distribution (Ministry of Health, 2004, 2006, 2008). The New Zealand

Health Survey 2006/07 showed that Māori women are one and a half times more likely to be obese than non-Māori women, and significantly more likely to be classified as overweight, whilst Pacific women are at least two and a half times more likely to be obese than non-Pacific women (Ministry of Health, 2008; Sundborn et al., 2010). Increasing BMI, in both adults and children, is shown to be positively correlated with low socio-economic status, low education level and high household deprivation scores, significantly so for non-Māori females, to a lesser extent for non-Māori females but with no effect on rates of overweight/obesity for all males (Ministry of Health, 2006; Turley, Tobias, & Paul, 2006).

Obesity/overweight is a highly visible indicator of not adhering to cultural/medical norms of health and as such is a highly contentious and stigmatised human condition (Puhl & Brownell, 2001; Puhl & Heuer, 2009). Increased surveillance, debate and panic about causes and appropriate solutions to global and local levels of obesity/overweight have intensified the stigma and bias associated with body size, particularly so for women (Latner & Stunkard, 2003). One effect of this censure of large-bodied women is that they are more likely to delay or avoid health care (Fontaine, Faith, Allison, & Cheskin, 1998; Maruther, Bolen, Brancati, & Clark, 2008; Wee, McCarthy, Davis, & Phillips, 2000). There are many reasons for large-bodied women's health care avoidance, in some cases due to historical disrespectful or inappropriate censure of their body size by a health professional, or for some as a result of implicitly ingrained feelings of shame, fear or embarrassment of their bodily size. Health care professionals need to be aware of the meaning of large-bodied women's experiences with general practice in order to ameliorate actual and potential barriers to large-bodied women accessing safe, timely and respectful primary health care.

1.1.1 Purpose of the study and its significance to health

Large-bodied women are a 'silent' voice within the primary health care system yet a population presumed to be at risk for obesity-related medical conditions. Current statistics about service quality for large-bodied women in general practice is located within performance indicators and national reports predominantly focused on the prevalence of obesity, morbidity/mortality costs, eating habits and physical activity levels. However this approach to service quality assessment is of limited

value if the principal stakeholder has had little or no opportunity to express *their* experiences as a consumer.

The objective of this study is to create an opportunity for a small group of large-bodied women to describe their experiences when accessing general practice services. To ensure large-bodied women feel safe, accepted and respected, there is a clear need to discover what enables and/or disables their engagement with general practice services. There are no previous studies in New Zealand that have specifically focussed on the voiced experiences of large-bodied women accessing general practice services. The intended audience for this study are health professionals working within the general practice system. Whilst this study is not expected to influence health policy it is envisaged that, through publication, it will provide a platform for reflection and discussion of health care professionals' personal attitudes and clinical practice towards large-bodied women.

1.2   Definition of terms

General Practice – normally the first point of medical contact within the health care system. It is a community based service that focuses on providing comprehensive primary health care across the lifespan (Royal New Zealand College of General Practitioners, 2011). Services such as screening for disease, managing and monitoring chronic conditions, health promotion and health protection are usually delivered by a general practitioner and nursing team (Ministry of Health, 2008).

Primary health care (PHC) – An umbrella term used to describe health care delivered by health care professionals within the community. PHC health professionals are nurses, general practitioners, pharmacists and allied professionals such as physiotherapists, occupational therapists and community health workers. PHC is a multidisciplinary approach that delivers core acute/chronic and preventative health care services (Ministry of Health, 2007, 2008).

Large-bodied woman – a female adult over the age of eighteen years of age who identifies herself as overweight or obese relative to accepted cultural norms.

General Practitioner (GP) – a medical doctor who has post graduate training in primary health care (Royal New Zealand College of General Practitioners, 2011).

Practice Nurse – a registered nurse working within the model of general practice. Practice nurses have expertise and comprehensive knowledge of primary health care and work with populations across the lifespan (Ministry of Health, 2005).

Sex – the biological (chromosomal, physical and hormonal) characteristics that *imply* an individual is either male or female (World Health Organisation, 2010). Often confused with the term gender and offered as a rationale for gender constructs. This will be discussed further in Chapter two.

Gender – a cultural and social construction of how a person performs or should perform their biological sex, including prescribed behaviours, activities, attributes and relationship roles (World Health Organisation, 2010).This will be discussed further in Chapter two.

1.3   Background to the study

Historically, a curvaceous female body was a celebrated sign of beauty, health and prosperity (Jutel, 2006, 2009; Murray, 2008; Raphael, 2008). During the mid 19th century medicine settled its gaze on the epidemiological status of fatty tissue (Jutel, 2009) and overweight/obesity became a diagnosis of ill health. It also became a matter of morality (Gard & Wright, 2005), demonised as a lack of individual self control against the mortal sins of gluttony and sloth (Fraser, 2009; Rogge, Greenwald, & Golden, 2004). Science and social narratives have since converged to create a powerful 'cult of thinness' that has made women particularly vulnerable to the pressures of adhering to highly prescribed norms of aesthetic beauty and 'health' (Hesse-Biber, 2007). The thin and sculpted female body holds considerable currency in the Western world and as such determines women's social desirability and mobility. Deviation from ideals of slimness leads to extensive censure for women.

Weight based prejudice and discrimination towards large-bodied women and girls has been demonstrated in employment (De Boni, 2000; Harcourt & Harcourt,

2002; Puhl & Brownell, 2001; Roehling, Roehling, & Pichler, 2007; Solovay, 2000b), education (Puhl & Brownell, 2001, 2006; Puhl & Latner, 2007; Rich, 2003; Solovay, 2000a) and within the domains of popular culture (Giovanelli & Ostertag, 2009; Jutel & Buetow, 2007; Raphael, 2008). Discrimination, bias and inequity of care towards large-bodied women also exist within the health care system. Health care professionals' beliefs and opinions about large-bodied women often reflect assumptions from society in the main. Negative stereotypical labels of laziness, lack of self control, reduced intelligence and inappropriate food choices have been revealed from physicians (Bertakis & Azari, 2005; Foster et al., 2003; Hebl & Xu, 2001; Huizinger, Cooper, Bleich, Clark, & Beach, 2009; Schwartz, Chambliss, Brownell, Blair, & Billington, 2003), nurses (Hoppe & Ogden, 1997; Jeffrey & Kitto, 2006; Schwartz et al., 2003) and dieticians (Berryman, Dubale, Manchester, & Mittelstaedt, 2006; Puhl & Brownell, 2001; Schwartz et al., 2003).

Research on weight based attitudes of physicians show that increased body weight in female patients strongly correlates with reduced consultation times, increased physician distrust of patients ability to follow instructions as well as physicians' reduced respect and desire to make an effort of care and assistance (Hebl & Xu, 2001; Hebl, Xu, & Mason, 2003). In their study of practice nurse attitudes to obesity, Hoppe and Ogden (1997) found that the nurses studied believed obesity was caused by preventable factors (lifestyle) and that failure to lose weight demonstrated patients' lack of motivation. This attitude was further supported by Jeffrey and Kitto's (2006) study of nurses perceptions of caring for obese patients in a Bariatric surgical ward. They discovered that there was a complex interplay between the nurse's fatalist notion of non-judgemental care and an undercurrent of disgust and/or blame towards the patient for allowing themselves to get so obese. This was clearly reflected in the following excerpt:

> Is it [attending to nursing care on an obese patient] any different to a shrivelled old man in the bed you know and you're doing a catheter....is it any different....like that's pretty gross as well isn't it...but you know....you don't say...I can't do that, it's repulsive...like we do some pretty repulsive things to everybody...you just don't have to be obese...it's just another side line thing that you are doing" (p.76)

The impact of these attitudes spilling over to the health care experiences for large-bodied women has potential for negative health outcomes. It is already established that large-bodied women are more likely to delay preventative screening services such as gynaecologic examinations, cervical smears and clinical breast examinations (Fontaine et al., 1998; Maruther et al., 2008; Wee et al., 2000), with women citing fear of recrimination, embarrassment and humiliation as reasons for deferring or avoiding these potentially life-saving procedures. Yet despite general practice being the most utilised point of access for health care services, there has been very little international or national qualitative exploration from the perspective of large-bodied women.

As a contemporary health care issue within general practice, there is increased attention being given to health professionals' role in caring for obesity/overweight patients. Recommendations from the Clinical Guidelines for Weight Management in New Zealand Adults (Ministry of Health, 2009) encourages the establishment of a therapeutic relationship which respects and considers the lived realities of an individual. In order to achieve this, health professionals need to bracket their own personal attitudes and cultivate an environment that reduces the burden of stigma for those living the reality of being large-bodied.

1.4   Researcher's background

Nursing has traditionally and almost unequivocally accepted and acted upon the medical model of obesity as a disease (Carryer, 2001) Certainly this was the case in my undergraduate studies when the focus of nursing intervention was clearly directed towards the role of nurse as a change agent - providing patient education about calorie reduction, promoting increased physical activity and discussing the inevitable dangers of excess adiposity. Twelve years later, I have found that adherence to this model of practice continues to dominate and shape expectations of my role as a practice nurse.

I acknowledge that for a large period of my nursing career I was heavily influenced by the generic medical discourse of obesity. I subscribed, albeit often uncomfortably, to the belief that individual self will, motivation and adherence to a calorie in versus energy out model was the simple answer to the obesity 'problem'. My eventual exposure to gender theory and an increasing focus on the

complexities of lived experiences on individual health has reshaped my approach to large-bodied patients.

Clinical experiences within General Practice have made me aware that the issue of body weight is a regular source of angst for many people – and particularly so for women wanting or needing to access sexual health care services such as cervical smears. I have noticed that many women verbalise their embarrassment with self depreciating humour as a means to 'break the ice' on the issue of their body size. When encouraged, many large-bodied women are pleased to articulate their experiences and opinions. Some women have openly admitted their tendency to hesitate initiating early contact with a health professional – wary and weary of retribution or unsolicited references to their body size when presenting with health care issues that they felt were irrelevant to their corpulent self.

Alongside noting these women's fears, I have also listened to casual conversations and clinical discussions between, and with other health professionals, which reflect negative and judgemental attitudes about the large-bodied female patient. Whilst these comments are often wrapped in humour with pseudo-respectful hushed tones out of earshot of the patient, the intention to demean is not lost.

Public debate surrounding the recent case of a verbally abusive bariatric surgeon towards a 'clinically obese' female patient (New Zealand Press Association, 2010) necessitated considerable personal reflection of my own attitude and practices, acknowledging past values in order to articulate my present assumptions. Thus, underpinning this research is my belief that in order to provide safe, sensitive and appropriate therapeutic care for large-bodied women, health care professionals need to understand the perspective of their patients.

1.5   Philosophical framework – post-structuralist feminism

In asking the question 'How do large-bodied women describe their experiences of accessing general practice' I wanted to understand the meaning and constructed realities of a small group of women. My conscious choice to focus on women warranted a feminist methodological approach in order to place gender at the

centre of this inquiry. However, deciding *which* feminist position best supported the aims of this study proved a challenge.

Whilst many feminisms anchor themselves as a political movement that confronts subordination of women, there is diversity and philosophical contention within and between feminisms regarding the causes, location and solutions to patriarchal oppression. Reflecting on my background and experiences of working within the medical discourse of obesity, I found myself asking several questions. How did this discourse became so powerfully entwined with fat censure in our social lives? Why are women so susceptible to the stigma of obesity and who sets these standards of health/beauty/virtue? Do women explain experiences in a way that demonstrates internalisation of these standards? Who stands to benefit from the status quo and how can nursing challenge these standards? These questions led me to explore the post-structuralist feminist paradigm.

Post-structuralist feminism draws on critical social theory to challenge traditional feminist debates about the causes and location of women's inequality (Alvesson & Skoldberg, 2009; Weedon, 1997). In this regard, post-structuralist feminism argues that women's experiences of oppression are not universally shared, and that factors such as race, age, sexual orientation, historical and geographical location as well as institutional hierarchies are continuously shifting an individuals' experiential knowledge. Weedon (1997) further notes that those working within a post-structuralist feminist framework seek to 'unpack' and challenge everyday situations at both a personal and local level – locating contradictions, hegemonic assumptions and mechanisms of power that shape our social lives.

Both post-modernism and post-structuralism take a critical approach to the formulation of grand theories and meta-narratives which essentialise women's oppression, and dismiss the ability of any theoretical position to assert it-self as 'truth' for all women, particularly theories borne out of positivism/empiricism (Alvesson & Skoldberg, 2009; Weedon, 1997). Whilst both post-modernism and post-structuralism share core epistemological beliefs in regard to multiple realities, partial/contextual truth and a need to continue questioning taken-for-granted assumptions, it is the role of language that differentiates the two approaches. It is for this reason that post-structuralist feminism was selected as the most

informative approach for discovering the constructed realities of the women in this study.

Increasing literary and experiential exposure to contradictions within the medical discourse of obesity has led me to believe that the language of medicine (and its subsequent uptake by society) is a powerful site of influence on women's sense of self. Analysing language within a post-structuralist framework will allow me to explore meaning both behind *and* within the context of these women's experiences as large-bodied women accessing general practice services. This approach is also compatible with my use of a descriptive qualitative research design, wherein the subjective voice of the participant, in near data terms (Sandelowski, 2010), can be used to reveal language as a site of power. This will be further discussed in chapter three.

1.6   Researcher's feminist position and assumptions

I work in the female dominated profession of nursing, I live in a society that consistently measures a women's worth on her looks and performance of feminine virtues and most importantly, I am a mother to a daughter who is learning what 'being' a woman means. Where I position myself within the myriad of feminist theoretical standpoints is fluid however, I consider my evolving feminist logic most akin to the post-structuralist feminist paradigm. This is characterised by my belief that womanhood, as a gender construct, plays a vital role in the organisation and subsequent oppression of social lives. The interplay between language, knowledge, meaning and power – all fundamental aspects of the post-structuralist feminist paradigm, has added the dimension of critical challenge to my world view. This has led me to confront previously taken-for-granted assumptions in both my social and professional life spheres.

From my post-structuralist feminist position I recognise that factors such as class, education, race, geographical and historical location all moderate the lived experiences of the individual woman. Because of this stance I do not believe that a fixed and finite truth to the cause and location of women's oppression can be found, but subscribe to the post-structuralist feminist ideology that truth can only ever be partial and context specific (Weedon, 1997). Thus, whilst acknowledging

that this study presents partial knowledge, women may find some aspects of meaning that relate to their own experiences of the medical model of obesity.

My assumptions as I began this study included;

1) Large-bodied people, in particular large-bodied women, are a highly stigmatised and vulnerable population.
2) Marginalisation of large-bodied women is influenced by social standards of feminine beauty and virtue.
3) large-bodied women are a silent voice within the health care system
4) Feminist research will provide a safe, respectful and collaborative means to encourage large-bodied women to talk about their experiences.
5) Health care professionals' beliefs and opinions about large-bodied women often reflect assumptions and stereotypical labels from society in the main.
6) This study will encourage health care professionals to reflect upon their own beliefs and attitudes of large-bodied women accessing their general practice services.

1.7 Overview of the thesis

Chapter one – This chapter introduced the topic of focus and justification for this study, whilst initiating early discussions on the methodological and theoretical underpinnings of the research design. My professional background and personal positioning with the research topic was expressed, as well as assumptions that I held prior to commencing the study.

Chapter two – A focussed review of the literature will examine both historical and current practices and beliefs about obesity. The interplay between medical and social obesity discourse will be examined, with particular reference to the stigmatisation and discrimination experienced by those living in an overweight/obese body. Evidence of health professionals' negative stereotyping, weight bias and fatalistic beliefs about their large-bodied patients will be discussed, along with the consequences of these attitudes for overweight/obese women. A gap in the literature of qualitative inquiry about the lived experiences of large-bodied women accessing general practice services will be exposed.

Chapter three – An overview of the methodological decision-making process is explained, starting with a brief overview of feminism. This provides context for the following sections on post structuralism, post-structuralist feminism and its application in nursing research. Tenets of feminist research are discussed before leading on to methods utilised in this study, including ethical consideration given to the selection and use of these methods.

Chapter four – The first of the data analysis chapters, 'Living large with stigma, presents principal information about these women's experiences of stigmatisation across a multitude of locations and periods of their life. The themes are 'Early experiences of body perception', 'Confronting stereotypes' and 'Contending with feminine beauty ideals'. This chapter provides context about these participants sense of self and the burdens they carry whilst navigating their lives within a society that has normalised corpulent bodies as targets of prejudice, stigma and shame.

Chapter five – This chapter, 'Living large and negotiating health' presents the themes of 'Perceptions of health' and 'Pursuing health'. These themes reveal the participants own interpretations of health and how they battle constant exposure to medical and social teachings of obesity as an indicator of illness.

Chapter six – The final thematic groupings in this study are presented within this chapter - 'Living large and accessing health'. The themes of 'Respecting the whole person' and 'Feeling safe to access care' are centred on these women's experiences of interpersonal interactions with their health care providers. Issues of trust, vulnerability, and a desire to be treated and respected as an individual are shown to be significant influences on these women's level of engagement with general practice services. The final section of this chapter, 'I want you to know', are the verbatim statements each of these women gave in response to being asked to inform health care professionals what they need to know about providing safe and respectful care to large-bodied women.

Chapter seven – The final chapter discusses the findings of this study, highlighting a disconnection between these women's interpretations of their general practice experience and current primary health care sector claims to patient-centred care. Recommendations are offered for health care professionals

to resist current social and medical pressure that perpetuate the stigmatisation of these women, with particular reference to the role of nurses in affecting a culture of change. The limitations of this study are identified, along with proposed opportunities for further research in this area.

1.8   Summary

This chapter has identified the topic of focus for this study – the experiences of large-bodied women accessing general practice services. Justification for this focus has been provided, along with its purpose and significance to health. An introduction to the theoretical perspectives that shaped the research design has been presented, as have my personal positioning and initial assumptions about the research topic. The following chapter provides the literary context for this study by examining the discursive field of obesity and its significance to women.

Chapter 2   Literature review

2.1   Introduction

In keeping with post-structuralist feminism, this chapter will firstly provide a brief overview of the historical tension between the terms sex and gender and how this has impacted on the construction of feminine beauty. The process of, and implications from the medicalisation of body size will then be explored. This will set the scene for the literary context of medicines' discourse of obesity, which will be shown to have drawn power from the principles of thermodynamic theory, perpetuating some of the biological assumptions about both obesity and women. A synopsis of the literature critiquing the dominant discourse of obesity, as well as competing obesity discourses will be offered, followed by contextual information showing the breadth of stigmatisation experienced by large-bodied women. The final section in this chapter will provide a review of the current small volume of literature related to the topic of large-bodied women accessing general practice services.

2.1.1   Parameters of the literature review

There is a significant amount of literature on the topics of overweight/obesity and women's health. It is not the intention of this study to explore causes or consequences of overweight/obesity and therefore this literature has not been reviewed. The purpose of this study was to ascertain the experiences of large-bodied women accessing general practice services. Thus the focus of my literature inquiry has been concentrated on how large-bodied women experience altered body size, and how beliefs and practices regarding obesity/overweight have influenced and continue to influence health professional approaches to the care of large-bodied women.

Historical and contemporary literature has been drawn from the disciplines of medicine, nursing, human biology, sociology, psychology and feminism. Online databases such as Pubmed, Scopus, CINAHL and Google Scholar were utilised, with an inclusion criteria refined to the following key word descriptors; overweight or obesity and woman/en, primary health care or general practice, bias and/or stigma, health professional(s). Included sources of text were periodicals (including journals and newspapers), published and unpublished dissertations, electronic

sources (including information databases and government websites), as well as books.

In the search for comparative studies to the one presented here, all feminist and other research methodologies which focused on obesity/overweight issues related to women's voiced experiences and/or stories were included. Studies that excluded women as participants and/or were set in secondary care services (such as hospitals, private bariatric service providers and weight loss clinics) were ineligible for inclusion.

2.2   Construction of feminine beauty

Traditionally the visual body has been given primacy for determining a person's gender, including a set of 'natural' meanings, values and roles assigned to the male or female form (Weedon, 1999). Biological determinism, that is – sex as an explanation of gendered attributes, is evident throughout Western history. Harrison and Hood-Williams (2002) as well as Tong (1998) illustrate how ancient religious and philosophical doctrines all consistently allocated the female form as an imperfect copy of the male, 'inside out versions of men' complete with inverted penises and female testicles. Bamberg-Smith (2007) further notes that common themes of this era were men as normative and powerful, whilst women were symbols of evil and seduction but necessary for the purpose of procreation. As architects of westernised patriarchy, Aristotle and Plato both created a system that ensured the allocation of wealth, land and positions of power to male lineage, whilst women were designated as bodily portals for ensuring replenishment of male infants (Ember & Ember, 2007). These early belief systems were largely perpetuated by the acceptance of traditional yet unproven myths which created "common sense" linguistic dualisms to classify and order "truths" in the natural world (Anderson, 2003; Bamberg-Smith, 2007). The soul over- ruled the body, reason out ranked emotion and the mind was a man's domain, whilst the lowly body became the realm of women (Dworkin, 1974; Hesse-Biber, 2007).

During this period of pre- Enlightenment, the visual state of the body was deemed to represent inner beauty and morality. For women external beauty was also important currency for appropriate matrimonial matches, an aesthetic standard not necessary for men who had land and wealth as guarantees of suitable family

alliances (Hesse-Biber, 2007; Jutel, 2006; Jutel & Buetow, 2007). Corpulent bodies were associated with the moral high ground of the wealthy classes – an aesthetic demonstration of the privileges of abundant food and sedentary lifestyle (Haslam, 2007; Jutel, 2006). Artwork from the Renaissance and Baroque era's, show feminine beauty as buxom, voluptuous and serene (Berry, 2007), a point which Ferris (2008) postulates may have been due to significant numbers of young women in paintings of this period showing evidence of goitre.

In the mid eighteenth century, the period of Enlightenment led science to make the paradigmatic shift from spiritual/religious and philosophical musings to a positivist approach of seeking truths based on observable, objective and 'absolute' fact (Goldenberg, 2006; Gower, 2005; Zinsser, 2005). Medicine thus shifted its gaze to the anatomical features within the sexed body and further defined biological differences between the sexes. As a result, Western culture has traditionally treated the term sex as a binary frame of reference, based on an assumption that an individual can only belong to one category which is a fixed and universally accepted state (Ember & Ember, 2007; Newman, 2008). Sex was therefore defined by bio medical discourse as the chromosomal, physical and hormonal characteristics of an individual, a recognition of genitalia which confirms a person as either male or female and the accompanying procreative functions which are implied (Annandale, 2009). When this medical gaze shifted to female reproductive features, a surge in medical facts sought to characterise the ovaries and womb as the epicentre of women's limitations. Biological determinism became fundamental to the authoritative definition of the feminine character.

The Victorian era gave way to organ based terms, such as hysteria, to reinforce beliefs that women were naturally intended for the non taxing private sphere. Activities that could sicken the innately weak and fragile female reproductive state, such as education, physical activity or political discourse, were justified by foreboding medical facts and warnings about infertility and psychiatric illnesses (Lee & Frayn, 2008). For the emerging large middle class, women's beauty and demure personality were external signifiers to society of a man's wealth (Hesse-Biber, 2007). Valued exclusively for their decorative charm and ability to improve the quality of breeding stock, bourgeois women were effectively enforced into lives of idleness and preening (Foucault, 1978). Early capitalists created and

perpetuated a growing need for beauty products, corsets and other bodily adornments and targeted this to women who wanted to keep up with fashionable symbols of femininity, house management prowess and mother/wife ideals. Perhaps ironically, enforced idleness, self occupation and self critique created hypochondriac and neurotic conditions for many women, further serving to reinforce the constructed fragility of the female mind and body (Berry, 2007; Foucault, 1978; Hesse-Biber, 2007). However, as noted by Newman (2008), coloured and working class women were seemingly exempt from this forced idleness, instead relegated to the appalling conditions of slums and sweathouses.

Following the Victorian era there have been periods of history that have either reinforced or discarded various sex based gender stereotypes. The Second World War saw assumptions of women's inability to perform 'heavy work' discarded as they were moved out of the private sphere and into the decimated male work force. They were however, promptly persuaded back into the home again when a patriotic call to replenish the nation with new citizens was instigated as the men returned from the trenches (Nolan, 2000). During the consumer driven period of the1950's, women were bombarded by written and visual media, including the burgeoning television market, portraying images of the idyllic and virtuous domestic housewife. Immaculately groomed women with perennial smiles and perkiness in their role as wives and mothers, continued to reinforce the rightful and natural place of women in the domestic sphere (Annandale, 2009; Hesse-Biber, 2007).

Apart from the brief period of time that an hourglass figure was admired in the 1950's (Alapack, 2009), thinness has been a valued fashion statement of the 20th Century. Once celebrated as a sign of beauty and financial success, a non-slender body was now deemed as unsightly and unhealthy. During an increasingly industrial and consumer driven era, the advent of mass manufacturing and standard sized clothing enforced slim body ideals (Hesse-Biber, 2007). Hesse-Biber further contends that during key periods of time when women were actively injecting themselves into the public sphere and claiming independence, slimmer feminine body ideals became more robust. The 1920's 'Flapper' provides one example of an extreme body ideal, which required binding to flatten the chest and narrow the hips, whilst the 1960's 'Twiggy look' marketed an emaciated, waif like

frame (2007). Intersecting medical censure of fat (as will be discussed further in the next section) and slim ideals of the fashion/beauty/advertising industries created, and continue to create the body as a cultural artefact (Bordo, 2003).

For feminists, biological determinism has been an area of some debate and relative to historical context. Earlier factions believed that the sexed body was central to women's experience of oppression, whilst others argued that it should be embraced as a point of difference (Beasley, 2005; Letherby, 2003). However, despite a contentious view of subjectivity, all feminisms agree that assumptions about women have been based on biological and physiological traits which have assigned women as 'other' (Bordo, 2003; Farganis, 1996a). Second-wave feminists, particularly those practicing within the post feminist paradigm, challenge this further by attempting to locate the various social meanings of the term femininity and why individuals accept or reject one particular meaning over another (Gard & Wright, 2005).

In contemporary Western society, and increasingly on a global scale, the slim body is prolifically advertised as the cultural ideal of an attractive and healthy body, for both men and women (Hesse-Biber, 2007). Social media – written, visual, cyber and verbal, offer us yardsticks to measure ourselves against, and increasingly the tools in which to achieve this ideal. Marketing of transformative images ('from flab to fab') to sell exercise equipment and weight loss supplements, reality shows depicting military style 'fat camps' based on weight loss competitions (for example, 'The Biggest Loser', 'Downsize me') and cosmetic surgery ('Extreme Makeover') are thrust into our lounges through the television medium. In addition to this there is a whole industry dedicated to selling the promise of 'true' femininity. Advertisements for makeup, shoes, clothes, hair products, perfume, food and even household cleaning products, show women what they 'need' to reach their full feminine potential. Articles and 'how to' guides in media - fashion magazines, television programmes and internet help forums, purport that slimness can be achieved by using images of thin, beautiful, and sexually desirable women as the goal for which to strive. However, media is not the only source of knowledge about this social ideal of slimness – it is located in discussions between friends, mothers and daughters, work colleagues, within school curriculums and the health care sector (Gard & Wright, 2005).

2.3   Medicalisation of overweight/obesity

As previously discussed every period of history has offered a definition of what constitutes an acceptable body weight. Evidence from the 16th, 17th and 18th centuries demonstrates early medical beliefs about a possible correlation between increased body fat and ill health, including reduced physical comfort, indigestion, angina, sleep apnoea, depression, diabetes, female infertility and menstrual disturbances (Banting, 1864; Gard & Wright, 2005; Haslam, 2007; Jutel, 2006; Vaughan, 1607; Venner, 1660). However, prior to the Enlightenment, excess weight was an arbitrary term, an undefined point of 'fatness' that was primarily a descriptive label, diagnosed without measurement and based on a cursory visual assessment (Jutel, 2001). Prior to the late 19th Century, weight was not even considered a core assessment criterion by the medical establishment. There was no such term as overweight, because there were no means to assessing or stipulating what constituted a normative weight measurement as a comparison (Jutel, 2006, 2011).

By the end of the 19th century marketing of affordable scales for physician use and the eventual mass recording and analysis of over 800,000 patient weights by the Metropolitan Life Insurance Company, signalled a defining point in the standardisation of acceptable body fat measurements in the population (Jutel, 2006). Whilst the ensuing Medico-Actuarial tables and height/weight ideals were firstly used to determine financial risk for health policies, they soon became a widely utilised tool for medical assessment (Campos, 2004; Jutel, 2001). The establishment of desired weight labels such as 'acceptable', 'ideal' and 'normal', all served to assign increased levels of body fat as a deviance from health. The corpulent body ceased to be a sign of wealth and/or beauty, instead becoming a sign of illness and disease (Gard & Wright, 2005).

When a human condition becomes a medical diagnosis it is accompanied by an implicit set of predicted outcomes, procedures and treatment protocols, firmly placing medicine as an agent of authoritarian knowledge (Jutel, 2009). If a particular diagnosis is also devalued as self-inflicted, then there is also potential for individuals to be socially judged, blamed and excluded based on presumptions of lacking self care. Reinforcing an undesirable social trait as a 'health' problem

becomes a coded word for a range of positive qualities a society wishes to see in its' citizens (Gilman, 2008). Classification as a deviation of normal creates a web of power, constantly reproducing itself to such a dominant position that all other points of view are rendered silent. Tools of power - such as the allocation of resources, establishment of specialisation within a professional field and defined focal points for research, ensures the strength of a diagnosis to endure scrutiny from opposing points of view (Jutel, 2011).

Contributing to the strength of obesity as a disease label, the first half of the 20th century saw a burgeoning influence of psychiatry and psychology to explain and diagnose deviations from 'normal' - for both mental and physical illnesses (Gard & Wright, 2005). Bruch (1948), an influential psychiatrist of this period, wrote prolifically on the topic of obesity and its manifestation in individuals who had a weakness of character. On the topic of childhood obesity she blamed neurotic, indulgent and weak-willed mothers who over fed their offspring in an attempt to quash their own feelings of disappointment, allowing their dreams of idleness to be realised in the lives of their children. Her psychoanalytic view of adults is summarised by the following excerpts: "Many obese adults, like fat children, are emotionally immature, passively dependent and helpless in meeting the exigencies of life. They seek comfort in over-eating in the face of failure and of frustrating experiences" (p.81): "Their fundamental attitude towards life is demanding and they do not tolerate denial of their wants" (p.81), and they have: "low capacity for independent decisions and achievement" (p.85). Portrayed as mal-developed, inherently anxious and damaged from the disappointment of being fat and desperately in need of 'fixing', these powerful and widely accepted beliefs of this era had a significant impact on societal beliefs and criticisms of obese persons. As will be discussed further in this section, the process of stigmatisation creates a powerful censorship of discredited physical and mental attributes.

The word obesity, derived from the Latin term *obesus* meaning to devour/eat and vulgar (Barnett, 2005), gives us an indication of early medical beliefs around the root cause of excess body weight. It also set the foundation for a medical discourse that places blame for obesity squarely on the individual – 'you are what you eat'.

2.3.1   Thermodynamics – the medical discourse of obesity

The privileged explanation and authority of disease within the western health paradigm is the biomedical model (Gard & Wright, 2005; Wainwright, 2008). One of the key assumptions of this model is that the body is a machine, a series of parts that work well, or fail, in a predictable manner. For over a century the dominant etiological discourse for overweight/obesity has been explained by the First Law of Thermodynamics and, like many laws emanating from the disciplines of *natural* science, is endorsed by medicine as explanatory fact for *human* science (Bray & Champagne, 2010; Mercer, 2009). The underlying principle of thermodynamics is conservation of energy, wherein energy can be transformed but never be created nor destroyed (Honey, 2008; Lustig, 2006). When this principle is applied to human functioning, equilibrium (or homeostasis) is simplified to an equation of - energy stored must equal energy intake minus energy expenditure. Applied to the medical discourse of obesity, the equation is exemplified as - if calories ingested are not sufficiently 'worked off' by physical activity, then fat will be stored, thus leading to overweight/obesity, however, if one restricts calories and/or increases physical activity, then fat storage will be reduced (loss of weight) (Gard & Wright, 2005; Lustig, 2006; Mercer, 2009; Wells, 2010).

Whilst healthy living mantras of wholesome food and physical activity to ward off corpulence had been in existence since the time of Hippocrates and Galen (Haslam, 2007), it was at the turn of the century that this energy in/energy out model became the mainstay of the medical management of obesity (Jutel, 2006, 2009). Emanating from the enlightenment ideology that the healthy body was a body controlled, dieting became a powerful means of encouraging management of oneself against temptation. Physicians and lay people began to lay claim to the overweight by educating them on ways to restrict food intake and encourage 'healthy' purging of toxic intake, and increasing the metabolism by increasing exercise to attain 'normal' body weight (Gilman, 2008).

The New Zealand health sector, like many other western societies (Gard & Wright, 2005; Jutel, 2001), relies on this thermodynamic principle (energy in/energy out) as evidence based practice for weight management guidelines in the primary health sector (Carryer & Penny, 2008). Recommendations include the use of BMI

as a screening tool for actual or potential for excess weight, routine screening for obesity-related illnesses (such as diabetes and cardiovascular disease) as well as implementation of a lifestyle approach to encourage weight loss to improve health outcomes. A three-pronged lifestyle approach calls for the first line of treatment of a reduced energy diet, combined with increased physical activity and behavioural strategies – such as self monitoring and effective problem solving (Ministry of Health, 2009).

These guidelines were developed using evidence from randomised controlled trials and systematic reviews (Ministry of Health, 2009), both of which rank highest in the hierarchy of robust scientific inquiries (Cogan & Ernsberger, 1999). In order to practice within this evidence based framework, and correctly adhere to algorithm determined clinical pathways, clinicians are required to ascertain an individuals' BMI. The globally accepted use of BMI as an indicator of obesity and potential associated risks with increased body fat is however, a highly contentious issue. Not least of which because the use of an objective measurement prioritises numerical fact over the perceived unreliability of the individuals' account of facts (Jutel, 2001, 2009). Thus the scales or BMI calculator are treated as undisputed fact, whilst the patients claims of sufficient exercise or controlled eating can be deemed as embellished representations of fact, since it directly disobeys the scientifically 'sound' law of thermodynamics. Foucault (1973) explained this reduction of the patient to a measurement, as the medical gaze viewing the presenting patient as a barrier to truth, with a need to position the patient in parentheses in order to prevent distractions to the establishment of pathological facts from within.

As will be discussed in the following section, there is an increasingly critical, although still marginalised, view of a medical reductionist approach to the complexities of obesity causation and treatment, because it assumes that all human bodies function identically.

2.4   Critique of the medical discourse of obesity; competing discourses

The current medical model of obesity management, along with its associated focus on the health benefits of weight loss, is a paradigm increasingly struggling to

maintain traction within the obesity research sector (Campos, 2004; Campos, Saguy, Ernsberger, Oliver, & Gaesser, 2006; Cogan & Ernsberger, 1999; Gard & Wright, 2005; Greener, Douglas, & van Teijlingen, 2010; Keith et al., 2006). Whilst thermodynamic theory is the dominant discourse from which GPs draw, there is even acknowledgement from *within* the clinical sector that current guidelines for weight management are unhelpful and provide no assurance of long term efficacy (Carryer & Penny, 2008, 2011; Epstein & Ogden, 2005; Hansson, Rasmussen, & Ahlstrom, 2011; Mercer & Tessier, 2001). Equally so, the burgeoning multidisciplinary arena of obesity research has an abundant collection of studies showing the energy balance theory as weak and misleading. Gard and Wright (2005) note: "researchers repeatedly concede an alarming lack of knowledge about even the most fundamental questions while, often within the same article, making bold and unsupported generalisations about the causes and cures for obesity" (p.36). Whilst the objective of scientific inquiry is to test an advanced hypothesis for cause and effect, much of the medical obesity studies touted as 'truth' are, at best, demonstrative of some degree of correlation only (Eagle, Bulmer, & Hawkins, 2003). Outside of the laboratory environment, that is – in real life, researchers have yet to find a way to control for the multitude of confounding variables that shape the individual experience of body size (Gard & Wright, 2005). Simplistic variables such as why a 'normal' sized person can eat a high fat diet, do little exercise but remain within a 'healthy' weight range, whilst an obese person can eat healthfully and exercise daily but cannot attain weight 'normality', has yet to be cohesively and comprehensively answered.

Despite the fact that there is little understanding or proof of the relationship between weight and health (Campos, 2004; Campos et al., 2006; Cogan & Ernsberger, 1999; Gard & Wright, 2005; Monaghan, 2005), public health authorities have continued to embrace and formulate guidelines reporting the health benefits of weight loss, claiming this to be based on strong evidence. However, there have also been several studies that have directly challenged this assumption. In a large scale epidemiological study, known as the HUNT study, 1.8million Norwegians have been followed for the past twenty four years, and at the ten year mark – mortality rates were measured based on height and weight data (Waaler, 1984). It was found that overweight individuals (BMI 26-28) had the

highest life expectancy whilst the very thin (BMI <18) had the lowest life expectancy. Those classified as having a healthy weight (BMI of 18-20) had a lower rate of life expectancy compared to those deemed obese (BMI 34-36). Other successive studies have also demonstrated the same pattern of mortality rates indicating that excess weight does not increase mortality risk (Durazo-Arivizu, McGee, Cooper, Liao, & Luke, 1998; Troiano, Frongillo, Sobal, & Levitsky, 1996).

There is also evidence that dieting and weight loss can be contrary to optimum health. The fluctuation of weight associated with frequent dieting attempts ('yo yo' dieting) has been shown to effect mortality rates. A study that followed up participants from a large scale epidemiological study undertaken thirty years ago showed that weight fluctuation was associated with a higher risk of all-cause mortality (ACM) and cardiovascular mortality (CM) in comparison to stable weight *non*-obese. Stable weight obese did not have increased ACM but did have increased CM. These associations were evident even after controlling for those with pre-existing disease, initial BMI and the exclusion of those with poor health or incapacitated (Diaz, Mainous, & Everett, 2005).

Dieting for weight loss, can take on many forms, including fasting, low calorie, whole food group avoidance (high protein/low fat/low carbohydrate/fruit diet/soup diet), liquid meal replacements, medications (such as orlistat and phenteramine) and purging (vomiting and/or laxatives). Yet in whatever form, and regardless of the reported scientific backing, frequent dieting can only provide short term weight loss (<5yrs) for the majority and can lead to bingeing, increased likelihood of eating disorders, a pre occupation with food, lowered bone density, negative mood/depression, rebound weight gain, and for sustained very low calorie diets – cardiac arrhythmias from electrolyte disturbances, lowered immunity, anaemia, muscle wasting, irritability and decreased concentration ability (Arroll, 2002; Berg, 1999; Cogan & Ernsberger, 1999; Gard & Wright, 2005; Miller, 1999). The practice of starvation, rigid food beliefs, purging and self admonishment for eating, characterised as problematic in those with eating disorders, is tolerated, if not encouraged, as acceptable practices for those who are 'fat'.

Medical conditions often associated with obesity, such as diabetes and cardiovascular disease, are often cited within clinical guidelines as a rationale for

the health protective act of weight loss. Yet the evidence is that any apparent improvements in clinical indicators (HbA1c, cholesterol level and blood pressure) during weight loss is temporary, and will often resurface in the long term even if the weight loss is maintained. If (when) weight is regained, then the poor health effects of weight fluctuation nullify any previous positive health advances (Burgard, 2009; Campos et al., 2006; Cogan & Ernsberger, 1999; Ernsberger & Koletsky, 1999; Gard & Wright, 2005; T. Mann et al., 2007). The conundrum for scientists to explain is the fact that the same diseases and biological processes attributed to overweight/obesity can also be seen in those categorised as a 'healthy' weight!

An explanation often offered by science as a reason for failure to prove the benefits of dieting is genetics, but even this area is yet to substantiate any cause and effect relationship – just a hereditary propensity subject to a multitude of other individual factors (Cogan & Ernsberger, 1999). In this respect, Gard and Wright (2005) describe genetics as a 'black box' - a convenient explanation of connectivity between two variables, such as thermodynamics and body weight, whilst ignoring the multiplicity of other factors that surround the issue at hand, such as history of frequent dieting, fitness level and socio economic status. In this regard the assumption of genetic causality is used as a proxy for gaps in knowledge in an attempt to salvage the legitimacy of the 'body as machine' model. In the meantime there is a fervent attempt by obesity researchers to find new biological causes of obesity to investigate, one of which is the specialty of 'infectobesity'. An article in the New Zealand Herald newspaper reported on a recent study (Gabbert, Donohue, Arnold, & Schwimmer, 2010) which posits the human-to-human transmitted Adenovirus (36) as another possible cause of obesity, the headline reading 'Western obesity may have been caused by 'fat bug' (Laurance, 2010). This sensationalist approach to relaying these results to the public domain not only creates anxiety about the idea that one can 'catch' fat, but further generates public panic and demand for protection with an anti-fat vaccination (D. Mann, 2010). When findings like this are embraced by the media as fact, whether potential or actual, there is a medically implied and socially reinforced abhorrence of excess adiposity.

Keith et al, (2006) researched alternative plausible contributors to the causation of obesity which, while attempting to divert attention from the questionable evidence

of thermodynamic theory, maintains a biological focus. The authors offer ten additional explanations - sleep debt, endocrine disruptors (industrially produced), increased ambient temperatures in homes, decreased smoking rates, pharmaceutical iatrogenesis (side effects), changes in distribution of age and ethnicity, increasing gravida age, intrauterine and intergenerational effects, increased reproduction rates of obese (genetic predisposition) and increased likelihood of obese to reproduce with obese. The authors conceded that the effects of each proposed explanation was likely small, but that the combined effects may be consequential.

In contrast to the purely biological and arguably moralistic tainting of the previously described attempts to solve the 'problem of obesity', the following discourse is well established and increasingly supported within the sectors of health, public and obesity research communities (Campos, 2004). The 'Health at Every Size' (HAES) movement was fundamentally established as an affront to ongoing oppression and stigmatisation towards the overweight/obese due to the pathologizing of body fat. The core principle of this discourse is that self acceptance and healthful living can be beneficial and achievable, regardless of an individuals weight. By eliminating weight loss as a factor for food choice and participation in physical activity, the focus turns to long term well being rather than adherence to a weight goal (Burgard, 2009). Those working from within the HAES paradigm support their stance by citing the poor evidence (as discussed earlier in this section) of weight loss as an achievable fix, and the overwhelming evidence that the denigration of fat is self defeating, harms the individual and perpetuates stigmatisation (Campos, 2004; Campos et al., 2006; Cogan & Ernsberger, 1999; Ernsberger & Koletsky, 1999).

This discourse however, is subjected to discrediting by those who stand to lose the most from the revocation and loss of power of the thermodynamic model, the weight loss industry. Burgard (2009) suggests it is rare to find pro-diet researchers who are not paid consultants for the weight loss industry – including pharmaceutical companies and programme providers such as Jenny Craig or Weight Watchers. Equally so, the current dominant discourse draws power from the fact that the health workforce are trained within a thermodynamic curriculum, and continue to work within best practice guidelines that enforce and validate the

theory of fat as inherently unhealthy and weight loss as health promoting. Not least of which, within this web of power is the intersection of science and society, which creates a potential to widely stigmatise and discriminate bodily characteristics on as little evidence as an assumption of being self created.

2.5 The social stigma of obesity

Goffman (1963) describes stigma as the discrediting of an attribute, which spoils the identity of an individual and differentiates them from other members within a social group. Goffman further defines three different types of stigma - physical deformities, blemishes of individual character (such as mental illness, homosexuality and dishonesty) and tribal stigma (race, nation and religion). Stigmatisation can either be discrediting or discreditable. This is dependent on two factors, the visibility and recognition of the stigmatising attribute by another person, and the ability of a stigmatised individual to recognise and minimise/disguise or eradicate that which has been deemed an undesirable attribute (Goffman). Highly visible and less easily disguised attributes such as race, facial deformities and obesity are all defined by their ability to immediately discredit an individual. This spoiled identity, Goffman suggests, leads to a stigmatised individual being defined and judged primarily by their point of difference, along with all the negative connotations that may accompany that discredited attribute.

There has been an increase of research activity in recent years in an attempt to determine the dimensions of stigma construction. Link and Phelan (2006) suggest that there are five components that lead to the generation of stigma, a model which is supported in Bresnahan and Zhuang's (2010) research into the validity of a multidimensional measurement of stigma. The first component is a social selection process which identifies and labels a difference as socially significant. Slenderness as a signifier of both health and beauty is a pervasive aesthetic norm within society, and one which holds particular significance for women (Bordo, 2003; Hesse-Biber, 2007). Obesity is an easily identified and highly censured social condition due to its high visibility, difficulty to disguise and labelling as a reversible trait.

The second component of stigmatisation is when a difference gets linked with undesirable characteristics, manifesting as stereotypes (Link & Phelan, 2006). Typical stereotypes of individuals who are overweight/obese demonstrate a mix of both characteristic and moralistic labels such as ugly, stupid, lacking in self control and lazy (Campos, 2004; Foster et al., 2003; Huizinger et al., 2009; Jeffrey & Kitto, 2006; Puhl & Brownell, 2001; Puhl & Heuer, 2009; Puhl, Schwartz, & Brownell, 2005). Stereotypes of this nature are closely tied to the social and medical construction of overweight/obesity as a disease which can be prevented or reversed by the individual 'just making an effort' (Bordo, 2003; Rice, 2006; Rogge et al., 2004).

The third stigmatisation component is when one group selectively labels and separates a stigmatised group by concentrating on exaggerated terms of difference between 'them' and 'us'. This is demonstrated in movie and television portrayals of the overweight/obese women as socially inept, clumsy, constantly eating, physically unfit individuals who are often singled out as targets for weight based 'jokes' by slimmer characters (Greenberg, Eastin, Hofschire, Lachlan, & Brownell, 2003). Social identity theory states that the separation and allocation of a stigmatised group to an outsider status generally leads to those members having a stronger affiliation and positive regard towards other members of their marginalised group (R. Brown, 2000; Latner, O'Brien, Durso, Brinkman, & MacDonald, 2008; Turner, Brown, & Tajfel, 1979). However there is strong evidence that overweight/obese individuals internalise the social stigma of overweight stereotypes and demonstrate levels of weight bias similar to those held by non overweight/obese (Carryer, 2001; Latner et al., 2008; Latner, Stunkard, & Wilson, 2005; Schwartz, Vartanian, Nosek, & Brownell, 2006; Vartanian, Herman, & Polivy, 2005; Wang, Brownell, & Wadden, 2004). Latner et al. (2008) further suggest that the potential for escape from the stigmatised group, through 'just losing the weight', may be a rationale for distancing themselves from other group members. The concept of providing options to escape from the undesirable stigma of overweight/obesity is certainly embraced as a marketing tool by the weight loss industry, despite the dubious long term efficacy of their products (Hesse-Biber, 2007; Latner et al.).

The fourth contributing component of stigma is the discrimination and loss of social status experienced by the stigmatised group. For women, a loss of social status and mobility is correlated with overweight/obesity in the contexts of wage inequity (Conley & Glauber, 2005; Han, Norton, & Stearns, 2009; Ministry of Health, 2006), low deprivation level (Athukorala, Rumbold, Willson, & Crowther, 2010; Ministry of Health, 2006, 2008; Zhang & Wang, 2004) reduced career potential (De Boni, 2000; Roehling et al., 2007; Solovay, 2000b), level of education (Athukorala et al., 2010; Ministry of Health, 2006) and attractiveness to prospective marriage partners (Averett, Sikora, & Argys, 2008; Conley & Glauber, 2005). In terms of discrimination, overweight/obese women are exposed to what Link and Phelan (2006) define as three distinct discriminatory practices. The first is overt and direct, such as overlooking the employment of an otherwise appropriately skilled and experienced overweight/obese woman purely for aesthetic reasons (see De Boni, 2000; Harcourt & Harcourt, 2002; Puhl & Brownell, 2001; Roehling, Roehling, & Pichler, 2007; Solovay, 2000b). The second type, structural discrimination, is more subtle. An example of this is the ongoing use of practical barriers that inadvertently compromise the dignity or exclude participation of overweight/obese people, such as narrow seating in theatres, restaurants and aeroplanes, as well as inadequate sized medical equipment such as chairs, examination beds and gowns. The third form of discrimination is insidious and is the result of embedded cultural stereotypes exposing overweight/obese individuals to frequent experiences of prejudice in a multiplicity of contexts. This leads the individual to engage defensive strategies in anticipation of continued exposure to negative and devaluing attitudes about their body size (Corrigan, Larson, & Rusch, 2009; Link & Phelan, 2006; Rice, 2006; Rogge et al., 2004). The effects of stigmatisation on women who are overweight/obese will be discussed further in this section, at this juncture however, it is suffice to say that pervasive exposure to devaluation of one's character can lead to feelings of shame, embarrassment, anxiety, loss of self esteem and social isolation (Ogden & Clementi, 2010; Puhl, Moss-Racusin, Schwartz, & Brownell, 2008; Rogge et al., 2004).

The final factor in the generation of stigma is the unequal distribution of power to the dominant group, rendering the stigmatised group powerless to reverse the situation (Link & Phelan, 2006). Social power is defined as the extent to which one

individual has the potential to exert influence over another (French, 1956). In his formulation of a theory to explain social power, French further added that considerable power is given to leadership positions that are structured as a legitimate authority – such as medicine and the media. Mass media is a significant portal for lay people obtaining health information and as such, has a strong influence on shaping and/or maintaining societal beliefs, attitudes and stereotypes about some medical conditions (Fishman, 2006; Hong, 2011; Latner, Rosewall, & Simmonds, 2007; Shugart, 2011). Public displays of implied or overt medical endorsement for various weight loss tools such as diet books[1] and diet supplements[2] all serve to confirm obesity as a serious but treatable deviation from health and beauty standards.

An insight into how New Zealand public health campaigns and media portrayals of negative stereotypes have shaped public opinion on obesity, is demonstrated within results from a telephone survey undertaken by the Counties-Manakau District Health Board (2007). This survey's objective was to measure the extent to which the public (n=401) viewed the problem of obesity for both the individual and the health care system. Whilst statistical results showed that severe obesity was considered to be an individual (85%) and healthcare system problem (95%), the ad lib comments from participants, although not measured, provide rich attitudinal data. The following excerpts are additional comments offered by participants in response to the question of whether bariatric surgery should be publically funded in New Zealand: " Why would we pay for stomach stapling surgery when parents should have taught them to eat properly and not eat 400 pies"(p.59): "...people that

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[1] 'Dr Phil', a syndicated U.S show currently screening on New Zealand television, is a self help style show lead by Dr Phil McGraw. He has written several books in a series called 'The Ultimate Weight Loss Solution'. Proclaimed as ground breaking and 'bottom line truth', the books focus on weight loss through dieting and exercise, including a cookbook, a food guide and a book specifically aimed at teenagers.

[2] The 'Tony Ferguson Weight Management System' currently advertised on New Zealand television, is a calorie controlled diet programme with supplementary shakes, vitamins, meal replacements and snack foods designed and sold by a Pharmacist. Reported to be based on 'scientific fact', the programme is hailed as an all encompassing weight loss programme which succeeds where other diet programs have failed.

want to go to McDonalds every day and eat 10 burgers for breakfast then tough tit, tough luck" (p.58): "Diet and exercise would solve the problem...if not prepared to do that then they don't deserve help...it's their own fault" (p.59): "They need self control" (p.55) and: "Most of the people who are grossly overweight are 90% beneficiaries, Māori /Pacific Islanders, this group needs to be targeted with education on nutrition" (p.59).

The strength and pervasive nature of obesity stigmatisation has intensified throughout the past forty years (Latner et al., 2007) despite an increasing body of contradictory evidence regarding the individual responsibility and benefits of long term weight loss. Whilst there is a significant volume of literature substantiating the presence, effects and locations of the social stigma of obesity (Puhl & Brownell, 2001, 2006; Puhl & Heuer, 2009; Rogge et al., 2004) there is a paucity of research offering comprehensive ways to combat it. Puhl and Brownell's review of existing psychosocial origins of obesity stigma (2003) offered two possible theoretical perspectives to attempt combating obesity stigmatisation, but concluded that the complex and deeply embedded associations between obesity discourse and social processes warranted a multifaceted and multidisciplinary approach. The sheer enormity of the problem of stigmatisation for overweight/obese individuals is perhaps best evidenced by the uptake of negative attitudes by those purported to be the caring profession of health.

2.6   Stigmatisation in healthcare

There are no New Zealand studies that have specifically assessed attitudes of health professionals towards overweight/obese individuals, however there is international evidence that health professional attitudes reflect those held by society at large (Foster et al., 2003) and that this negative bias is a spreading global phenomenon (Brewis, Wutich, Falletta-Cowden, & Rodriguez-Soto, 2011). On this basis, studies from overseas may provide insight into attitudinal influences on New Zealand health professionals' approaches to large-bodied women.

Despite a large volume of obesity literature, there are relatively few focussing on subjective experiences of large-bodied patients accessing health care services. Of the studies located and subsequently presented throughout this section, the majority used a quantitative approach of either survey or questionnaire research

designs to obtain their data. This approach to explain the complexities of human experience can, however, constrain participants' views to comply with positivist demands of value free, objective and measureable data (Denzin & Lincoln, 2000). Therefore, the results can provide a limited explanation of the social meaning of participant's experiences when contextual information such as language and socio-cultural influences are stripped from the data gathered (Jeffrey & Kitto, 2006). However, these studies are useful to show the existence and location of stigmatisation within the health care sector and, as many of the authors have conceded, provide justification for further qualitative inquiry.

2.6.1   Patients' perception of stigma and weight bias

A large scale survey of two samples of adults (n1= 2449 women, n2= 222 men/women) in the United Sates, utilised an online battery of self-reported questionnaires to assess the experiences and sources of weight stigma, as well as coping strategies used when faced with stigmatising practices (Puhl & Brownell, 2006). Sex and BMI were used as primary variables in the analysis of data. Results showed that the experience of stigma positively correlated with weight ($p<0.05$), with both women (67%) and men (64%) reporting doctors as being a frequent source of perceived stigmatisation. For women however, doctors were ranked as *the* leading source of interpersonal stigmatisation, ahead of family members (63%), sales clerks (50%), general community members (45%) and nurses (39%). Sixty two percent of women reported that doctors made frequent inappropriate comments about their weight. There was no difference in the variety of coping strategies used by men or women dealing with weight stigmatisation, with the most frequently used reported as positive self-talk, humour, faith, eating more, deflecting negative remarks and seeking social support.

Wadden et al. (2000) provided a questionnaire to 259 female patients who were enrolled in one of three randomised clinical trials for weight loss services in tertiary units within the United States. Consistent variables for each of the purposively selected participants in this study were that they had a BMI >30kg/m^2 and had previously failed at weight loss efforts. It was thus predicted that the sample would have a greater likelihood of experiencing negative weight-related interactions with their physician. Participants were asked to rate the satisfaction

with their health professional for both weight loss support and general health care services. Results of this survey showed that participants were satisfied with their care for general health issues but were significantly (*P*<.001) less satisfied with weight-related interactions and subsequently had less confidence in the expertise of the physician. A very small percentage of the participants (0.4% to 8.0%) identified regular negative and discriminatory experiences with health care professionals. Although the authors were reassured by this low rate, they did acknowledge that the participants were actively engaged in seeking weight loss treatment from the clinic where the study was undertaken and that social desirability bias may have impacted on the minimal disclosure of negative ratings.

A large scale survey study from Sweden used a nationally representative sample of 2588 participants (53.9% women and 46.1% men) to measure perceptions of generalised discrimination relative to body size. Classified into sample groups of normal weight (n=1112), moderate obesity (n=1362) and severe obesity (n=314), results only showed a strong association of increased perceptions of health care discrimination by the severely obese, but this was particularly more marked for women. A higher level of education was noted to modify the likelihood of discrimination in health care, which the authors believed may be due to health professionals being less tolerant to those who 'should know better' (Hansson, Naslund, & Rasmussen, 2010).

Wee et al. (2002) investigated the influence of body weight on patient satisfaction levels in a large scale survey of 2340 randomly selected participants (33% male and 66% female) from eleven primary care practices in the United States. Self-reported BMI's lead to a sample consisting of underweight (n=106), normal weight (n=1180), over weight (n= 675) and obese/morbidly obese (n=379) adults. Multivariate analysis showed that obese/overweight patients indicated lower levels of satisfaction with their most recent physician consult, but that this was no longer statistically significant when adjusted for co-morbidities, socio-demographic and insurance status. This finding was not further explained due to the survey tool prohibiting patient generated explanations to clarify variances or conditions of (dis)satisfaction. In addition to this, sex was treated as a confounding variable in this study, so there was no explicit breakdown of satisfaction levels for comparison between male and female participants. Whilst the study did provide evidence of

increased dissatisfaction, the authors concluded that qualitative inquiry was required to provide a greater understanding of this issue.

Brown, Thompson, Tod and Jones (2006) conducted a qualitative study using face-to-face interviews with twenty eight patients purposively sampled from the databases of five general practices within the United Kingdom. The sample consisted of men (n=10) and women (n=18) who were identified as having a BMI >30kg/m^2 and being fully aware of having a medical diagnosis of obesity. The questions asked were predominantly focussed on the perception of support given by health professionals (GP or practice nurse) if, or when, weight loss advice and/or treatment had been sought. The authors identified that the majority of participants cited frustration at being told they had a medically defined problem yet being offered no practical assistance beyond written and/verbal advice on diet and exercise. Mutual ambivalence and embarrassment to broach the subject of weight was admitted by many participants and approximately two thirds said that, if it was mentioned, there was little explanation regarding possible causes for the weight gain. Participants filled in gaps of knowledge with internalised constructions of obesity, such as self blame, personal shame, embarrassment and disgust at their appearance. Despite this, most patients did perceive positive interactions with health professionals for general medical care but tended to fault the busy nature of general practice services as a direct cause of their disappointment with weight loss advice and support.

2.6.2   Medical and nursing attitudes and practices

In addition to studies of patients' perceptions of weight bias from health professionals, there are several studies that have provided some insight into the attitudes and practices of both medical and nursing health professionals. An attitudinal survey of 620 primary care physicians in the United States showed that over 50% viewed overweight/obese patients as 'awkward', 'unattractive', 'ugly' and 'non-compliant', whilst one third of the sample viewed them as 'weak-willed', 'sloppy' or 'lazy' (Foster et al., 2003). Some physicians (37%) also admitted to having negative reactions to the appearance of their large-bodied patients. Physicians were asked to rate their beliefs of the causation of obesity. The top three rated were listed as physical inactivity, overeating and a high fat diet.

Authors suggested that physicians' belief of personal responsibility/blame for obesity is a likely influence on the negative assumptions about characteristics of large-bodied patients. Supporting this suggestion, a similar study demonstrated that physician respect for obese patients decreased with every ten unit increase of BMI (95% CI: p=0.006) (Huizinger et al., 2009).

Hebl and Xu (2001) tested the attitudinal response of 122 physicians in a six-cell randomised study that required the physicians to evaluate a medical chart of a male or female patient who was either average weight, overweight or obese. The charts portrayed the patient as healthy but presenting with a migraine. Two thirds of the allocated charts had an additional exception of the patient being either overweight or obese. The physicians were asked to outline their attitudes and treatment plans regarding the presenting complaint. The results revealed that whilst physicians would prescribe more tests for heavier patients (p=<0.03) they would allocate less consultation time to them (p=<.0001). Physicians were also more likely to prescribe antidepressants (p=0.17) and/or refer the heavier patient to a psychologist (p= 0.04), which authors suggested may reflect a stereotypical belief that overweight or obese patients are inherently depressed or unhappy about their physical size. Attitudinal data showed that heavier patients were likely to be judged as more unhealthy (p=0.00), less self-disciplined (p=0.00) and needing stricter advice (p=0.64) than slimmer patients. Coinciding with this, physicians were also more likely to deem the consultation as a waste of time (p=0.01) since there was a lesser likelihood (p=0.00) of the overweight/obese patient following their advice in comparison to less heavy patients.

In Poon and Tarrants' (2009) study of the attitudes of nursing students (n=352) and registered nurses (n=198), both groups equally endorsed negative stereotypes of obese people as lazy, unattractive and liking food too much. However, registered nurses were found to have higher levels of fat phobia in comparison to student nurses on almost all other aspects, including perceptions of obese persons as weak (p= 0.03), shapeless (p=<0.001), insecure (p=<0.001), slow (p=0.01) and self indulgent (p=0.02). Thirty percent of the total respondents admitted feeling disgusted when caring for obese patients, and a further fifty percent believed that obese adults should be put on diets when hospitalised.

There are very few studies that have focussed on attitudes of practice nurses, however Hoppe and Ogden (1997) did survey practice nurses (n=586) to examine their beliefs and attitudes about the cause's and prevention of obesity. Although undertaken more than a decade ago, it does demonstrate the uptake of medical discourse within the domain of nursing. Asked to rate level of agreement with twenty four statements, practice nurses ranked lifestyle choices of sedentary lifestyle, overeating and high saturated fat intake as the most important causative factors for obesity. Subsequently, they also rated laziness and non-compliance with advice to be the most likely reason for patients' failed weight loss attempts, ranking inadequacy of treatment modalities as the least important factor. In a related study, Ogden and Hoppe (1998) tested the sustainability of these beliefs by assessing the intervention effect of an alternative brief weight loss educational tool that had a patient-centred approach. They concluded that, despite some brief periods of changed practices and attitudes, the practice nurses beliefs remained unchanged over time. This was suggested as evidence of the medical discourse of obesity being assimilated and entrenched into nursing practice.

In a UK study of general practitioners (GP) and practice nurses (PN) attitudes towards obesity management in Primary Care Trusts, interview data showed that both GPs and PNs lacked any enthusiasm to take responsibility for overweight/obesity issues (Mercer & Tessier, 2001). GPs often passed off obese patients to practice nurses for lifestyle management education, citing this practice as a more effective use of their time. Practice nurses stated they felt 'put upon' to provide information about an intervention that frequently lacked success.

In a similar Swedish study, semi structured interview were used to determine GPs (n=10) and district nurses (n=10) conceptions of encounters with overweight/obese patients in primary health care centres (Hansson et al., 2011). The general view of both groups was that obesity was not a disease that warranted their responsibility, demonstrated by the following excerpt from one GP: "I don't think you should take it for granted that we're the ones to intervene. We're trained in medical care. Overweight and obesity are more of a societal problem" (p. 4). Other key themes included consensus that the current clinical guidelines and evidence of treatment modalities were not sufficient and that patients inherently showed no real motivation to make lifestyle changes anyway. One

district nurse stated: "It's not so easy to change old routines. I think most people know how to eat, but its' one thing to know how and another thing to actually do it." (p.6) and another: "They often say 'I don't understand it, I don't eat anything', but actually we know they do" (p.7). Some of the participants also admitted to using scare tactics and threats of fatal outcomes in order to motivate patients to lose weight, despite their recognition that the evidence on weight loss is inconclusive.

This finding of GP ambivalence towards obesity management is consistent with a study undertaken by Epstein and Ogden (2005). They conducted face-to-face interviews with GPs (n=21) to ascertain their views of treating overweight/obese patients. The results showed that GPs primarily believed that, in keeping with thermodynamic theory, management of obesity was the responsibility of the individual: "She is a woman who has had a sort of fairly appalling diet, clueless really about …what a calorie is …" (p.752). Several examples of beliefs that obese patients inherently lie about their calorie intake and/or exercise level were also highlighted: "What I feel is almost a classic response from women who want to lose weight, but are big, is the sort of 'but I only eat a lettuce leaf approach" and: "Usually patients say, 'It's in my genes, so we're all overweight — we all eat nothing and we're all overweight" (p.752). The GPs belief of personal responsibility was contradicted by what they believed their patients expected: "He was looking to what I was going to do about his weight rather than what he was going to have to do about it" and "He wanted me to magic him lighter" (p.752). The study highlighted GPs frustration and lack of faith in existing treatment options to offer their patients. Many admitted that they offered treatments, knowing that they have dubious efficacy, in an effort to maintain a good patient-doctor relationship.

Ogden et al. (2001) and Ogden and Flanagan's (2008) studies also support this contradiction between medical and patient expectations for obesity management. Each of the studies highlighted that, whilst laypeople endorsed a holistic notion of obesity causes, GPs coherently believed that behavioural causes (high food intake and low exercise level) were the primary reason for increased body size. Authors of both studies suggested that the shifting of responsibility for obesity management to a personal level may impact on perceptions of interaction quality for both medical professionals and patients. Consistent with previous studies, both

of these surveys also showed that GPs had an ambivalent attitude towards current modalities of obesity treatment available on a primary care level.

Research also indicates that negative attitudes are also held by health professionals who specialise in overweight/obesity management. Attitudinal studies on health care professionals have mostly relied on questionnaires that require assignment of attributes to overweight/obese individuals. However, both Teachman and Brownell (2001) and Schwartz et al. (2003) minimised the response bias of social desirability by using an Implicit Association Test (IAT). Aimed to measure automatic biases beyond conscious choice, Teachman and Brownell studied eighty four clinicians specialising in obesity care and found significant anti-fat biases of obese individuals as lazy (p=<0.0001) and bad (p=<0.0001). In a replica study by Schwartz et al., researchers and clinicians (n=389) attending an international obesity conference were tested. Results also showed implicit negative stereotypes of obese individuals as lazy (p=<0.0001), bad (p=<0.0001) stupid (p=<0.0001) and worthless (p=<0.0001). Authors in both studies concluded that, whilst there was some buffering of health care professionals' responses from experiential knowledge of working with overweight/obese patients, the findings of implicit weight bias highlighted the pervasiveness of weight stigma in society.

2.6.3   Implications of stigma on women's health

The impact of stigma on overweight/obese women's engagement with primary health care services has predominantly focussed on areas of reproductive health. Several studies have measured compliance rates with cervical screening, mammograms, pelvic and breast exams. Fontaine et al (1998) utilised data from the United States Cancer Control Supplement and used a method of multistage cluster area probability sampling to survey 6981 women. This study included covariates of age, race, socio-economic status, level of education, insurance and smoking status to ascertain possible influences on use of preventative health care services. BMI status was calculated on self reported height and weight. After adjustment of covariates, BMIs of 30 or higher correlated with significantly delayed pap smears (p=0.02), breast exams (p=0.04) and gynaecological exams (p=0.001), despite an associated finding that increases of BMI correlated with

increased frequency of visits to primary health care physicians (p=.002). Authors concluded that, either physicians were reluctant to encourage these screening procedures, or that obese women were embarrassed or intimidated by the necessity for body exposure and/or the perceived (or actual) attitudes of the physicians undertaking them. A lack of qualitative data in this study prohibited any clarification of the specific reasons for women delaying these screening procedures.

In a similar U.S study, a population based survey of women eligible for cervical screening (n= 8394) and mammograms (n=3502) found that overweight and obese women were less likely to be screened for breast of cervical cancer (Wee et al., 2000). This was despite adjustment for other known barriers to care such as socioeconomic level, insurance status and illness burden. The author suggested that one of the reasons for this may be reluctance by health professionals and/or heavier patients to undertake routine screening due to perceived technical difficulties and discomfort/embarrassment issues. Ludman et al. (2010) also found that obesity was significantly linked to reduced cervical and mammography screening rates in their telephone survey of 4569 women in the U.S. They found that increasing age, level of body dissatisfaction and obesity, were all associated with lower cervical smear rates, whilst a co-morbidity of depression significantly lowered the rate of obese women accessing mammograms. Authors from both of these surveys indicated that the reduced screening rates of large-bodied women may impact on higher cervical and breast cancer rates if the issue is not addressed at a clinical practice level.

Aramburu – Alegria Drury and Louis (2002) broadened their study to explore the stigma of obesity and its effect on delaying and/or avoiding primary health care services in the main. A sample of 216 women conveniently sampled from church sites in the U.S completed self administered questionnaires. The proportion of obese women in the sample (34.7%) represented the percentage of obese women in the population. Results showed that there was a direct correlation between obesity and avoidance of health care in the past twelve months (p=0.002), whilst 34% of the obese participants indicated they had avoided/delayed health care 'ever'. The most common reasons cited for avoidance included 'gaining of weight' and 'not wanting to be weighed', whilst for the morbidly obese (BMI >40)

'undressing in the providers office' and anticipating 'being told to lose weight' were rated highest. Levels of self esteem and self blame were shown to have little effect on rates of avoidance/delay. Interestingly, although perhaps not surprisingly given the stigma associated with obesity, the 'normal' sized participants also indicated that they have avoided/delayed health care if they perceived themselves as having a weight 'problem' (p=0.003).

Although a twenty year old study, Packer's (1990) mixed method study of 118 women has been included in this review because of its' early contribution to the development of knowledge about the effects of obesity on women's access to healthcare. Using survey and interviews, Packer compared the health care experiences of two groups of women – active dieters (n=58) and members of a 'pro-fat' organisation (n=60). Whilst there are fundamental differences and agendas between these two groups, the survey results showed that within both groups, the heaviest members had high rates of health service avoidance and little confidence in their physicians. Interview data further defined these issues. Participants cited previous experiences of disrespectful communication from their health care providers and inappropriate blaming of all ailments on weight as significant factors. Packer's study also showed that physicians cited increased weight as a precluding factor for initiating diagnostic tests, medication and birth control – with some women reporting that their gynaecologist refused to believe that they could, or should be sexually active at their size.

Whilst much of the research assessing quality of care for obese patients focuses on outcome data from weight loss interventions, one study from the United States did evaluate non-weight loss related care outcomes from primary care services (Chang, Asch, & Werner, 2010). Data from two national population surveys, with one from the Medicare Beneficiary survey (n=36 122), and a second from the Veterans Health Administration performance evaluation program (n= 33 550). Eight performance measures were selected for review – diabetes screening, eye examination and HbA1c, pneumococcal vaccination, influenza vaccination, mammography, colorectal cancer screening and cervical smears. The authors used claims data and/or chart abstraction in order to avoid potential bias from patient self reporting stating that: "obese patients who feel that physicians are negatively biased may also have a greater tendency to under report care"

(p.1280). Their conclusions were that both male and female overweight/obese patients have an equal, and in some cases superior, likelihood of being offered these eight services (if eligible). There was, however, no measurement of the quality of interaction between physician and patient when these tests, services and procedures were offered. One also suggests that many of the clinical indicators used in this study are those reported to be closely associated with diseases of obesity, and thus physicians may have had a diagnostic bias.

Surveying the literature, there is also an emerging collection of studies focussing on the effects and acceptance of public health care messages about obesity. A qualitative study undertaken in Australia, used in depth interviews with 142 obese (mean BMI = 39.3) male (n=36) and female (n=106) adults to determine their perception of public health messages about obesity (Lewis, Thomas, Hyde, Castle, & Blood, 2010).Whilst the majority of participants (82%) had bought into the notion of obesity as a risk factor for poor health outcomes, women were more likely to ascribe risk to poor mental, rather than physical health outcomes: "It's mainly because of the way other people perceive fat people and the way other people treat fat people" (p. 4). Many of the participants believed that there was too much emphasis on physical risks of obesity, which neglected the emotional and psychological toll that obesity stigmatisation can inflict. Participants spoke of this toll in terms of being the subject of campaigns which reinforce societal beliefs of them *choosing* a large body size: "...my choice in being obese is no more than somebody's choice of being homosexual" (p.5). The simplification of health messages to a reductionist model of energy in/energy out also made them feel more 'isolated', 'distressed' and 'different', whilst increasing distrust in the true intent of the messages set forth: "...I know people who are actually fine, but they are totally scared they are going to drop dead of a heart attack because they are a bit fat...(p.5). Twenty six of the women cited medical conditions and medications that contributed to weight gain and hindered weight loss efforts and felt they were unfairly labelled as stereotypical obese, a sentiment shared with other participants who felt that all overweight/obese individuals are judged as a homogeneous group. Overwhelmingly, participants emphasised that they did seek healthy lifestyles, despite assumptions of the contrary. Many could not relate to examples

of stigmatised unhealthy behaviours of obese portrayed in public health messages:

> Whenever you go to your local doctor you see pictures of large, overweight men, or large, overweight women eating hamburgers and thick shakes and saying 'one in three people over the age of 45 in this weight range are likely to suffer heart attacks'. I think, well that's not me, because I don't eat a hamburger and large chips every day. (p. 5)

2.6.4   Lack of large-bodied women's perspective

Whilst there is compelling evidence on the effects of stigmatisation and weight bias for both large-bodied individuals and health care professionals, these studies have focussed on specific factors such as satisfaction levels, rates of screening uptake and barriers to access. Much of the literature around discrimination, stigma, stereotyping and prejudice, emanates from a perspective of how dominant groups negotiate their responses to minority groups. An alternative approach is to study stigmatised groups from an inside perspective, to allow the experiences of how they respond to, and experience their positioning as both a constructor of their own reality, and a receiver of negative beliefs, attitudes and behaviours that impact upon that reality (Oyserman & Swim, 2001). However, there is a scarcity of research from this perspective related to large-bodied women's experiences of accessing general practice services, with an extensive literature review resulting in just three such studies.

The only New Zealand study located, focused on the lived experience of being a large-bodied woman in society (Carryer, 1997, 2001). It did however include a section which demonstrated participants' interactions with the health care system. Using a feminist frame work, Carryer interviewed nine women on five occasions over a two and a half year period. Participants disclosed difficulties and negative experiences with accessing medical care, including inappropriate clinical assumptions and comments about their weight from general practitioners and other medical specialists. This study however, is now fourteen years old and obesity stigmatisation has since intensified.

Merrill and Grassely (2008) conducted a feminist study of women's stories and experiences of being overweight patients within the U.S health care system,

including the primary health care sector. In depth interviews of eight self identified overweight/obese women were then analysed using a framework of hermeneutic phenomenology. Themes identified were centred on feelings of embarrassment, experiencing inappropriate and demeaning comments from physicians, difficulty with 'fitting' medical equipment and/or space, and feelings of lack of support and respect. Participants described accessing medical care as a constant struggle, often anticipating negative interactions as a protective mechanism. Relationships with their family physicians (GPs) were mostly positive, in part because they knew what to expect from them due to previous encounters. However referrals to specialists and other unknown providers were fraught with anxiety and fear about reactions and comments about their weight. The busy nature of general practice was mentioned by many participants, with both medical and nursing staff conveying a lack of listening skills and empathy within time pressured appointment slots. Women in this study also described a feeling of being less than human whilst being dismissed and treated as liars by some health professionals.

In a similar study, twenty six women with a BMI >30 were interviewed about their perceptions and experiences in regards to health care and health care providers (Buxton, 2010). The majority of the participants cited a physician (96%) based in a health clinic (88%) as their primary health care provider. Data was interpreted using the Colaizzi method of phenomenological analysis, which generated the major themes of 'perceptions of health', 'I am more than just a woman who is obese', 'establishing a health care connection' and 'I am assertive'. Subthemes included participants feeling that their health care professional (HCP) treated them as unhealthy, despite their own assertion of good health and commitment to healthy lifestyle practices. Many women stated that their lives were stressful and chaotic: "My weight creates stress, it is a constant...but sometimes I think my healthcare professional needs to know more about the stresses of my vocation and my family life" (p.68). The need for their health care professional to see them as an individual and not just a BMI, to listen and document their story to provide context, was discussed by many of the women, particularly those who have a strong family history of overweight/obesity. Similar to previous studies, participants felt rushed and hurried during visits with their health care professional, with many describing instances of being fobbed off or concerns being ignored. Some women

said they found themselves becoming pushy and demanding when asking for health care advice, despite this being contrary to their usual personality, in an effort to be heard or situations to be dealt with. Positive interactions were noted when participants felt that their heath care professional respected them, didn't focus on weight as an all encompassing cause for ailments, showed empathy, took their time to listen and mutually collaborated with them when problem solving.

2.7   Summary

This focussed review of the literature has highlighted the complex issues which have shaped and strengthened the medical theory of thermodynamics as the dominant discourse of obesity. The reduction of this multifaceted and poorly understood condition to the simplistic message of 'you are what you eat' has interwoven with a powerful societal repugnance of fat, to create highly stigmatising and discriminating social and health care environments for the overweight/obese – especially so for women who are judged harshly for deviation from bodily 'norms'. There is clear evidence of the uptake of negative stereotypes by health professionals which can result in reduced engagement of large-bodied women for some primary health services. This study will fill a gap in the current body of qualitative research of large-bodied women's experiences of accessing general practice services, adding another dimension of 'knowing' to the development of safe clinical practice and systems for this vulnerable population of health care consumer.

Chapter 3   Methodology

3.1   Introduction

As demonstrated in the preceding chapters, large-bodied women are vulnerable to the powerful pressure for slimness. There is strong evidence that large-bodied women are highly stigmatised within all domains of public and private life, including the health care system (Hebl & Xu, 2001; Puhl & Brownell, 2001; Puhl & Heuer, 2009; Schwartz et al., 2003). Despite a plethora of published obesity research, there have been very few qualitative studies that have specifically focused on the experiences of large-bodied women accessing general practice. With this in mind, the aim of this study was to elicit a straight descriptive set of data directly from the voiced experiences of a small sample of large-bodied women. On a philosophical level my desire to validate the stories of women compelled me towards a feminist research approach. Choosing an appropriate methodology was dictated by a feminist imperative to ensure my methods reflected an ethic of care and respect for women. This chapter will first provide a brief overview of the history of feminism followed by a closer examination of the principles of post-structuralism and post-structuralist feminism, with reference to feminist musings on women's bodies as a site of oppression. Core tenets of feminist research will then be discussed, followed by an overview of qualitative methodology. Finally, methods of sampling, processes for data collection and thematic analysis will be outlined, with reference to ethical considerations given to each method selected.

3.2   Feminist theoretical perspective

Feminism is a collective term for various feminist movements which, whilst sharing a common quest to understand how and why women are marginalised within patriarchal society, vary in their interpretations of the location and solutions to ongoing gender inequalities (Campbell & Wasco, 2000; Letherby, 2003; Weedon, 1997). As discussed in the preceding chapter, the entanglement of sex and gender have created hegemonic assumptions about the natural role and tendencies of women – in turn limiting women's access to the resources and opportunities generally afforded to men. For this reason feminists seek to ensure women's

voices and experiences are recognised as *the* legitimate source for knowledge in their quest to expose sites of inequality (Campbell & Wasco, 2000).

There have been three distinctive waves of feminism in the past three hundred years (Haslanger, Tuana, & O'Connor, 2011). The first wave, represented by the suffrage and temperance movements, encompassed the period leading up to the First World War and specifically focussed on challenging women's inequitable rights to political and public sphere participation, and exposing the living conditions of working class women (Haslanger et al., 2011; Letherby, 2003; Tong, 1998). As discussed in the preceding chapter, this period of time was ruled by the Cartesian dualist notion of the mind body split. This perpetuated an assumption of the natural allocation of women to the private sphere, with feminine roles and virtues prescribed as beauty, reproduction and the bodily care of others (Bordo, 2003). Whilst there was a scarcity of overt feminist writing prior to the 19th century, Mary Wollstonecraft (1792, as cited in Bordo, 2003) highlights the emerging feminist critique during this period:

> To preserve personal beauty, women'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. (pg 18)

From the late 1960s to the 1980s the second-wave of feminism, borne of the political Women's Liberation Movement, began to fight for greater equality amongst all sectors of women's lives. Issues of education, employment, economic opportunities, sexual division of labour, reproductive rights, rape/violence and objectification of the female body became the focus of, amongst others, the Liberal, Radical and Marxist movements (Haslanger et al., 2011; Weedon, 1999). Whilst feminist body politics were well established in the period leading up to the second-wave, it was during this period that the slogan 'personal is political' became synonymous with the feminist movement (Bordo, 2003; Farganis, 1996b). During this time feminists argued, amongst other issues, that the female body was controlled and constrained by patriarchal notions of feminine virtue. The result of which is perhaps best summarised in the following passage from Dworkin (1974):

> In our culture, not one part of a woman's body is left untouched, unaltered. No feature or extremity is spared the art, or pain, of improvement....From head to

toe, every feature of a woman's face, every section of her body, is subject to modification, alteration. This alteration is an ongoing, repetitive process. It is vital to the economy, the major substance of female-male differentiation, the most immediate physical and psychological reality of being a woman. (pg 113-114)

Since the late 1980s the third-wave of feminism has continued a struggle with the same kinds of issues as previous feminist movements, however the focus of inquiry starts from the perspective that factors of race, class, sexual orientation, social and historical context modify differences between women and their subsequent experiences of oppression (Brooks, 1997; Haslanger et al., 2011; Letherby, 2003; Weedon, 1997, 1999). Within these feminist frame works are various feminist stances that emanated from critical social theories of post-modernism, post-structuralism and post-colonialism. Established in an era that sought to legitimise all those who were marginalised, these theories were adopted by feminists as a critique against prior feminist perspectives which tended to universalise women's experiences of oppression (Brooks, 1997; Weedon, 1997). Third wave feminists assert that essentialising the experiences of women was to overlook the individual as well as the historical and social context. Incorporating theories of difference demonstrated an epistemological shift to issues of exclusion and invisibility for certain groups of women in society, including lesbians and women of colour (Bordo, 2003; Weedon, 1997). As the theoretical focus of this study, post-structuralist feminist views on the issue of women's bodies will be discussed in the next section.

3.3   Post structuralism

Post structuralism evolved during a period of great social changes following world war two. During this period, various critical social theorists began to challenge the validity of accepting science as an all encompassing provider of truth (Farganis, 1996a). Major contributors to the post-structuralist doctrine included Foucault's (1926-1984) theory of discourse and power, Lacan's (1901-1980) symbolic order of language and Derrida's (1930-2004) deconstruction of linguistic dualisms (Alvesson & Skoldberg, 2009; Farganis, 1996a; Weedon, 1997, 1999). Despite

differing assumptions between these key philosophers, they are post-structuralist because of their mutual agreement on the following two core issues.

The first of these is a critical view of the beliefs and knowledge born from the era of Enlightenment and the way in which this knowledge ensured the ability for some to exert power over others. Positivism is a key theory of knowledge production that arose during the shift from philosophy to natural science (the Enlightenment) as the natural provider of absolute truth (Gower, 2005; Kuhn, 1970). An inherent assumption of positivism is that there is but one single constant reality determined by the laws of nature, which exists independent of time, and can be located and therefore studied (Denzin & Lincoln, 2000; Dixon, 2005). However, post-structuralists argue that the objective, value free stance of positivism creates a body of grand theories and meta-narratives which has historically been used to exert knowledge power and control over others (Farganis, 1996a). At an epistemic level, post-structuralists assert that truth can only ever be partial and relative to the social and historical context at a given point in time. They assert that an individuals view of the world is shaped by the experiences they have had relative to what they have been *allowed* to see. One's location, socialisation processes, exposure to structural powers and specific bodies of knowledge all continuously shape and alter an individuals subjectivity, which therefore negates any positivist claim of ability to generalise (Weedon, 1997).

The second mutual agreement between post-structuralists is that language is a site of political struggle. As clarified by Weedon (1997, 1999) post-structuralists assert that meaning is generated within language, not as a reflection of a fixed reality, but changing with the ebbs and flows of discourse, cultural and historical locations. As such, language provides transparency to identify how various discourses gain momentum and power within societies (Alvesson & Skoldberg, 2009). It is the use of deconstruction (Derrida, 1992), the fracturing of dominant discourses to lay bare those that have been displaced, which exposes the power of language. Derrida further proclaims that traditional Western binary oppositions, such as male/female, reason/emotion, nature/nurture, are not value free descriptors but agents for a hierarchy that always privileges the first term over the second. As will be discussed further on in this section, this approach is both useful and pertinent to nurse researchers utilising a post-structuralist feminist approach.

3.3.1 Post-structuralist feminism

From a post-structuralist perspective, feminists argue that society is structured by a web of power and knowledge that systematically marginalises women to the category of 'other' (Alvesson, 2002; Farganis, 1996a). By actively critiquing the authority of science, history, power and knowledge – post-structuralist feminists seek to expose the mechanisms of action that lead to one discourse having power over another (Alvesson, 2002; Weedon, 1997). Deconstructing taken-for-granted assumptions about our social lives, post-structuralist feminists ask 'who stands to benefit from winning a discursive battle, who doesn't, and whose discourse/voice is silenced in the process'? Spivak (1990) clarifies this by stating "When a narrative is constructed, something is left out. When an end is defined, other ends are rejected, and one might not know what those ends are" (p.18-19).

The feminist appropriation of post-structuralism has not been without its share of criticism and debate. Many second-wave feminist movements viewed the establishment of post-structuralism, and its rejection of grand theories, as a direct affront to the theoretical and political gains of their previous struggles (Alvesson & Skoldberg, 2009; Farganis, 1996a; Francis, 2000; Weedon, 1997). Both Weedon and Brooks (1997) challenge this by asserting that post-structuralist feminism is not a replacement for feminism, but an alternative approach to start from when gaining perspectives on the multiplicities of women's experiences of oppression. Further to this, they add that theory is not abandoned within post-structuralist feminism, but recognised as partial and context specific, thereby allowing alternative and sometimes conflicting interests to be represented.

Perhaps the most controversial aspect of post-structuralism, at least for feminists, is a hesitancy to use labels such as 'woman'. Strong adherents of post- structuralism believe that because the meaning of any word is only relative to the context in which it is used, naming a category of people as 'woman' or 'men' is a mute point (Alvesson, 2002; Weedon, 1999). For feminists, this presents a philosophical dilemma – when gender, by definition, is *the* fundamental focus of their motivation for equity. However, both Weedon (1997) and Alvesson (2002) note that there is no prescriptive element to post-structuralist feminism that

precludes using sex categories - as long as the post-structuralist acknowledges that the term is not a universalising category.

How feminists practice variants of post-structuralism is not dictated by any discernable framework or step-by-step manual (which would arguably constitute a theory and be antithetical to post-structuralist tenets), but relies on an approach that starts from a position of healthy scepticism towards truth claims within a status quo (Alvesson, 2002; Alvesson & Skoldberg, 2009; Farganis, 1996a; Francis, 2000; Weedon, 1997, 1999). Therefore it is important to clarify my particular positioning within post-structuralist feminism, relative to its application in this study. I have specifically utilised this lens of view when reviewing the literature because it ensured attentiveness to locating the mechanisms of power which have lead the biomedical discourse of obesity to be dominant. Similarly, by applying the same focus when analysing the data, sites of power, agreement and resistance to dominant teachings of obesity can be revealed. Whilst each of the following terms is associated with a specific post-structuralist style (such as Derrida, Foucault and Lacan), I have chosen to take a pragmatic approach. This is due to this study being an exploration of a topic that has had relatively little direct examination, but is encircled by hegemonic assumptions based on dominant discourses of femininity and body size. I use the word discourse as a means to acknowledging power within theoretical bodies of knowledge which shape and regulate our social lives. Deconstruction is used in its literal context, that of picking apart or fracturing a discourse to reveal what is not said, whose voice is not heard and who stands to benefit from current claims of truth. In this respect, I have taken care to ensure that this study does not make grand assumptions about all large-bodied women on the basis of the experiences of a few. Nor do I uphold any particular discourse of obesity as an all encompassing truth.

3.3.2   Post-structuralist feminism and nursing

From a nursing perspective, there are interesting congruencies with post-structuralist feminism which have attracted many nurse researchers to embrace this theoretical perspective (Francis, 2000; Wall, 2007). Nursing, constructed as a natural caring role for women, is positioned within a powerful dualism that both linguistically and tangibly places them as the 'other' to medicine, the rational and

scientific (Francis). This hierarchy of power, despite the current prolific use of phrases such as partnership, is equally demonstrated in the dualisms of doctor/patient and nurse/patient. Additionally, there is considerable tension between the nursing discourse of holism and the medical discourse of body as machine. Utilising a post-structuralist framework nurses can examine and deconstruct taken-for-granted assumptions within the health care arena, an approach which Francis further cites as a useful tool when utilising an exploratory descriptive research.

As discussed in the first chapter, I entered into this study acutely aware of the power behind and within the dominant medical discourse of obesity. I wasn't content to accept the status quo as natural and 'common sense' and was particularly interested in the gendered aspect of the formation of this discourse. Post-structuralism, in refuting an essentialist notion of gender, supports the social construction of the feminine body. Refuting biology as the sole determinant of gender, Foucault (1978) and Bordo (2003) (drawing on Foucault) speak of the controlling medical gaze upon the docile female body, thus ensuring individual surveillance and conformity with practices which reward and gives power for adhering to specified norms of health, beauty and virtue. As shown in the previous chapter, the web of power between medical, social, media and cultural portrayals of feminine ideals has lead to wide spread powerlessness and stigmatisation for large-bodied women. On this basis, I reasoned that post-structuralist feminism, whilst adhering to the core tenets of feminist research, provided a sound choice of theoretical perspective for this qualitative descriptive study.

3.4   Tenets of feminist research

Feminist research is both a methodological and philosophical stance (Letherby, 2003; Reinharz, 1992) and is thus used as a collective term for a variety of feminist theoretical perspectives. These perspectives have largely been influenced by feminist theories in the main and as such reflect a discursive foci of what explains the subordinate position of women in society and how best to emancipate them from oppression (Letherby, 2003). Denzin and Lincoln (2000) note that theoretical perspectives are influenced by varying philosophies of science and social theory, further reinforcing the complexities of feminist research

epistemology. Both Letherby (2003) and Lather (1991) substantiate this by claiming that whilst feminist research has traditionally 'straddled' both the post-positivist and post-modernist paradigms, a positivist approach is not precluded. Thus there is no prescriptive element within feminist research to embrace any particular philosophy, epistemology, methodology nor choice of methods (Campbell & Wasco, 2000; Hesse-Biber & Leckenby, 2004) Reinharz (1992) qualifies this by noting that "feminism supplies the perspective and the disciplines supply the method...the feminist researcher exists at their intersection" (p.243). Whilst factions of feminist researchers may approach the same research question in many different ways, there are broad epistemological, ontological and axiological tenets that are agreed to by all feminist researchers in the main (Letherby, 2003).

All feminist research approaches begin with the belief that women have a subordinate status, both within traditional practices of research and within the structure of society in the main (Anderson, 2003; Hesse-Biber, 2007; Letherby, 2003). This underpins both the ethical and political focus of feminist research that carries the assumption that any research undertaken with women will be for their direct benefit with a view to invoking social change (Hesse-Biber & Leckenby, 2004; Liamputtong, 2009).

The use of gender as a unit of analysis is considered an essential component of the feminist research design process (Lalik & Felderman, 2009; Letherby, 2003).The research question, collection, analysis of data and the presentation of findings need to acknowledge that lived experiences of men and women differ in terms of equality and equity. Disparities exist in the presence of enduring social constructions of gender that constrain women's roles and position them to the voiceless private sphere (Hesse-Biber & Leckenby, 2004; Letherby, 2003; Tong, 1998). However, feminist researchers acknowledge that oppression is not just isolated to the domain of gender. Context for an individual is influenced by a multiplicity of factors such as race, socio-economic status, time, place and culture. Thus, feminist researchers do not make any grand claims to knowledge about all women just because the partcipants *are* women.

An assumption about the feminist researcher and participant relationship is that each enters the research domain with their own values, experiences and beliefs, and this needs to be explicitly acknowledged (Campbell & Wasco, 2000; Letherby, 2003; Liamputtong, 2007, 2009). The personal is always political, and as such the researcher is expected to incorporate reflexivity (their personal stance) from the outset and thence throughout the research process (Gillies & Alldred, 2002; Piatelli & Hesse-Biber, 2007). Reflexive practice is the acknowledgement of actual or potential power differences between participant and researcher, and how this may affect the research process. This speaks to the guiding feminist philosophy that the research process should not further marginalise women and must have the ability to benefit or emancipate women from situations of oppression (Hesse-Biber & Leckenby, 2004; Letherby, 2003; Ramazanglu & Holland, 2002).

The relationship between the researcher and the participants is built on the principle of reciprocity (Campbell & Wasco, 2000; Letherby, 2003; Piatelli & Hesse-Biber, 2007) and as such there is an expectation that knowledge production is a two way process within an emotionally engaged and caring relationship (Blakely, 2007; Campbell & Wasco, 2000). As clarified by Letherby, a participatory model of research directly confronts traditional positivist/andro-centric methodologies which ensure a passive and subordinate participant (subject). By practicing reciprocity, hierarchies and manipulation are consciously avoided. This can be demonstrated in the act of returning transcripts, drafts and findings directly back to the participant for critique, the researcher contributing their own personality into mutual dialogue and in the authority that is given to participants to help shape the research process.

Incorporation of these core tenets of feminist research will be demonstrated and further discussed within the methods section of this chapter.

3.5   Qualitative descriptive research

Qualitative research methodologies are utilised to obtain a rich and deeper understanding of the human experience. The underlying assumption, in synchronicity with feminist philosophy, is that multiple realities of truth are shaped by context, time and place (Hesse-Biber & Leavy, 2006). Descriptive research is not a prescriptive methodology. Rather, it is an emergent design that facilitates the

use of varying research methods in order to best answer the research question (Caelli, Ray, & Mill, 2003). This approach aligns with the feminist research philosophy that research processes need to be reflective and responsive to the specific situations and needs of women (Hesse-Biber & Leckenby, 2004).

As a frequently used methodology within the fields of nursing and other practice based disciplines, descriptive qualitative inquiry is often used for investigating quality and access issues for service stakeholders (Sandelowski, 2000). Positioning participant experience as a legitimate source of knowledge, descriptive qualitative designs ensure the researcher can report findings in a way that is both accessible and meaningful for participants and audience alike. This supports the functional aim of this study, to illuminate the experiences of a sample of large-bodied women accessing general practice services and communicate this to health care professionals.

Descriptive qualitative inquiry is a generic approach within the naturalistic paradigm, and aims to provide a straight description of the studied phenomena in 'everyday' or near data terms (Sandelowski, 2000, 2010) and is particularly useful when wanting to explore a relatively unknown subject matter. However Sandelowski (2010) notes that there has been some confusion over the fluid nature of qualitative descriptive inquiry, with some researchers misinterpreting 'near data terms' as justification to present findings in a raw state so as to avoid interpretative analysis. On this issue Sandelowski clearly asserts that whilst qualitative descriptive inquiries are less data transforming than, for example grounded theory, some level of data interpretation is required. Further to this she notes that, as an approach that has no prescriptive theory or framework, a researcher's theoretical assumptions, positioning with the topic and judicious processes for selecting specific methods/techniques need to be explicitly described. Acknowledgement of these concerns and the incorporation of these mitigating strategies have been used within this study. This, Sandelowski contends, will enhance rigour and ensure transparency of my methodological decision-making processes (2010).

3.6   Research methods

Methodological decision-making processes have been discussed in the preceding sections. The following discussions are descriptive processes about specific methods/techniques selected for this study, including relevant ethical considerations.

3.6.1   Ethical Approval

In accordance with the Massey University Code of Ethical Conduct (2009) a research proposal for this study was given to the Massey University Human Ethics Committee (Southern A) prior to the commencement of this study. After several minor grammatical adjustments were made to the information sheet and interview guide, ethical approval was granted (see Appendix A).

3.6.2   Participant selection

Self-identification of being a large-bodied woman was the fundamental criteria for inclusion in this study. Using self-assessment of body size was based on two key factors - that women are socially-constructed to be acutely aware of their body size in relation to cultural norms, and that an inclusion criteria based on Body Mass Index (BMI) may have unduly influenced the recruitment process. This is because BMI is a medical term to categorise deviations from 'normal' body weight, thus its use may have created a perception that the study was focussed on a medical 'problem' rather than that of women's experiences. Furthermore, many women may not be aware of their own BMI category and this may have been a potential barrier to volunteering for participation.

Sampling methods in feminist research are ethically chosen on the basis that populations of interest are often marginalised groups and difficult to locate and engage in research (Liamputtong, 2007). For this reason, several purposive sampling strategies were utilised. To ensure a large catchment area I contacted two community publications which deliver free weekly newspapers to every Invercargill household. 'The Eye' ran the pre-approved advertisement approximately two weeks after initial contact (see Appendix B). 'The Southland Express' reporters and advertising staff were enthusiastic about the topic of this study and decided to run a small editorial (see Appendix C). In fact I was

invigorated by the responses of these female reporters/advertising staff, some of whom were large-bodied themselves, endorsing the study with their own snippets of personal experience. Whilst I anticipated that fear of confidentiality within a small community may have deterred many women from volunteering via this method of recruitment, two participants did make contact with me after seeing these advertisements.

Another means of access to potential participants was through a gatekeeper. Gatekeepers act as an entry point to the population of interest, either as a guardian or leader of the community, and have the power to either facilitate or impede access to potential participants (Hesse-Biber & Leavy, 2006).The gatekeeper for this study was a community liaison nurse employed at the Invercargill Primary Health Organisation (PHO). Her role is to act as an advocate and facilitator to accessing primary health care services for 'at risk' populations in the Southland community. She has no affiliation with any particular general practice or other health care provider, thus her client base is primary health care consumers from throughout the Southland district. Permission was sought and granted from both the liaison nurse and her employer to assist in the recruitment of participants.

The gatekeeper was given information sheets to give to potential participants. Information sheets detailed the purpose of the study, requirements of participants as well as contact details of the research supervisor, acknowledgement of Massey University Human Ethics Committee approval, provisions for confidentiality, process of withdrawal and potential benefits of this research for both the participants and primary health care sector. It also advised who would have access to interview material and transcriptions. This recruitment method resulted in one referral for participation.

The strategy most heavily relied upon for this study was 'word of mouth' within the community, known as snow-ball sampling. This technique is frequently used in feminist research and involves using personal networks in order to continuously recruit participants until saturation of data has occurred (Letherby, 2003). It is a particularly effective means to accessing difficult to reach populations because it relies on 'word of mouth' from trusted members inside the vulnerable group

(Liamputtong, 2007). In this study it involved giving several information sheets to participants and asking them to consider other women in their social network that might wish to participate in the study. This approach, whilst effective, can be slow to gather momentum and there were times during the recruitment phase that I felt I would never reach a suitable sample size. Eventually however this method resulted in recruitment of a further seven women.

Qualitative sample groups are usually small in number because the aim of the inquiry is to find rich accounts of women's experiences, not a quantifiable frequency. It was envisaged that the sample size would be between six to ten participants but with some flexibility in numbers according to progress towards data saturation and time constraints for completion. The total sample size at the completion of the recruitment phase for this study was ten, however two women later withdrew from the study.

All potential participants upon first contact with the researcher were informed of the purpose of the research, the researchers' background and subsequent participant requirements – such as the selection of a pseudonym. They were also given brief descriptions of the types of questions that would be asked of them. In some cases this was as a response to anxious questions from the participants regarding what they were expected to divulge. For others, it provided an opportunity to start thinking about previous experiences with general practice as opposed to other health care services. This was necessary because some women were discussing visits with specialists during the initial contact phone call.

I endeavoured to ensure that all participants had been given the opportunity to read the information sheet prior to organising an interview. However, most women, particularly those who had discussed the study with their referring participant, felt comfortable to pre-arrange an interview. In these situations, the information sheet was thoroughly explained prior to signing the consent form and the commencement of the interview. The consent form provided the choice of agreeing to audio-recording of the interview, having the audio-recording returned to them at the conclusion of the study and option for accepting follow-up contact if required.

At the beginning of the study it was proposed that transcriptions would be undertaken by the researcher. After completing four, it became clear that time constraints would necessitate the use of a professional transcriber. The remaining four participants were advised of this at time of first contact and advised of the confidentiality statement signed by the transcriber.

3.6.2.1 Ethical consideration to sample recruitment

At the planning stage of this study, ethical consideration was given to the potential of a woman volunteering for inclusion whom may not be considered to be large-bodied in a reasonable sense. It was decided that a discussion between myself and the volunteer would be undertaken in order to come to a satisfactory agreement between both parties. Further to this, information about counselling services would have been offered if, upon professional judgement, the discussion elicits any concerns regarding body image issues. Fortunately, this situation did not eventuate during the course of this study.

During the conceptual stage of this study it was acknowledged that a potential participant may be a patient of the researchers' general practitioner employer. A possible implication of having a patient/participant is that the data collection process may be influenced by participants censoring their experiences. Social desirability bias, the desire to present a positive image (Bowling, 2009) may stem from a participants' fear of future retribution if citing negative aspects of their care. Integral to this potential confounding issue is acknowledgement of the power differential within a nurse/patient relationship. In order to mediate this potential risk, I notified participants of my place of employment at the time of first contact. If a nurse/patient relationship was identified then potential participants were advised that, whilst patient *identification* would be compromised by my role as their practice nurse, *confidentiality* of their participation would not be. Equally so, participation would not harm or compromise the patients' access to future health care services. Legal and ethical obligations of my role as a registered nurse and researcher were specifically discussed with the potential participant at the point of first contact and followed up with a specific patient/participant section in the information sheet (see Appendix D).

From the outset of this study I have been acutely aware of the difficulties in preventing breeches of confidentiality when contextualising information obtained from participants. Invercargill is a small town with general practices that have been a stable fixture within the local healthcare system for many years. The acute shortage of general practice capacity within the region means that patients are currently forced to remain at their enrolled practice, and it is for this reason that most women in this study were anxious not to jeopardise relationships with their current general practice. Whilst many feminist studies elect to introduce individual participants' demographic and contextualising details at this stage of the presentation, I have given assurances to participants that protection of identification will take precedence over all other research needs. Therefore, upon agreement with the individual participant, general introductory information will only be included if specific context or explanatory reasons deem it necessary.

3.6.3   Data Collection

With a very limited selection of international and local literature to draw from, an exploratory approach was required for data collection. The main form of data collection in this study was gathered from face-to-face interviews with participants. This method is particularly useful to elicit understanding of a phenomena that cannot be directly observed, and assists in understanding the perspectives of others (Patton, 2002). Interviews are utilised to elicit rich, in-depth and participant orientated information (Hesse-Biber & Leavy, 2006) and are commonly used in both descriptive qualitative and feminist research inquiries.

In order to direct the inquiry to the domain of general practice, an interview guide was used, providing a framework to work with during the interview session. This provided consistency of topics discussed with each participant and ensured that the interview period was efficient use of time for both the researcher and the participant. Interviews guides are however flexible in their structure and this is particularly useful when exploring unknown phenomena which may elicit differing factors of interest from participants than those anticipated by the researcher. The interview guide for this study was based on a set of questions that had been successfully used in a similar study overseas. The principle author of the study (Merrill & Grassley, 2008) was contacted and gave written permission for her

questions to be replicated in this study. Examples of the questions used included, 'what is it like to be a woman who is large-bodied/overweight?', 'what is it like for you to be a patient in the doctor's clinic?', ''describe your relationship with your GP/practice nurse/clinic reception staff' and 'have you ever hesitated or delayed going to your doctor's surgery because of your body size?' (see Appendix H). During the first interview I asked the participant, 'what would you like to say to health professionals working in general practice? This directed the participant to think about specific areas for potential change and elicited some insightful comments, allowing the participant to articulate what they felt was important for me to feed back to health professionals on their behalf. I therefore included this as a standard question towards the end of each interview thereafter.

With informed consent of the participants, the interviews were audio-taped on a digital recorder. Recordings were then copied into a windows media format that enabled the sound recording to be transferred electronically to the transcriber. These copies were then stored on my computer in a password controlled file until the completion of the data analysis stage, at which time the files were permanently deleted. Participants were advised of this protocol in the information sheet. Within the consent form there was an option for a copy of their recorded interview to be returned to them prior to the deletion phase. None of the eight participants wished to retain a copy of their interview.

An assumption of qualitative inquiry is that all observed data relating to the study is worth consideration for inclusion (Sandelowski, 2000). For this reason I kept a journal throughout the research process for two specific purposes. Firstly, contextual data was collected during the interview process, including field notes on participants' body language, the environmental setting, hesitations in speech and the emotionality of the conversations that took place. Secondly, the journal was used for documentation of my initial thoughts about the interview, key statements from the interview and 'hunches' about emerging themes. The use of memos (journaling in this instance) marked the beginning of the data analysis phase which, in qualitative inquiry, is concurrent with the data collection period (Hesse-Biber & Leavy, 2006; Patton, 2002). Memos provide contextual background to the interview. They also ensure a 'paper-trail' of the inductive reasoning process of the

researcher, including a transparency of personal feelings and possible biases, thus enhancing the rigor and integrity of the study (Patton, 2002).

The location for the interview was negotiated with the participant according to their individual needs. Feminist researchers are sensitive to the social positioning of women and acknowledge that roles as mothers and caregivers may present difficulties in committing to an interview at an external location (Hesse-Biber & Leavy, 2006; Letherby, 2003). Whilst provision for the use of a meeting room at the local Primary Health Organisation was made, all the women in this study chose to have their interviews conducted in their own home. An appropriate time was negotiated between each participant and myself whilst taking into account the need to minimise distractions from children, other members of the household and work commitments. Personal safety precautions, such as carrying a cell phone, were undertaken prior to each interview.

It was anticipated that each interview would take between one and one and a half hours and that one interview would be all that was required. The possibility of need for re-contact in the event of gaps in data or need for clarification during the transcription phase was included in the consent form prior to the interview taking place. This was also further re-iterated at the conclusion of the interview. Each of the participants gave consent for further contact if required.

Transcription of the raw data was completed by myself for the first four interviews however, as more participants came forward, this proved to be too time consuming and beyond my capabilities. A transcriber from another location was contracted. Upon receipt of the completed transcriptions, I then validated the accuracy of the transcription by comparing it with the applicable audio-tape. At the completion of the initial transcription, participants were sent a copy of the transcript to review for accuracy. It is in this method of reciprocity that feminist research challenges the traditional power differential between the researcher and the researched, by including the participants as a collaborative partner. This provided an opportunity for the participants to either clarify or challenge the raw data, thus enhancing the rigor and validity of the data as an authentic representation of their voiced experiences. During this process some of the participants did in fact remove or

alter the original material, and as such, these changes were incorporated into the final transcripts prior to analysis.

3.6.3.1   Ethical consideration to data collection

Ethical considerations are important due to the reciprocal nature of the relationship between the feminist researcher and participant, and the possibility of emotional work that comes out of the research process (Liamputtong, 2007). It was acknowledged that some of the interview conversations may have created heightened awareness of insensitive practices and/or distress for participants, which was evidenced by some participants becoming emotionally upset during the interview stage. Whilst these participants dismissed any need for ongoing support, information regarding support services – in one case, the Health and Disability Commission were offered.

This research was undertaken within a relatively small and easily identifiable general practice community, and as such, there was the possibility of having confidentiality breeched by the inclusion of specific details of any general practice consultations. Thus, potential identifying details of the participant such as age, focussed medical history and specific details of the reason for accessing general practice have been managed by using only a general descriptor if possible – such as 'a foot problem' or 'a metabolic disorder', or if not contextually relevant then has been withheld.

Since there are very few female general practitioners within the Invercargill region, the sex of the participants' general practitioner was withheld from the point of transcription. Since there are no male practice nurses within the Invercargill region the sex of the practice nurse was not considered a potential identifier. All participants were asked to choose a pseudonym and these were used from the point of transcription onwards.

The dialectical nature of conversation in feminist research means that the researcher becomes a part of the research process, and their voice is included as part of the data collected. This presented an ethical dilemma regarding the extent to which I chose to share in this process whilst maintaining personal and professional privacy, since my name and location of employment was identified to

participants from the outset. In order to mediate potential implications on my responsibilities as a registered health professional and employee, ethical consideration was given to the inclusion of 'workplace stories' and 'inside' information I had about specific practices and individuals within the local general practice community.

Protection of participants' privacy was integral when considering the storage of data during and after the study period. The research journal, along with other printed material – such as transcripts, were kept in a locked safe throughout the study and will continue to be stored there for a further five years, prior to safe disposal. Data files such as audio-recordings and transcriptions were stored in the researchers' personal computer and protected by passwords throughout the study period. These files were permanently erased at the end of the study period.

3.6.4   Thematic analysis

Thematic analysis is a generic form of qualitative analysis, a 'way of seeing' (Boyatzis, 1998) that offers flexibility in its application, and a widely utilised tool in nursing and/or descriptive research (Caelli et al., 2003; DeSantis & Ugarriza, 2000; Hansen, 2006; Sandelowski, 2010). As a way of explaining and connecting previously known knowledge with the new, thematic analysis is a process of encoding and managing large amounts of qualitative data into meaningful themes for interpretation (Boyatzis, 1998; Braun & Clarke, 2006). However the term 'theme' can be interpreted on many different levels (DeSantis & Ugarriza, 2000) which warrants an explicit operational definition to be given by the researcher at the outset of the analysis stage. Thus, the use of the term theme in this study is best defined by De Santis and Ugarriza (2000):

> A theme is an abstract entity that brings meaning and identity to a recurrent experience and its variant manifestations. As such, a theme captures and unifies the nature or basis of the experience into a meaningful whole. (p.362)

Several authors have written extensively on proposed methods of conducting thematic analysis (Boyatzis, 1998; Braun & Clarke, 2006; DeSantis & Ugarriza, 2000). After reading through each of these it became apparent there was general

consensus on an iterative approach, a process whereby the researcher immerses themselves in the data corpus, actively searching for patterns of similar text within a body of information which initially appears to be random. It was also evident that there is no prescriptive element to the coding process, other than it must be conceptually meaningful, close to the data and used consistently across the corpus (Boyatzis, 1998; Braun & Clarke, 2006; DeSantis & Ugarriza, 2000). Based on these readings, and discussions with my research supervisor - who has extensive experience with thematic analysis, an eclectic process was agreed upon.

The coding process in this study was developed primarily in an inductive manner, with the emergence of codes being driven by the content of the raw data (Boyatzis, 1998; Braun & Clarke, 2006). Starting from the point of data collection, I actively searched for recurrent patterns of verbal and nonverbal cues embedded within participants' dialogue and behaviour during the interviews. Initial thoughts and impressions of recognisable patterns of data were recorded within a journal at the conclusion of each interview. During the validation phase of comparing written transcripts with the audio-recordings, I ensured that emotional responses (crying, laughing, sarcastic tones and anger) of the participants were noted within the relevant data sets. This process was enhanced by the concurrent use of the journal memo's to complement and contextualise the raw data that had been transcribed. Grounding myself within participants' speech ensured that pauses, hesitations, utterances and specific words used to describe experiences could be included for analysis.

The written transcripts were then read and cross-checked several times, with notations and preliminary naming codes jotted down next to every data set, ensuring that variation of theme was maximised. After the third reading I collated the coded data sets into potential themes and, with relative ease, identified eighteen preliminary themes. However, upon further re-readings of each of the transcripts I noticed that several of the themes were closely related and thus could be clustered. The final theme count at this stage was ten, and after a considerable period of reflection, writing, and frequent discussions with my supervisor, the ten themes were refined into a final theme count of seven. At this stage of the process, I felt somewhat overwhelmed with the task of delineating these seemingly

intricately related themes into separate category groups. What ensued was a rigorous iterative process of reading through the themes, anchoring myself to the voices of these women. Drawing on the same post-structuralist feminist lens as used when reviewing the literature, I underwent this refinement process alert to sites of power, discursive challenges and areas of resistance between these women's construction of obesity and those of biomedical/thermodynamic teachings. The three categories became apparent when I was able to clearly see that the contextual information about these women directly impacted upon their experiences as large-bodied patients.

Congruent with this study's post-structuralist feminist positioning, thematic analysis allowed both manifest and latent themes to be included in the analytic process. Manifest themes, the visible use of and/or frequency of content – such as a word or phrase, was useful for identifying the incidence of an experience. It did not, however, seek to explain possible underlying meanings behind a participants' choice to use that particular word or phrase to describe the experience (Boyatzis, 1998; Braun & Clarke, 2006). In order to expose spoken and unspoken cues of the participants' constructed meaning of being large-bodied women and how this, along with social/cultural/structural context, influenced their health seeking behaviours and experiences, both surface and deeper interpretation of the data was required for this study.

3.6.4.1   Ethical consideration to analysis

Feminist researchers acknowledge and seek to mitigate the traditional shift in power of the researcher/participant relationship that ensues during the analysis and interpretative stage of research. This is because it is, in fact, the researcher who ultimately determines what and how the findings will be presented (Hesse-Biber & Leavy, 2006; Letherby, 2003). Thus, participants were given the opportunity to read and modify the theme report prior to further analysis. A covering letter was attached, explaining the current stage of analysis, a statement addressing the issue of editing and a further reassurance of confidentiality. All participants gave either written or verbal endorsement of the preliminary themes and permission to go ahead with the next stage of analysis. They also coherently agreed that reading the experiences of others to be both interesting and self-

reassuring. This was demonstrated by written notes from two of the participants: "Was a good read. Nice to know that you are not the only person who feels this way" and "Thanks for representing us 'fatties' so well – for choosing this topic"

The nature of a small and specific sample group can also create ethical dilemmas during the editing and publication stages, particularly when attempting to balance privacy with the demands of research credibility to present an accurate representation of experiences (Liamputtong, 2009; Preissle, 2007). For this reason the same attention given to maintaining confidentiality during earlier stages of the study was also carried through into the analysis and writing stages of this study. Each of the participants were anxious not to compromise (or further compromise) relationships with their current general practice, predominantly due to the near impossibility of finding an alternative health care provider in this study locality. As discussed previously it is for this reason that, whilst endeavouring to include as much context as possible, I felt ethically obliged to eliminate some potentially useful descriptive data for this study, in favour of placing participant confidentially before personal gratification.

3.7   Credibility in feminist research

Reflexivity is a fundamental principal for demonstrating adequacy in feminist research (Hall & Stevens, 1991; Letherby, 2003; Liamputtong, 2007; Pillow, 2003) and is practiced on two levels. Firstly, it is a purposeful introspective act that is practiced by the researcher in 'real time' throughout the research period (Weick, 2002), an effort of constantly critiquing and acknowledging possible influences on decision-making processes. The ability to define and articulate one's own assumptions, attitudes and beliefs assists the researcher to recognise competing perspectives to their own. This is important for ensuring clarity, particularly in the analytic stages of the study, because all researcher driven judgements of what data counts as interesting or pertinent to a study will inevitably privilege some accounts whilst denying others (Hall & Stevens, 1991; Riach, 2009; Symon & Cassell, 2004).

My own assumptions at the outset of this study were influenced by exposure to clinical experiences and literature which had provided me with evidence of social and health professional stigmatisation and prejudice towards large-bodied women.

Whilst I was able to recognise and articulate personal reflections and potential influences within the journal and thesis itself, as a beginning researcher the practice of bracketing these assumptions during the interview process was difficult. Upon reading the first four transcripts it was evident that, at times, I was trying too hard to inject my own knowledge into the conversation, particularly when participants were asking me questions – which in hindsight were probably rhetorical. I realised that in my desire to ensure rapport, trust and a non-hierarchical relationship with the participants, I was not allowing sufficient silence to encourage a richer explanation of participants' experiences. The conversations, at times, went off-track and were quite unrelated to the focus of the study. After discussion with my research supervisor, and in recognition of effective interviewing as a learned skill, I endeavoured to ensure that my voice was transparent but less intrusive on the conversations. On reflection however, despite these initial concerns, the analysis stage did not indicate any significant projection of my assumptions into the participants' articulations. Whilst this belief was reinforced by all of the participants endorsing the validity of their transcripts, I also acknowledge that my social positioning, as a practice nurse, may have influenced their comfort level for negative responses. The majority of participants did, however, feel safe to provide negative examples of practice nurse interactions during the interviews (albeit often with an apologetic precursor), and on this point I felt that the level of trust and rapport provided a protective mechanism against possible social desirability bias.

Familiarisation with the topic also created some personal difficulty with accepting that the analytic process could purely be an inductive approach when, at least to some extent, I had some preconceived notions of what the coding frame was likely to include, particularly since the questions used in the interview guide were based on those used in a similar study. In recognition of these tensions, and in the interests of transparency, I carefully considered some additional steps that could be taken to mitigate the projection of my own attitudes, emotions and values into the analytic process. Boyatzis (1998) suggests that such contamination can be prevented or reduced by striving for consistency of judgement and high inter-rater reliability. My decision to submit the preliminary theme sheets back to the participants for scrutiny was an axiomatic step within a feminist research

framework. The participants' uniform agreement with those themes provided me with some reassurance that the data sets selected for further analysis reflected what the *participants* wanted to share. In addition to this, I also shared the transcripts, theme sheets, coding framework and evidence of the theme emerging process with my research supervisor for inspection.

The second aspect of reflexivity in feminist research is participant-centred, an active inclusion of participants in the decision-making processes shaping the direction of the study (Pillow, 2003; Riach, 2009). This is an important aspect of feminist research, in that the findings of feminist inquiry must be an authentic representation of the experiences of women. Participant-centred reflexivity has been facilitated within this study by ensuring that participants had an opportunity to voice their opinions on the studies' direction and processes. This included dialogue that took place at the outset of the interview process, such as seeking approval of the questions that have been formulated and the lens of theoretical focus that would be applied in the analysis stage. The participants were also asked to make comments and/or suggestions about the evolving direction of themes at the early stage of data analysis.

Triangulation is an additional mechanism of enhancing credibility in this study, and involves the comparison and verification of emerging themes with what is already known about the focus of study (Lincoln & Guba, 1985). This can, however, be a tenuous process within a post-structuralist frame work because its theoretical underpinnings lay claim to the fact that 'truth' can only be a partial perspective. Convergence or divergence from the findings of other studies is thus not a validity construct, but 'just' another perspective within the multiplicity of social phenomena (Moran-Ellis et al., 2006). Thus, in this study, whilst it was inherently satisfying to see distinct similarities between my emerging themes with findings of other inquiries into this topic, I concede that these findings can only provide a layer of knowledge relevant to the context of *this* study.

3.8   Summary

In asking the question 'What are the experiences of large-bodied women accessing general practice services', this study has utilised a post-structuralist feminist approach. The philosophical underpinnings of this methodology have

been discussed, with reference to influences and rationale on the decision-making processes for this study's design. I have outlined the research methods for data collection and analysis, and described the processes used to ensure credibility and ethical needs have been addressed.

In the following chapter the data is presented.

Chapter 4   Living large with stigma

...the most potent weapon in the hands of the oppressor is the mind of the oppressed
(Steve Biko)

4.1   Introduction

The functional purpose of this study was to explore the experiences of large-bodied women accessing general practice services. Analysis of the interview material resulted in the emergence of three broad themes: 'Living large with stigma', 'Living large and negotiating health' and 'Living large accessing health care'. These thematic groupings and their sub themes will be discussed in the following three chapters, with each contributing issue to the theme further explained. As previously discussed, these themes have emerged from utilising a feminist poststructuralist lens. This has enabled me to be alert to sites of power, agreement and resistance between these women's construction of obesity and traditional dominant obesity discourse.

As previously noted, there is a considerable body of literature regarding the social stigmatisation of large-bodied persons' (see for example Campos, 2004; Puhl et al., 2008; Puhl & Heuer, 2009; Wang et al., 2004) and, as such, there was an expectation going into this study that the participants *would* be likely to have some experiences of this nature to share. Certainly the analysis did reveal that these women were acutely aware of their social positioning as large-bodied women living in a society which cultivates slimness as both a beauty and health ideal.

This chapter, 'Living large with stigma', discusses the multiple locations and experiences of stigma that have shaped these women's perspectives of trying to fit into a society that positions them as self made deviants of bodily norms. From a post-structuralist perspective this is an important act of providing contextual information because, after interviewing the eight participants for this study, it quickly became evident that the effects of social stigmatisation were intrinsically related to these women's definition of self. As will be shown in the following chapters, this ultimately influenced how they positioned and expressed themselves as patients accessing general practice services – a service which, similar to the social context, draws on a discourse of obesity that censures an individual as the architect of their own fatness.

The themes discussed in this chapter are: 'Early experiences of body perception', 'Confronting social stereotypes' and 'Contending with feminine beauty ideals'. Whilst each of these topics is discussed separately, each are components of these women's sense of self and of living large as best they can, and thus cannot be read as separate entities but rather as inherently inter-related.

4.1.1 A brief introduction to the participants

As discussed in the preceding chapter, the location of this study means that I have chosen not to provide detailed demographics of the participants. However, in respect of the need to provide some context, I will give a broad overview. The eight women interviewed for this study ranged in age from their mid-thirties to early sixties, with all identifying as European/Pakeha. Four of the women interviewed had either trained previously, or were currently working within the health care industry in varying roles. Three of the women were single whilst five of the women were in a relationship. Apart from one participant, all of the women are mothers, with children ranging in age from preschooler to adulthood. Three of the women are grandmothers. Some women disclosed their current weight during the interview period however I have chosen not to include this as part of their demographics. Suffice to say that all of the participants were visually and professionally regarded by me to be considered as overweight or, in the majority of cases, obese.

4.2 Early experiences of body perception

Whilst most of the women in this study recalled being slim as a child, for some, the onset of puberty and adolescence was defined as a period of weight gain and recognition that their appearance was an instant signifier for others to make judgements. The consequence of deviating, even slightly, from the feminine slim ideal, resulted in weight-based social commentary from friends, peers and family. The resulting hurt, shame and humiliation of being teased and labelled as being someone who had failed their body and required 'fixing' was emotionally palpable in their recollection of these stories several decades later:

> *I think about 12 when I started blossoming. I went through puberty. Like I*
> *remember being 54kg and thinking 'oh god I am so fat'. The comments (about*

weight) don't come now, but when I was going through the teenage years – the formative years, you know, 'Get out of my way you fat cow'. You know it hurt, really hurt. You remember those horror stories. I remember being on a bus trip and I was in a pair of size 15 jeans, and I was so proud that I could get into a pair of size 15 jeans, not a 16. The bus jolted and I slid into someone...all I heard was 'Get off me you fat cow'...funny how those sorts of comments come back to haunt you. (Alana)

Looking back on photo's that I have found I wasn't overly big but I was always criticised by my family that I was fat. But when I look back on the photo's I was actually an average sized kid...I wasn't the skinny version but I wasn't overly overweight. [Entire family called her derogatory weight based nick names]...that's what I grew up with. It all came down to self esteem, which I didn't have any. Its major baggage, still is now. Going back over what happened in my childhood it's sort of like...you know in the back of your mind you've got this 'See, things never change'. It's an inbuilt response. (Loreen)

Labelled as overweight, several of the women described concerted efforts by their parents to encourage their daughters to restrain their uncontrolled bodies.

When I was 11yrs old my mother took me to the dietician for the first time. But to be honest, she was giving me everything that I ate so it wasn't really anything to do with me. (Laura)

My parents were always making me go on diets and all that sort of stuff...it was ok but all it did was make me binge eat because you are constantly called fatty, constantly picked on because you weren't this pea stick of a kid... (Loreen)

It is unclear whether these first dietary efforts were parentally endorsed as being for health or appearance reasons, but exposure to either of these two obesity discourses (fat is unhealthy; fat is ugly) present a powerful, culturally mandated (fashion/beauty) and authoritative (medicine) call for action to be taken in the 'fight against obesity' (Gard & Wright, 2005; Tischner & Malson, 2008). Regardless of the reason for teasing, bullying and implementation of early food vigilance practices, studies have shown that the experiences of these social control

practices in childhood/adolescence can cause patterns of disordered eating (Haines, Neumark-Sztainer, Eisenberg, & Hannan, 2006) and poor self body image (Annis & Cash, 2004). For Loreen, the construction of her adult sense of self has been dominated by childhood memories of constant taunts and 'treatments'. As she spoke about this period in her life, and her subsequent battles with weight, her emotions were raw and difficult to witness. For her, despite the outer shell of nonchalance that she often used to describe her experiences of stigmatisation, the pain of her childhood was very close to the surface:

> *If you're constantly told you are fat as a kid then no matter how much...I mean it still has such a major hold on me...I've been anorexic, I've been bulimic – you know, I've done the lot and I will never ever get down in body size...I stand on the scales every morning now. I'll diet and then I'll binge...it's just ridiculous. I think it's very much like 'I'll prove you wrong, but all I do is just get sicker. Cos it's so ingrained that 'You're fat, you're always going to be fat, nobody's gonna want you cause you're fat'.* (Loreen)

Of the others who experienced stigmatisation at an early age, almost all also spoke of enduring practices of binging and dieting:

> *I know I comfort eat...I can eat a whole bag of lollies...even when I am doing it I know that I shouldn't be but I can't actually stop it..but you see, the other thing I do – which is wrong – is because I'm feeling horrible about the way I am, you know, I'll stop eating. I can't eat this, I can't eat that, so I'll just stop eating.* (Alana).

Here, Angela describes her 'episodes' of bingeing. Her verbal account was narrated in tones of both shame and anger at herself for not being strong enough to overcome the effects of lifelong weight stigmatisation:

> *When I was feeling really down and out I would actually go and...I'd have a whole pile of stuff and sit there and eat it then get really sick...it's that self loathing...which I've probably let society do to me...I mean I've let them do it...I haven't protected myself enough from it...* (Angela)

Whilst listening to these stories, it soon become clear that there is a paradox between these women's expression of lifelong dietary practices, and enduring social stereotypes of gluttony and lack of self control. These women have, in fact, spent an enormous amount of time and effort constraining their desires and metabolically driven need for food and harshly punishing themselves for tightly defined 'mishaps'.

For those who reflected upon their relative slimness as a child or adolescent, there was a consistent sense of sadness and regret recognising that they spent those years falsely believing they were overweight and therefore 'abnormal'. Angela described her body as both slim and athletic until developing a chronic inflammatory condition in her late teens. Her narrative illustrates the convergence of two discourses of obesity that she espouses, 'normal' is slim and aesthetically pleasing, and acknowledgement that obesity is not necessarily caused by gluttony and lack of willpower. For Angela, pain, fatigue and bouts of depression proved to be a significant barrier to maintaining her previously high level of physical activity:

> *It all started out ok, I was normal. But I got sick, in all this pain and they (health care professionals) didn't listen. It got really out of control. That's the hard thing, when I was 16 or 17 years old, and I didn't know it then, I looked <u>really</u> good. In those days I thought I was fat.* (Angela)

For Monica, fears and beliefs about the primary cause of obesity being excessive and inappropriate food consumption were projected on to her from her large-bodied mother:

> *...I've always been big, right from the time I can remember being young - thinking of course that I was bigger than I was, I probably wasn't. I was probably average, but I thought I was fat. I had a large mother and all my aunties were like wee barrels, but that's no excuse – my mother would say, 'It's not in your genes – it's in your mouth'.*

And Selina:

> *I remember comments made when growing up, about my weight. By my teenage years I was convinced I was a big/fat person. Looking back on the photos though – I can only see a slim person!*

And finally Theresa:

> *...when I got married I was 9st 9lb...I was told I was big then – 'she's a big girl isn't she'. They always said that. We weren't, we were skinny kids...I look at pictures of me then, I was slightly overweight but nothing drastic.* (Theresa)

Whilst social pressures to conform to appearance norms are experienced by both male and female youth, the pressure for slimness has a particularly salient impact on girls and women's experiences of their bodily self (Bordo, 2003; Hesse-Biber, 2007; Smolak & Murnen, 2007). During the formative years of childhood and adolescence, a matrix of processes begins to shape and construct women's sense of femininity, health and body image. Increasing exposure to mass mediated images of feminine slim ideals set a cultural standard for which to constantly compare to and strive for. All the while, reinforcement of these messages are upheld within primary group relationships with peers and parents (Leavy, Gnong, & Sardi Ross, 2009) and by sanctioned 'authorities' such as medicine and media . As a result, girls enter into puberty significantly more likely than their male peers to overestimate their body size, be generally dissatisfied with their bodies and more vigilant towards self-imposed 'body work' such as dieting (Leavy et al., 2009; McCreary, 2002). Women learn early in life that adhering to cultural and dominant group norms of slimness can potentially reap significant rewards, whereas being large invites social censure and targeting for 'fixing'.

Talking about their childhood and adolescent experiences of emerging body perceptions, it became clear that for many of these women, the impact of cultural ideals on their self image was moderated by the degree to which they appeared and/or were accepted as 'normal' by significant others. Some continue to be haunted and hurt, others seemed unaffected or indifferent, yet all spoke in dualist terms suggesting that exposure to dominant obesity discourses endorsing beliefs

of slim/good and fat/bad during their childhood/youth provides context to their adult view of self.

4.3 Confronting social stereotypes

Link and Phelan (2006) maintain that stereotypes, as a powerful component for perpetuating stigmatisation of an individual, gather strength when they become entrenched within the social fabric of a society. Similar to existing literature on embodied experiences of largeness (Carryer, 1997, 2001; Ogden & Clementi, 2010; Puhl, Moss-Racusin, et al., 2008; Rogge et al., 2004), and despite differing backgrounds, the women in this study provided similar narratives of multiple situations in which they perceived negative stigmatising reactions to their body size. Living in a social milieu that strongly grounds itself in an obesity discourse based on thermodynamic theory, it is perhaps no surprise that hegemonic assumptions of overeating and indolent lifestyles are at the core of obesity stereotypes acknowledged by these women:

> I don't think that people believe that fat women have any brains or sense, or are house proud... we are just not capable of doing anything accept sitting and watching TV and eating. (Laura)

> ...it's that lazy thing, that you're greedy, gutsy, stupid. (Angela)

> A lot of them think that you're not fit, you can't do anything, that you don't have a life, they think you are lazy, you're fat and lazy and it's your own fault and you should get yourself going and stop eating. (Monica)

> ...'I've got a bad diet, I'm always eating lollies, I'm always eating cakes or lollies' – which is not true but that's an assumption people make... (Theresa)

As a consequence of these enduring societal assumptions of gluttony and slothfulness, many of the women admitted to feeling a heightened state of anxiety and embarrassment when faced with buying food, eating or exercising in public:

> I go to the takeaway bar or something and you just know walking through that door that those people are just looking at you and thinking 'oh for gods' sake'...it's assumed that you are living on six pizza's and KFC every night...walking through that door and looked at like you should not be there –

that's probably the worst feeling in the world. (Selina)

And Loreen:

> *...say if you go out for a drink with a friend, you know a cafe, people will look at what you've got and it just makes you feel like you shouldn't be there because 'you shouldn't be eating that'...*

Selina and Loreen both perceived a feeling of being classified as intruders within these spaces - 'should not be there' and 'shouldn't be eating that'. The social and medical censure of high calorie foods for the overweight, assumptions of excess intake, and the powerful stigmatisation practice of intense social surveillance, all serve to further limit the places of acceptable visibility of overweight/obese in the social world. In support of this, and consistent with other studies (Thomas, Hyde, Karunaratne, Herbert, & Komesaroff, 2008; Tischner & Malson, 2008), supermarkets and other sites of food purchasing were cited as a frequent source of prejudice. Specific references to the perception of others checking their trolleys, the sense of being monitored and under surveillance for confirmation of assumed poor eating habits, were common themes amongst the participants in this study:

> *...like someone at the checkout judging my food choices...people staring at what you are putting in your trolley, standing there and someone will walk past and give you a look...it's a bit like 'did you realise you got fat?'* (Angela)

> *... like at the supermarket checkout and you feel like somebody is looking in your trolley to see what you've got in there....I've seen people do that...and I was kind of like – hell I've got the veges and meat and you have a problem with me having a packet of biscuits in there for my kids lunches!* (Selina)

And yet it seems that this judgement of food choices is not just limited to the slim, as indicated by this statement from Theresa:

> *When I go shopping I don't buy those sorts of things (processed and 'junk' foods)...whereas the stuff that I see young people put in their trolleys...*

This common act of voyeurism, checking and attaching judgement to the food purchasing habits of others, reflects conventional obesity wisdom that 'you are what you eat' (Gamman, 2000). Foucault (1977) proposes that the act of

surveillance or, in the very least, the ubiquitous potential for scrutiny, is a "discipline mechanism" (p. 209) for encouraging adherence to social norms and 'rules'. In essence, obesity discourse draws strength and power from the underlying principle that the large-bodied person *can* become slim (and thus 'normal'/healthy/attractive) – if only some individual effort is applied, evidence of which can be gauged by an individuals' restraint (or lack thereof) in eating habits, food purchasing practices and efforts to exercise.

Exercising in public, however, proves to be a difficult negotiation between widely held assumptions of laziness and the ensuing ridicule or selective censure of exercise options potentially chosen. Both Selina and Angela spoke of the potential for being targets of abuse when walking around the streets or at the swimming pool, and for them, the risk of humiliation far outweighs any possible physical benefits. For Loreen, despite having lost a significant amount of weight over a decade ago, her corpulent body defies the exorbitant amount of time and effort she has made to restrain its' outward appearance. She described the unfairness of being judged as lacking self care on the basis of her current body size:

> *I really struggle because people look at you as if to say 'well you don't'...the impression comes across that I don't look after myself, but they don't know where I've been to recognise where I am at the time, and it's actually really hard even going to the likes of the gym because I feel like people are looking at me thinking 'oh'.*

Laura also expressed the dilemma of balancing exercise choice with self-preservation:

> *He/she (her general practitioner) said to go swimming. Again – I think this is where he/she has no insight. I don't think he/she is not compassionate, but I think he/she doesn't have insight into the self image and social things that fat people go through...all I thought was, one - I have to find togs my size, and two - I have flaps that hang where they shouldn't hang. It's that whole self image thing...*

There was a clear incongruence of interpretation between herself and her general practitioner (GP) about what constituted a reasonable form of exercise. For Laura,

'reasonable' was taking into consideration her ability to 'fit in' – with both the surroundings (level of public exposure) and the equipment required (level of body exposure). For the GP, 'reasonable' was a method of low impact exercise that would be compatible with Laura's chronic foot issues.

The perception of public surveillance was also narrated in terms of being looked at by other (slimmer) women as an object of fear:

> *...quite a lot of the times it's strangers and it's usually the younger ones, and it's mostly women...maybe they think they could get fat themselves...it's all that, you know, security bit.* (Monica)

> *...the older people are the ones' that look you up and down and think, 'Oh gosh', you know, 'Am I going to end up like her'?* (Theresa)

Participants often gave a precursory statement of perhaps being overly sensitive to this concept of being feared. Their perceptions, however, are reinforced by Schwartz et al. (2006) who revealed that slimmer women rate weight gain as so undesirable that they would trade marriage, fertility, mental health and a longer life span if it meant avoiding becoming obese. The ever present visual and moral repugnance of overweight/obesity serves as a reminder for women to maintain body vigilance. Assisted by social and medical governance which encourages and assists women to obtain femininity through controlling their bodies with practices such as dieting (Bordo, 2003; Hesse-Biber, 2007; Tischner & Malson, 2008), there is an implicit expectation for women to view the fat body as an object of fear.

For some women, this sense of being a spectacle for public amusement and judgement has lead to periods of social isolation. Angela provides a poignant example of collateral damage to the individual human experience whilst living large in a society that is saturated in anti-obesity campaigns which place gluttony at the forefront of the obesity 'epidemic':

> *I don't go out and eat in public if I can help it because it makes me so anxious that I feel sick...I take lunch at a different time at work because I don't like to eat if there are others in the staff room with me. I get so worked up about it, thinking they are watching and what they may be thinking.* (Angela)

Selina also considers the potential level of personal risk when making decisions about attending social events:

> *I would say that in social situations I think twice before even going...there are many times that I would just not want to go there because I don't like the way I look...you have to prepare yourself mentally before you go.* (Selina)

Similar to findings of Carryer (1997), these acts of self-preservation from potential/actual acts of stigmatisation, are both self-imposed and socially endorsed. Withdrawal from even the most fundamental aspects of daily living can have significant impacts on large-bodied women's sense of belonging and self acceptance – and ultimately their sense of health and health seeking behaviours. Goffman further suggests that when a spoiled identity (Goffman, 1963) is constructed on the belief that the individuals' discredited attribute is self made, disqualification from particular social life spheres becomes a powerful tool for the dominant group to control the opportunities and 'acceptable' locations of visibility for the stigmatised (Sprague-Zones, 2005). The act of control can be through weight bias attitudes that are either explicit, such as verbal abuse and publicly endorsed jokes, or implicit, an individuals' unconscious and automatic bias against the corpulent body (Schwartz et al., 2003; Teachman & Brownell, 2001; Vartanian et al., 2005). Consistent with previous studies (Carryer, 1997; Puhl, Andreyeva, & Brownell, 2008; Puhl & Brownell, 2001; Puhl & Heuer, 2009; Thomas et al., 2008) the women in this study described experiences of regular exposure to both explicit and implicit negative weight biased attitudes, across a multitude of contexts:

> *You get so many people now that are so quick to judge you or say something. I mean I get it in everyday life, at the supermarket, at the dairy, walking down the street...* (Angela)

> *It's not very nice having people stare at you...* (Theresa)

> *I remember my last relationship, we had this great row and he turned round to me and said something about 'you fat cow'...it's embedded in there and you try not to take it on board but you can't help it.* (Alana)

> *I feel like I don't fit into conforms of society. I mean everything you do you get people looking at you in particular ways and it sort of makes you feel like you*

shouldn't be there. (Loreen)

You hear people going on about fat people on the TV...just cause they can. But they forget that there's people with feelings out there...the media has got a lot to answer for...I don't think a lot of people really realise the effect that it's having on the fat person. I'm absolutely certain of that, otherwise they wouldn't do it. They don't do it intentionally. They just think that it's not a thing – it's not a personal thing, that anybody's going to take any offense. (Monica)

The premise of understanding perpetrators of fat stigmatising attitudes and behaviours as unaware and naive was a common belief amongst the women interviewed in this study, particularly for those trying to reconcile experiences of bullying and teasing within trusted relationships – such as partners, friends, family and health professionals. Yet literature suggests that the promotion and strength of stigmatisation is bolstered when the stigmatised trait can be explained and justified by the dominant group as a self made attribute ('you get what you deserve') and/or morally reprehensible (Crandall, 2000) – factors that feature strongly within readily available contemporary obesity discourses. Crandall further suggests that blaming the victim, teasing, bullying and explicit discriminatory practices are therefore consciously justified by the dominant group as being deserved and 'for their own good'.

4.4   Contending with feminine beauty ideals

Whilst the performance of both femininity and masculinity are constructed within a discourse of individual responsibility for bodily health and well-being (read – slim and controlled), the pressures of appearance as a signifier of worth is distinctly feminised (Tischner & Malson, 2008). Bordo (2003) and Hesse-Biber (2007) suggest that as a rule, women have come to accept that slim beauty standards are a matter of course for demonstrating social expectations of femininity. Certainly the literature indicates that women's upward social mobility (largely linked to income, career and relationship potential) is moderated by their ability to adhere to culturally enforced slim beauty ideals (see for example, Athukorola et.al., 2010; Averett et al., 2008; Conley & Glauber, 2005; DeBoni, 2000; Ministry of Health, 2006; Zhang & Wang, 2004). So if it has come to be accepted that a women's worth is wrapped around the bodily self, how do these large-bodied women

describe *their* bodies and how do they 'fit' within a highly feminised culture of fashion, aesthetic judgements, bodily exposure and social desirability?

In a society which has prolifically espoused dualist frameworks of fat/ugly and slim/attractive, and by normalising slim ideals, the visibility of a large body means that the ability to 'blend' in and avoid becoming a target for stigmatisation is difficult. Laura summarised the sentiments of several of the women in this study:

> *The thing is that people notice overweight people. If you were just a normal sized person, people wouldn't even notice or look at you. But being overweight, people do stare and you do stand out...it's almost like being special needs. You know, people look or stare at people with special needs walking down the street and I think, people look at overweight people the same way.*

Laura's use of the term 'special needs', whilst comparable to obesity on the basis of being a visually identifiable discrediting trait, is at least acknowledged as being 'not their fault' and usually met with some degree of sympathy (Goffman, 1963), and certainly there are legislative acts in place to protect those medically defined as disabled from (at least explicit) discrimination (Ministry of Justice, 1993). Obesity as a socially-constructed disability (Carryer, 1997), and yet equally a visual cue for categorisation and potential condemnation, remains unprotected by any legal or moral codes of conduct (Harcourt & Harcourt, 2002).

Acknowledging the construct of slimness as sign of 'normal' feminine beauty and virtue, several of the women spoke of expected assumptions of others, drawing on a discourse of 'obesity-as-an-implied-aesthetic-flaw'. Laura relates back to a sense of public surveillance of the overweight, but then clearly demarcates judgement of attractiveness as a distinctly female construct:

> *Nobody looks at a fat person and thinks she's attractive.* (Laura)

Selina's observation, during a discussion about the demise of her previous relationship, suggests that for her, slimness is a quality that is more likely to attract a partner:

> *...what guy do we know, or anyone know, that would choose a large women*

over a skinny one...I don't believe that many would. (Selina)

The women in this study also spoke about ways they attempt to hide or conceal their bodies, and they did this in several different ways. Some women choose to socially isolate themselves, or limit their participation in activities that necessitated public exposure and posed high risks of stigmatisation, such as the previous examples of Angela's avoidance of eating in public and Selinas' mental preparation before attending social functions. For many of the women, clothing is used as an instrument of disguise, an attempt to render themselves as invisible as their body will allow:

> *I buy a lot of clothes that are plain. I don't want to stand out in a crowd because obviously deep down inside I'm not happy about the size I am and I...I <u>say</u> I accept who I am but I don't really deep down think I do.* (Alana)

> *It stops you wanting to try and look nice because it means you have to look in the mirror. The more I can wear to cover up the better...I'm not stunning as it is.* (Loreen)

Further to this subject of fashion, several of the women spoke about the difficulty of finding clothing that was comfortable and stylish at an affordable cost, some acknowledging that they resort to a 'uniform' of oversized T shirts and track pants. With a sense of frustration, not fitting into 'standard' sized clothing was just *another* example of their perceived and actual isolation from socially normalised sites of 'performing' femininity.

However, despite the prolific and imposing nature of feminine slim/beauty norms within popular culture, participants showed evidence of ways in which they resist these messages and have come to understand the media spin as an issue of social control:

> *Look at those models on TV, they just look heinous. The thing is it is a societal concept that we have to be skinny, that we have to be this or that. It does my head in cos' I'm not going to fit into that.* (Alana)

I think it (slim ideals) has got something to do with the top models and that. Those people are really skinny and some of them are unhealthily thin. Why can't we be fat though? (Theresa)

They say you are a nice person if you are skinny but you are horrible if you are fat...that large women aren't sexy...but who decided that large women aren't sexy...or pretty...or healthy? (Angela)

Despite a shared condemnation of social stereotyping, several of the women's narratives highlighted a distinct blurring of the lines between who is classified as 'them' and 'us', realising that they too are active participants of social control when they critically appraise the bodies of other women:

I do find that a lot of fat old tarts like myself and my mates – and I try and refrain from it – do comment on other people as well, that are big. Like I heard the other day, 'Did you see that?' or 'Have a look over there', and I'm thinking, please don't do that, we're in the same position, you're in the same position. I try very hard not to do it, and I don't think I do, but maybe I do? When we fatties do it, comment and stare, it just amazes me. (Monica)

Literature suggests that overweight/obese women internalise the social stigma of overweight stereotypes and demonstrate levels of weight bias similar to those held by non overweight/obese women (Carryer, 2001; Latner et al., 2008; Latner et al., 2005; Schwartz et al., 2006; Vartanian et al., 2005; Wang et al., 2004). Surveillance, condemnation and a lack of solidarity between members of a stigmatised group demonstrates the power and normalisation of social control processes within a society (Paquette & Raine, 2004). In other words, if you can recognise that there are others you perceive to be larger than yourself (and therefore a 'worse' example), internalised weight biases applied to yourself can be *justified* and thus applied to other large-bodied persons.

The various levels of awareness and internalisation of slim beauty standards by these large-bodied women have potential consequences on how they both view, and expose their bodies. Acts of self-preservation, such as isolation and concealment need to be acknowledged as contributing factors towards these

women's ability to trust those that require intimate viewing of their body, such as health professionals, not to judge and further perpetuate stigmatising practices.

4.5 Summary

The thin sculptured female body holds considerable currency in society, whilst corpulent bodies have become normalised targets of prejudice, stigma and shame. The women in this study have described ways in which they encountered, negotiated, interpreted and internalised their lived experiences with stigma, across a variety of locations and stages of life. Before they even enter into the domain of health care, they have been labelled as lazy, gluttonous, ugly and stupid – socially diagnosed as having a self-inflicted disability and widely prescribed as needing to be 'fixed'. It is therefore not surprising that they enter into all encounters with health professionals carrying a considerable emotional burden.

In the following chapter 'Living large and negotiating health', the participants own interpretation of health will be explored. These narratives of managing and seeking health co-exist within a health care environment that actively instructs, both patients and healthcare professionals alike, that large-bodied persons are inherently unhealthy. Yet, despite increasing social and medical censure, these women negotiate and interpret health in ways that have meaning to *them*, which can, at times, directly challenge conventional medical 'wisdom'.

Chapter 5   Living large and negotiating health

5.1   Introduction

The previous chapter, 'Living large with stigma', set the historical and social context of these women's experiences of weight based stigmatisation. Before proceeding to a discussion on the themes that dominate this chapter, 'Living large and negotiating health', the conceptual relationship between the preceding and following chapter will be reiterated.

As has been shown, exposure to weight bias and prejudice across multiple locations and periods of time has been a dynamic and subjectively defined experience for these women. Allocated the position of 'other', in terms of both gender and body size, all these women demonstrated, at least on some level, interpretation and internalisation of social slimness ideals. From a post-structuralist perspective, this contextualising material cannot be disregarded or read in isolation (Weedon, 1997) because it is a contributory aspect of an individuals' constructed meaning of obesity. Furthermore, as shown in chapter three, social constructions of obesity are innately entwined and exacerbated by the primacy given to biomedical explanations within the discursive field of obesity.

Although argued as tenuous claims to truth, the master narrative of medical teachings about obesity is that fatness is an indicator of ill health and implicated as a precursor to a host of medical conditions (Campos, 2004; Carryer & Penny, 2008; Eagle et al., 2003; Gard & Wright, 2005; Jutel, 2006, 2009; Monaghan, 2005). Biomedicine actively imposes the 'problem' of obesity to society from a position of governance over all things pathological. As members of greater society however, all health care professionals have access to the same competing discourses of obesity as others. Yet research has shown that, for many, adherence to the dominant yet unfounded theory of thermodynamics is evident through the uptake of universal social views of the overweight and obese as being gluttonous and lazy (Epstein & Ogden, 2005; Foster et al., 2003; Hebl & Xu, 2001; Poon & Tarrant, 2009).

This chapter, 'Living large and negotiating health' will examine the participants own interpretations of health and well-being. What follows is an insight into the

ways in which these women navigate the general practice domain. Armed with coping strategies they either, 'put up with' or 'deal to' their perceptions of health care professionals (HCP) attitudes towards their body size. These issues will be discussed within the themes of 'Perceptions of health' and 'Pursuing health'.

5.2   Perceptions of health

Descriptive labels for the body are, in themselves, sites of power for medical/biological obesity discourse. Terms such as overweight, obese and morbidly obese, are all terms of reference that position the large body as 'other', the dualist opposition to 'normal' and a means of categorising individuals in an objective and numerically defined way (LeBesco, 2004). Far from neutral terms, the frequency and acceptance of these terms in everyday language, along with their pre-loaded assumptions and stereotypes, means that it is a powerful site for further polarising the large-bodied from the 'normal' and the 'healthy' (Price, 2009). For Selina, categorisation as morbidly obese meant that she was automatically entitled to a free flu vaccination. But for her, the term morbidly obese implies far more than her weight to height ratio:

> *It is embarrassing when somebody points out that you are morbidly obese. I think the words 'morbidly obese' always make me think that I could drop dead at any minute – I hate that term.*

The Body Mass Index (BMI) and oversimplification of weight being a proxy for health was also a point mused upon by women in this study, who were able to intellectualise the contradictions of this notion from their everyday experiences:

> *That's what annoys me ay! The BMI...I just look at the scale, I just can't work it out. You get really, really skinny people and they are the only ones that fit within the normal category...it's like some people who have a high cholesterol and are so flippin' skinny, and then you can get someone who is a bloody size 28 and their blood sugar is low and their cholesterol is low...and you think 'how does that work'?* (Alana)

> *The BMI is really bad. It should be shifted. I've seen thin people that say they've got to lose weight and it's wrong...* (Theresa)

Notwithstanding the dominant beliefs and teachings of bio medical obesity discourse, the women in this study showed that they were able to hold several interpretations of what constituted health for them, and for most, this was certainly not defined by the number of kilo's they weighed in comparison to medically defined norms. Perceptions of health are wholly contextual and individually specific, however there were several domains of daily living that similarly moderated these women's sense of well-being, including their physical ability to do things that they wanted to do and the presence and degree of impact on their lives from chronic pain conditions.

Most of the women in this study, whilst acknowledging that their bodies defy medically defined norms for health, described themselves as being healthy. Consistent with the findings of Buxton's (2010) study, recognition of risks widely reported to be associated with obesity, were central to these women's definition of well being, and for many, the absence of any such conditions was viewed as a sign of good health:

> I don't have any heart disease and blood pressure hasn't been a problem. Joints, well I don't think I have any problem other than the usual wear and tear as you get older. I find it harder to get off the floor than I used to...but no – I'm pretty much healthy. I don't spend a lot of my time at the doctors'. (Selina)

And Theresa:

> I don't have diabetes, I don't have high blood pressure...so really, I only go to the doctor twice a year, because I'm not sick.

And Maggie:

> I don't smoke. I hardly ever drink. But I'm on a bit of medication for blood pressure, and I know the only way I can get that down is go swimming...I don't like it, but you know, it's being motivated to actually do something, and I think the older you get the harder it gets as well.

In contrast to similar studies (Buxton, 2010; Merrill & Grassley, 2008), apart from one participant with diabetes, obesity implicated conditions were not a feature of these women's interpretation of health. However, chronic pain was a frequently

discussed aspect of these women's definition of well-being, with the most cited source of pain being muscular-skeletal. For these women there was a sense of frustration between their desire to be more physically active and living with daily pain which creates a significant barrier to doing so. Angela's chronic arthritic condition means that even brief periods of physical activity results in both physical and emotional anguish:

> *I know that if I could go back to my fittest time I would lose the weight. But I seize up, fall over or collapse just going to the letter box, and this is a daily thing for me. I know exercise is important, but I just can't. It's not just an excuse. One thing leads to another and all of a sudden you are really fat. I don't exactly wake up each morning and think 'I love being in this grotesque body and I am going to keep it'. Do you think it's a conscious choice? Like I am too lazy to do anything about it...* (Angela)

Both Loreen and Laura have ongoing issues with a painful foot condition, which impacts on their ability to walk long distances, whilst Theresa has osteo-arthritic hips and Maggie has a degenerative knee condition. Most of these issues were as a result of previous injuries, some from as far back as adolescence and early adulthood. Each of these women had actively sought support and various treatment modalities from health professionals, some for a period of over a decade, and each had been dismissed from treatment options on the basis of their weight. The irony of the situation, being told to lose weight yet their inability to exercise effectively (thus possibly reducing their chances of weight loss and/or overall fitness), was not lost on these women, as Loreen exemplifies:

> *I've had a bung ankle for years and ACC won't even let me go for treatment for it to be loosened off so I can carry on doing stuff...they're saying that they can't fix it because 'I'm too old and I'm too fat' was the exact words that ACC used...I've lost 50kg, if I can't get out to exercise as much as I would because plays up so severely, how am I supposed to lose weight so that I can get it fixed?*

Yet, despite their limitations and medical disregard towards their physical disability, all these women '*put up with*' and push past the pain in an effort to '*keep*

going'. Maggie best summarises the sentiments of these women in the following excerpt:

> *You know, I don't sit around and feel sorry for myself, that's not me. I'll just keep going no matter what. But there's things I'd still like to do and I get frustrated because I can't do them because of my weight or because of, basically the pain...it's not something that I really dwell on. I'm too busy to dwell on. You know, my days still full and I try not to let it slow me down. I'm always on the move. I don't sit around thinking 'oh I can't do it because I'm big. It doesn't come into it. I'll still have a go.*

Corresponding with the findings of Harris, Bradlyn, Coffman, Gunel and Cottrell (2008), some of the women in this study considered themselves to be more healthy than those who are slim/'normal' weight. This act of direct resistance to the commonly endorsed notion of fat being a sign of ill health is evident within the following excerpt from Alana:

> *Now you can't tell me that those models...you can't tell me that a person who eats a lettuce leaf a day is actually healthy versus someone my size...ok who might be a little out of shape and get a little out of breath because I walk a long distance or whatever...but in the end who's the healthier one? But they think she <u>looks</u> better than I do...the thing is – we have more to come and go on.*

Although the women in this study described themselves as healthy, many also spoke of their body size as a barrier to feeling a complete sense of well-being. Selina, Laura, Alana, Monica and Theresa, whilst initially reporting that they were 'comfortable' or 'ok' with their weight, then (perhaps as their level of comfort with me increased) began to describe a sense of tension between what they 'ought' to do/think or feel and how they actually experienced their body. Again, and contrary to conventional medical teachings, their ability and desire to be more physically active was central to their feelings of being 'unhealthy', not any direct measure of actual or potential pathological status:

> *I am certainly not happy with the weight I'm at, because I do feel unhealthy. I don't feel fit and active as I would like to be. It's not necessarily the size that*

bothers me but the fact that I would like to be more active. So in that sense, you know, I kind of feel a bit fatigued and tired. (Selina)

I would love to be thin because I would love to do more stuff with the kids physically. I don't think I like anything about being fat actually...yeah I can't say I like anything. But I'm not, well sometimes I am, but on the whole I'm not <u>desperate</u> to be thin...it would make my life easier...but at the same time, as much as I would like it, I don't hate myself because I'm not. (Laura)

I talk about myself being obese, but I mean – ok I am, but there are a lot of women out there who are bigger than I am...I think I should probably lose some weight, but I think the more you think that and the more you focus on it...is it gonna make me...if I'm a size 12 am I actually going to feel better about myself as a person? I don't think it does. (Alana)

...to be honest, I'd like to lose a lot of weight. I'd like to be just not noticed for my weight...'cause I'm sure that's what it is at the beginning, (Monica)

They (health professionals) do try to encourage me to try and lose it (weight) probably because it would be better for myself. But who's to know? I mean, I'm quite happy. Why should I have to be thin? I'm quite happy. I want my hips done so I'm going to have to lose it because they're not gonna do it. Otherwise I'm just gonna die with bad hips and (laughing) they're gonna have a job getting me in the coffin. (Theresa)

Despite being exposed to multiple sources of health teachings about the inherent health risks of obesity, the women in this study were able to articulate their own interpretation of health – by negotiating between various discourses of well-being. For them, health was not merely defined by the presence or absence of disease, but their ability to physically participate in activities that have meaning for them. Negotiation with medical and social stigmatisation, chronic pain, feelings of dis/satisfaction about their bodies and their sense of self worth are all factors that impact on these women's perception of health, and ultimately influences their sense of self agency towards pursuing and/or maintaining their state of health.

5.3   Pursuing health

Health literacy (World Health Organisation, 1998), that is "...the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health" (p.10), is a means to recognising that health care messages are interpreted by recipients as intended. Mass media, a contemporary vehicle for widely disseminating public health messages, frequently imparts the medical stance of health as an individual pursuit – for the good of oneself and for society in the main. There is an expectation that individuals can, and should, practice health seeking behaviours like eating healthfully, exercising regularly and being vigilant about alterations to their body and sense of health. It is also expected that one will dutifully approach their primary health care provider at least annually for a routine 'check up'. Deviation from these expected norms of behaviour, or in the case of obesity – the visual cue of assumed deviation from health seeking behaviours, has resulted in an amplified effort to fight the 'epidemic' of individuals who seemingly ignore the perils of over-consumption and indolent lifestyles (Campos, 2004; Gard & Wright, 2005; Puhl & Heuer, 2009). These often hysterical and unchallenged claims (Gard & Wright, 2005), further perpetuate the 'justification' for highly censoring the overweight/obese individual – but often with no regard to the actuality of their health care practices.

Similar to the findings of Merrill and Grassley (2008) and Buxton (2010), these women narrated health in terms of their own sense of self agency. Acts of compliance to medical norms, such as health seeking behaviours, and acts of resistance, such as health care avoidance, were described as a form of response to imposed assumptions of health care professionals that they are unhealthy and lacking in self care.

The majority of the women interviewed, whether physically restricted or not, made concerted and sometimes painful (including emotional) accomplishments of regular physical activity. Each recognising and interpreting that, for them, health seeking behaviours were innately linked to optimising their physical fitness. Furthermore, self appraisal of dietary habits was a central concern to these women's perceptions of health. There was a distinct disconnect from social and

medical assumptions of overindulgence and 'improper' eating by these women, with many at pains to assert that they were very aware and vigilant towards ensuring they ate a healthy diet within the constraints of their individual circumstances, such as finances, time and family commitments:

> *...it's all very well for a dietician to sit there and say you have to have this many fruit and vegetables, but in my case, that would nearly double my grocery bill. It's easy for them to tell you all this stuff but when putting it into practice it's not always practical...* (Selina)

Determinants of health, that is – factors which impact on the health status of an individual, such as income and social status (World Health Organisation, 1998) - is a salient point to consider when acknowledging the lived experiences of large-bodied women, not least of which because obesity/overweight is positively correlated with being female, lower income levels and high household deprivation scores (Ministry of Health, 2006; Turley et al., 2006). Many of the women in this study cited frustration and anger at public health messages pushing for healthy food options, whilst showing little regard to the impact of the cost's on their social circumstances.

Simultaneously, many of the women spoke in terms of good/bad food, demonstrating, at least on some level, that they have internalised medical and social constructions of what a large-bodied person should or should not eat. It seems that the controlling practice of surveillance not only impacts on their eating habits in public, but on their own self assessments of adherence to social eating norms whilst in the privacy of their own homes:

> *I'm not a food fanatic, like there's days I just can't be bothered with food, I won't eat. But then I probably eat the wrong things, you know? And if I get stressed – 'Right, what have we got'? Comfort eating. Which is probably normal.* (Maggie)

> *...to be quite honest, if you put what I eat in the day, although obviously sometimes it's not that great, give that to a skinny person and I don't believe they would gain 30kg in whatever time frame. I don't believe that at all.* (Selina)

Corresponding with other studies (Buxton, 2010; Carryer, 1997; Merrill & Grassley, 2008), the women described attempts to control their bodies in terms of battle. There was a sense of discord between health messages that oversimplify the message to '*just lose weight*' and their reality of a body that is constrained by physical limitation. Many spoke of the fruitlessness of dieting and recognised the arduous task of losing the weight through near starvation – just to '*gain it all back again and then some*':

> *When I hear of kids that are going on diets I think, please don't. Cause once you start you are on the wrong road, you'll never get off it. You get your weight off and then as soon as you go stupid and have the first thing wrong, you go back and put it all back on again...and a little bit extra. This is how you build up the weight usually. But you learn that from experience...I know that now, looking back.* (Monica)

> *(On dieting)...some just go from one extreme to another and I feel I haven't got the time or the energy to do that...* (Alana)

> *It's really hard to lose weight unless I...you've got all these diets – fine, you can take pills, you can get all sorts of things but it doesn't help unless you are moving a bit. I did ask for some pills once...'would they help'? They (general practice) were really good in a way because they said 'no'.* (Theresa)

For some, giving up this yoyo dieting regime is a natural consequence of being faced with unrelenting pressure from healthcare professionals:

> *I feel some doctors in the medical practice actually have a lot to answer for people being big. There is some, not all, but there is definitely some out there that part of the reason why some people are so big is because they make us give up...give up trying. Why try 'cos you will never succeed'...It's kind of like, once they programme you, it's hard to change the programme.* (Loreen)

A lack of trust in the health care system to help them to negotiate the difficulties of healthy living was a common thread amongst these women's narratives. Similar to other studies (Buxton, 2010; Carryer, 1997; Merrill & Grassley, 2008), many spoke of frustration with a lack of appropriate, effective and/or respectfully offered advice

when discussing the issue of their weight with their health care provider (HCP) in general practice.

> '*I look at them and think that they are only doing what is fed to them. They give you the fear (of weight-related health problems) but they don't give you a lot to resolve the issue if you desire. I have asked several times for assistance with my weight issue and haven't really been given the solution or tools that I need to help with that. I think they are too scared to approach it and don't know how to approach it without being negative or scaremongering. And I think skinny people certainly don't like telling bigger people how to lose weight – and if they do then I do think it comes across as quite patronising.* (Selina)

> *He/she said that the only thing I could do is lose weight. I thought 'yeah right'...between my (metabolic disorder) and the fact that I can't walk...* (Laura)

For some, 'lectures' about lifestyle changes had been given by HCPs amid assumptions of the women perhaps being ignorant about 'good' food and exercise choices:

> *It was very good practical food healthy food information, but I knew that already. I've heard it a billion times over. It's drilled into our heads...* (Selina)

> *It's all down to the way I am. The way I look and the way I am received. Because I don't want the lecture. I know the lecture – so don't frickin give it to me! It's almost like a power play because you have this person who's like a size 12 or so dealing with a size 18 or 20 and giving that sort of 'friendly' chat about their eating habits. Does it not make them feel good about themselves? It's that power and control thing. 'I'm telling you, because look at <u>me</u>'.* (Alana).

> *I've been told I eat too much fruit...probably because there is too much sugar in it...* (Theresa)
> *Is he/she supposing you're eventually going to get diabetes?* (Researcher)
> *Um, I think everyone is...but I've never had diabetes. I've never had anything wrong with me really* (Theresa)

Unsolicited advice by health professionals, particularly from nurses, was an occurrence frequently mentioned by the women in this study:

> *Even though I now have a lovely doctor, the nurses can be very uppity and judgemental. They have these suggestions like, giving me advice on food. But she had no idea about my life and yet she is trying to give me advice. I reckon the nurses just think 'oh well she is just getting fatter'...it's the way they speak to you – the tone they use like you are stupid. She speaks to me like I am a five year old.* (Angela)

Whilst Maggie was chaperoning a family member during an appointment with a practice nurse, the focus of weight management was quickly shifted to herself:

> *We were just talking. I got her weighed and we were talking there and she said, 'nana needs to lose some weight as well'. She said 'do you want to go to a dietician?' and I said, 'yeah, ok then' – I'll play your game...* (Maggie)
> *Did she even ask what your diet was like before offering to refer you to a dietician?* (Researcher)
> *No. She assumed, because I am big...but I didn't go.* (Maggie)

This exemplar demonstrates how unsolicited advice based on assumptions about an individual and their body size clearly breaches both the Code of Conduct for Nurses (Nursing Council of New Zealand, 2009) and Code of Patient Rights (Health and Disability Commission, 1996). Maggie was *not* the patient in this consult and thus did not enter into the encounter with an implicit expectation of advice or care. Assumptions about her health status and lifestyle behaviours were based on the nurses' cursory assessment of her body size and were inflicted upon her with little regard to rights of privacy and dignity. Whilst Maggie did give consent for referral, it was obtained under duress and most certainly not executed in a mutually respectful and fully informed manner.

Of note within both Alana's and Maggie's accounts of engaging with general practice is their use of the terms 'power play' and 'game'. In context of the 'battle', these terms suggest that, as large-bodied women, they feel they enter into the realm of health care services in a somewhat powerless position, as pathological beings rather than equal partners in a health care relationship. Several of the

women stated as much when they spoke about their altered role and personality when entering into the general practice domain. Some labelled themselves as typically 'strong', 'independent' and 'assertive', but when confronting HCPs they sometimes felt passive and put upon:

> *It's the different roles that we have. I think when I was married I was more assertive with work because that's where I could be, because I was the one in control. But when I go to someone else for a service then I am no longer that person in control...* (Alana)

Maggie, who works in a challenging environment which demands her to be authoritative, described her disbelief at the way she consistently '*puts up with*' her GPs nonchalant attitude towards her ongoing knee condition. Others spoke of bracing themselves for defence before entering the general practice domain. Some used humour or chattiness to deflect possible comments about their weight:

> *I get into them before they can get at me. It is a protective thing. I get straight in and I'll start waffling...it is a self conscious thing...I didn't really realise until I was talking to you that that's actually what I do...* (Monica)

Selina, in describing her use of advanced apologies for her weight, stated:

> *I do it a lot, I say that I'm not in denial. I know that I am overweight. And that is usually my opening sentence when I am seeing them (HCPs) for anything* (Selina).
> *So it's like your disclaimer?* (Researcher)
> *Yes. It's like opening the door because, ok, yes I know I am fat and now I'm waiting for you to tell me what I should be doing about that. I laugh, but that is probably a mechanism that I use to cover the embarrassment.* (Selina)

Others felt they had to be more assertive which they felt was sometimes interpreted as being combative:

> *...the moment they start talking about it (weight) there's just this whole defense wall that comes up.* (Loreen)

...I think they think I am aggressive...what comes of me being assertive is being able to show a bit of self worth and they just have to cut it down because, that person is too fat to be able to feel good. (Angela)

5.4   Summary

Large-bodied women negotiate their health within a nexus of social and medical values which regard large-bodied women as unattractive, lazy and unhealthy. Medical teachings perpetuate the notion of body size as a proxy for health status by assigning labels such as *over*weight and *morbidly* obese, labels which serve to frustrate these women when they, in fact, interpret themselves as healthy. Yet there is a constant 'battle' for these women to traverse the constant exposure to illness teachings from biomedical obesity discourse, social perpetuation of these health values and their own interpretations of health. Many of the women spoke of their chronic pain from physical disabilities, how they have actively sought treatment options from their HCP in the past only to be faced with an attitude of ambiguity and despair about their worth for support. It is perhaps no wonder, that these women approach the general practice domain with an air of uncertainty and distrust, when previous encounters have shown them that HCPs focus on weight loss spiels with no regard to their patient's personal context.

This chapter provides context as we head into the following chapter, 'Living large and accessing health' which examines these women's views of experiencing the general practice consult.

Chapter 6   Living large: accessing health care

6.1   Introduction

The following themes of , 'Respecting the whole person' and 'Feeling safe to access care' will provide some insight into these women's experiences and interpreted meanings of being a large-bodied woman and accessing general practice services. Several of the women in this study spoke in dualist terms about experiences of interacting with their general practice provider, referring back and forth between stories of previous and current providers. In this context, they showed that they wanted to, and were able to, compare and contrast qualities and practices of each healthcare provider (HCP) when expressing their opinions about what helped or hindered the HCP/patient relationship. Thus, where clarity is required, excerpts will be annotated at the outset as being attributed to either their previous or current HCP.

The final section of this chapter 'I want you to know...' pays homage to these women's responses when invited to directly tell HCPs what they need to consider to provide safe and respectful care to large-bodied women. For many of the women, having never been asked for views on this subject, this was valued as a safe opportunity to be heard and acknowledged as experts.

6.2   Respecting the whole person

Acknowledgment that the patient is a complex and multifaceted individual who has rights to respectful, non-judgemental and appropriate care is a fundamental principle of ethical and legal guidelines for the practice of all health care professionals (Ministry of Health, 2003b; New Zealand Medical Association, 2008; Nursing Council of New Zealand, 2009). However, corresponding with the findings of Merrill and Grassley (2008) and Buxton (2010), the concept of feeling that they are not treated as a whole person by their health care provider was a consistent concern raised by several women in this study. This theme, 'Respecting the whole person' captures how these women interpret the attitudes and practices of HCPs as either being respectful or dismissive of them as a holistically constructed being.

6.2.1   My weight should not define me

The women in this study want their HCPs to know that they have complex lives and that they have stressors and obligations which exist outside of the health care environment. In describing their lived experiences, many intertwined their historical context - such as childhood and genetic weight factors, with their current social lives, including financial, care giving, employment and social living stresses. They identified that they valued relationships with HCPs when they felt that they were viewed and respected as an individual. They appreciate and value HCPs who demonstrate a willingness to see past the corpulent body before them, showing interest in other aspects of their lives and acknowledging their personal history:

> *...just don't see the medical part of the person, of course that's what you are there for, but you've got to see the whole person first before you see what you're trying to 'fix', because a lot of its combined I reckon, well it's all combined really.* (Monica)

> *I managed to find another doctor and I was really, really lucky to get a good one...took years, talking to him/her and mentioning things. He/she would ask 'What's going on with this?'. He/she took an interest, and not just an interest in my weight, but he/she took an interest in my pain and my arthritis and other things that were happening in my life. Nothing to do with my weight at all...weight's not mentioned unless I bring it up. Like if he/she got a report from a specialist about my medical condition, he/she would ask about the medical condition that and not the fact that the specialists have talked about my weight.* (Angela)

Angela's interpretation of finding an understanding GP as good '*luck*' was indicative of these women's sense of serendipity about to access safe primary health care services. They were aware that whilst they have the right to change providers if desired, there is a scarcity of general practitioner options in this, and of course many other localities. In essence, those unfortunate enough not to be able to find an alternative general practice are forced to stay with their current provider. Those that have been able to enrol elsewhere have largely depended on 'luck' as to whether new providers would be willing to treat them as individuals irrespective of their weight status. The women's perceptions of what they believe constitutes a

'weight friendly' practice was one where they are '*treated as individuals*', '*the equipment fits*', the HCPs demonstrate a '*caring*', '*non-judgemental*' attitude and understand that large-bodied women <u>are</u> sensitive to stigmatisation because they *'get made to be'*. Of those women who have managed to find a supportive HCP, several cited that having a large-bodied GP conferred a sense of confidence, feeling that perhaps they were more understanding of the experience of being a large-bodied person negotiating a slim valuing society - and thus less likely to be judgemental:

> *I do feel very fortunate having the GP that I have. My GP actually has a, well if you want to a call it that – a weight 'problem', a similar weight as mine. So I don't feel that same level of stigma. I feel that my GP understands and doesn't necessarily make comment. He/she appears to be more empathetic and caring.* (Selina)

> *I now have a new GP in the same practice. <u>Normal</u> size! I never go to the GP but when I went to him/her twice in the past six months I felt comfortable going...because I just can. He/she just knows...I feel like I can say what I like to him/her. They are not going to judge me about my size because they are probably bigger than me...and that's why I go. I shouldn't see it like that, but underneath it all I'm still a woman who's overweight, regardless of my intelligence.* (Alana)

Laura described several conversations between herself and her GP about the ways in which overweight and obesity are portrayed in the media. For her, the openness of the dialogue was a positive indication that she was acknowledged as an equal contributor to the topic:

> *I was getting really paranoid about my weight...my GP wrote me a letter. He said that 'just because you are overweight it does not mean that you are unhealthy, there are a lot of very thin people who are very unhealthy'. Another time, we talked about the TV show 'The biggest loser' and he asked 'do you think it's realistic?' I said no it is not realistic because for one, most people cannot lose weight like that...we don't have personal trainers...a lot of us cannot afford the foods that are suggested...* (Laura)

Yet, whilst Laura stated that she felt that her GP was *'very professional'* and always ensured that *'the attention is on you'*, she also believed that he/she may still very well have some preconceived negative notions of her, but he/she doesn't *'make an issue of it'*. This view was reported by several of the women, demonstrating that on some level, the women believed that HCPs are capable and '*likely'* to hold negative views of them as large-bodied women. What differentiated these women's level of respect and positive regard towards their HCP was the ability of that HCP to demonstrate that they could bracket off these attitudes and deal with them as an individual:

> *They (the HCPs at her general practice) are very very good. They might go out the back and be human and say 'God did you see him' and this and that and everything else, 'Did you smell her' or something like that. They're not prejudiced about weight or anything like that. Well they don't <u>seem</u> to be...*
> (Monica)

For these women, despite the level of professionalism exhibited by their HCP, their consistent exposure to stigma has sensitised them to be wary and vigilant for signs of weight bias, and this – like the proverbial 'elephant in the room' is ever present within the general practice environment. As will be shown in the following section, their wariness is justified when they reflect upon examples of health care encounters when they have been blatantly disrespected and insulted by the very profession that claims to be caring.

6.2.2   Don't just look – <u>listen</u>

Similar again to the findings of Buxton (2010) and Merrill and Grassley (2008), the women in this study described their sense of frustration, anger and disappointment when their HCP dismisses or belittles their presenting problems. Many felt that their body size distracts the HCPs attention away from the presenting complaint and erroneously places their body size at the forefront of any diagnostic reasoning:

> *(Previous GP) It got to the point that everything about you was your weight. Whether you were sick, whether you went in for something like an infection on your leg – everything was about the weight. You're really sick and you have to see somebody. You would go in there and the file would be on the table, and I*

hated that he/she would never even take two minutes to read my notes, just look at me, see my weight and that was it. That was all the consultation would be about – whether I had the flu, chest pains, leg cramps, migraine, it was weight, weight, weight...(Angela)

The clash of these opposing agendas, the women wanting their health concerns to be validated, and the HCP situating weight as the primary concern, meant that the women often felt that they were not being listened to:

Don't look, but <u>listen</u>. That's the thing. If you could just blindfold them all... (Monica)

So what do you do? Stand behind a screen and just tell the doctor so he doesn't know what he is dealing with? It's the problem you are dealing with...not the fat. You've got to show you care and you have to listen. (Maggie)

I feel there is never a 'sit down - what do <u>you</u> want?' or 'what do <u>you</u> feel?' (Alana)

Going to the Dr's surgery...you go in there for maybe a fifteen minute appointment and they've got to fix something else and have to decide what's wrong with you really quickly and because it (body size) is so obvious – that's it, it's your weight. You leave and they go off on their own little life and they forget about you. But I have to live it every day, and for them it is no longer their problem. But for me – that fifteen minutes goes over and over and over in my head because it's quite important. I relive it for how long depending on what is said during that visit. (Angela)

Whilst the women in this study acknowledged that the general practice environment was often pressured and busy, they also wanted HCPs to take time to listen to their concerns. Several women reported incidences when their GP had walked to the door in the midst of conversation – signalling the end of the consultation:

Walking out on a patient when they haven't finished is just soul destroying in a way. It's like they're not interested, that they don't want to hear what you've got to say. When you sit and discuss what's wrong with you it's just like you

*are cut off, you're cut off at the knees. You don't get a chance to explain
everything, and at times I've been in there and I've been quite upset. He/she'll
give you a tissue but he/she'll still keep walking out the door. It's not often that
he/she will actually sit down and listen.* (Maggie)

Selina presented to her previous GP with concerns about frightening experiences
of sleep apnoea/paralysis and heart palpitations. Ever mindful of dire warnings
about the risks of cardiac issues in the obese, she eventually mustered the
courage to disclose these fears to her GP after a long period of avoiding the issue
because *'he/she might think I was making it up or paranoid'*. Rather than dealing
with Selina's fears, the GP chastised her for thinking she was having a heart
attack, replying to her requests for referral as having '*no point, they won't do
anything'*:

> *I still wanted to talk to him/her about something else but he/she got up and
> walked to the door and stood there like it was time for me to leave. He/she
> needed to listen to me and reassure my fears.* (Selina)

Alana expressed her anger at the fact that she repeatedly went back to her GP for
the same health concern and was not taken seriously by her GP:

> *Part of me would like to go back to my previous GP and say to him/her 'every
> time you treated me like a hypochondriac I've had to have surgery, how do
> you think that makes me feel'.*

Whilst many of the women explained that they needed to '*push*' or '*nag*' their GP
to get responsive action for their health concerns, others described themselves as
'*not forceful enough*' or '*too soft*' to speak up about their concerns. Consequently,
for most of the women in this study, experiences of accessing first point healthcare
from general practice was fraught with battles to be heard and, as Angela
eloquently summarises:

> *If you aren't going to listen to <u>me</u>, then why should I listen to <u>you</u>?*

6.3   Feeling safe to access care

Health care professionals are inherently ascribed a position of trust in the community, often there for your most vulnerable and precarious moments in life and death, and all the bits in between. 'Marketed' as a value neutral position within the complexities of social life, and found as a core proclamation in various HCP oaths and codes of ethics, there is an expectation that if there was one place in our society that you could feel safe from persecution and prejudice – it would be the health care system. Yet some of these women described experiences that demonstrated anything but a safe place to fall.

6.3.1   Stigma in the general practice experience

Several of the women spoke with a sense of resignation that stigmatisation was part of living in a large body, but there was a sense of disappointment that weight bias was also something they had to face within the confines of a health care consultation that promotes itself as a place of caring:

> *Now it's become acceptable at hospitals and other places like that. I don't need that. When you are ill, or you are sore, when something bad has happened, you certainly don't need it then.* (Angela)

> *It's this old judgemental thing coming in to it. They don't have the right to do that. Everybody is equal, doesn't matter what size they are, what culture, what anything...you know, stop doing that. You're a professional. You've been trained in medical school for how long to help people...a person who judges people because they are big, to me, is narrow minded and shouldn't be in the profession because that's not what they are there for.* (Maggie)

In addition to previously discussed experiences of weight serving as a proxy source for all their health concerns, several women also disclosed incidences when their HCP had subjected them to inappropriate 'jokes' about their size. Angela's previous GP had said to her, '*Have you tried swimming? Cos you would definitely float!'* and on one occasion, after falling and breaking her leg he said *'Did you think you would bounce?'* Other comments included, *'You're healthy, no under nourishment there!', 'Pheeww there is a lot of you'* and *'You're a big girl'.* She reflected on these experiences and stated:

> *The GP sort of joked about my weight like it was an 'in joke' between the two of us – but he/she was the only one laughing.* (Angela)

What may have been deemed as 'light hearted' remarks by this HCP, were in fact, thinly veiled personal insults and a purposeful attempt to humiliate her '*to make me feel bad enough that I won't go out and stuff my face'*. She has since changed her provider, and now enjoys a respectful partnership towards her healthcare needs, but these comments continue to haunt her.

These women enter into the health care arena with a desire to be treated with respect and dignity, not only in general practice, but in the specialist and emergency room settings to which they are referred. Several women spoke of their fear and purposeful choice not to disclose health concerns to their GP if it was likely that they would then be referred to other providers – particularly if they had no control over who the provider would be. All of the women in this study could provide numerous examples of incidences when specialists had verbally chastised them, 'joked' about their weight and/or demonstrated a body language beset with disapproval, rendering these women vulnerable and offended:

> *(The specialist) said shush. Then he was working out my body mass index and he got really excited and said I was the largest person he had ever had to treat. The whole thing after that was him just telling me how 'huge' I was. It was the words that he used – I was 'grotesque', I was 'enormous', 'huge', 'disgusting'. I said to him 'You can't talk to me like this' and he said 'Yes I can because you are just so disgusting and large'. You know – he hadn't even opened my file or asked any questions. He hadn't even asked why I was there. He just said my last hope was banding. He didn't treat me like a person at all...I thought, you know, maybe I deserved it cos' I'm bigger...but the appointment wasn't even about banding or my weight. But I got hammered on a really personal level about my appearance. It just floored me – it still floors me.* (Angela)

Theresa attended a specialist for a surgical opinion about her degenerative hip condition:

> *He said 'How heavy are you?' and I immediately said 'I don't know'. He said*
> *'Well that just tells me that you don't care'. And I thought – no it doesn't you*
> *silly man. It shows I'm too embarrassed to say'. He suggested 'Well, we can*
> *put you in a rest home – they'll make you lose weight'. I was only 60 years*
> *old!* (Theresa)

Similar to several other women who had been seen by a specialist and encountered comments, Theresa refuses to go back to him, or any other specialists for a second opinion, thus choosing to live with chronic pain rather than facing further humiliation.

Within these narratives is evidence of HCPs strong adherence to the belief that an individual actively chooses their body size. As a self appointed authority over all things pathological, these HCPs have seemingly assumed permission to be rightful persecutors and disciplinarians of these women's bodies. Their comments cannot however, be read as anything but rude, disrespectful and entirely inappropriate from a health care professional.

6.3.2 Trust is important

Trust is an integral component of the health care provider–patient relationship, particularly so for those who are, or feel they are, vulnerable. Selina spoke of her need for a 'circle of trust':

> *As a big person, you have trusted people around you but you wouldn't trust*
> *anybody else. Like once you have built a relationship with these people, yes*
> *you can trust them and you know you can approach them.* (Selina)

Angela also spoke of her need to trust a HCP to feel comfortable to safely disclose health concerns:

> *You're embarrassed because of your weight. You don't want people to look at*
> *you so you put things off until they are really bad. And then you've got to trust*
> *them, it took a long time to work up enough trust with my new GP*. (Angela)

Calnan and Rowe (2006) conceptualise trust as a futuristic term which reflects one's attitude towards an ongoing relationship, whereas satisfaction level, a measurement value often used in studies assessing quality of care towards large-bodied patients (see for example: Wee et al, 2002; Wadden et al, 2000), as largely reflective and focussing on the performance of the HCP. Segregating these terms is important because many of the women in this study showed that they were able to concurrently hold interpretations of the <u>actions</u> of their HCP as satisfactory, yet still harbour feelings of mistrust and low confidence that the HCP would be able (or willing) to take care of their health needs in the future. The following excerpt from Maggie captures the feeling of some of these women when they described their relationship with those HCPs they felt were intolerant or ambivalent about their size. Maggie felt that whilst her GP could satisfy her health care needs in acute situations, perceived weight bias in the context of conditions that could be blamed on her body size made her feel a sense of distrust that he/she could or would be as proactive with these issues:

> *I tell her/him what I want, I tell her/him what is wrong with me – he/she finds the solution, I get it. Whether it's only a temporary solution, it's giving me some relief or whatever. So if I got that I'm happy and I've got no pain or anything like that or it's an infection, it clears up and I've got what I want...I have talked to him/her about my knee issue and that I am still having problems with them, and it's like I get the nose up, the glasses down the nose and he/she just walks out...I've probably just about given up on him/her...*
> (Maggie)

As discussed in the previous section, many of these women were either uncomfortable or unwilling to discuss health care concerns if referral to unknown providers was a possibility. Within the general practitioner – patient relationship, there was also evidence that disclosure was avoided because they could not trust the HCP to treat them with dignity and respect. Theresa spoke of her frustration and lack of trust with a previous GP who was '*unprofessional*' and dismissive when dealing with her health care needs. Having heard firsthand the ridiculing comments and 'jokes' he/she had made about other people, Theresa didn't trust her GP. As a consequence, she avoided disclosing health concerns which may have lead to physical exams:

Even though he/she was unprofessional, you still had that relationship with him/her that had taken years to build anyway, and sometimes you go to the doctor and talk about personal things like cervical smears and things like that. It's personal to a woman, a lot of things that are wrong with her, and to even tell someone that acted the way that he/she did, well would you want to? Are you gonna get sort of poo pooed when you leave, oh – a big joke between them, him/her and the nurse? (Theresa)

As a consequence of this, she required surgical intervention for a precancerous condition that could have easily been detected sooner and potentially treated with non-surgical options. In addition to Theresa, and corresponding with previous studies (Fontaine et al., 1998; Wee et al., 2000), many of the women in this study admitted to either delaying or avoiding personal exams such as cervical smears and breast exams. Similar to the findings of Arambru-Alegria Drury and Louis (2002) the women cited embarrassment and potential humiliation of exposing their bodies as a significant reason for actively averting such procedures:

I choose not to go for certain things. I will avoid anything that will expose my imperfect body or go to the utmost extreme lengths...smears and all that exposing type thing unless I really have to. Probably it's due to the fact of how many bad times I've had with people that I just don't feel comfortable...you're constantly looking for responses. (Loreen)

You realise that you have to go, but when you have had bad experiences it doesn't actually encourage you to go back. (Alana)

Of those currently overdue for routine cervical screening, most had a history of experiences with a smear taker who made inappropriate comments, '*grunted and sighed'* excessively or demonstrated facial expressions that indicated the women were a '*nuisance*'. Some had been on the receiving end of comments such as '*It would be a lot easier if you were smaller'*. Many felt they couldn't trust not only that the HCP would constrain any negative bias that they may have about their weight, but that the equipment used would be appropriate for them and make them feel safe:

He/she had this narrow little bed thing behind the screen, it just felt really uncomfortable. (Angela)

...the width of the bed, you have to lie there with your arms sort of falling off the sides cos you have taken up the whole bed. (Laura)

I've had a note from the doctor or the doctor's nurse to say that I need a cervical smear and I won't go because, it's the wrong position...I won't have a smear unless they figure out another way to do it. The beds are very narrow...it makes you feel so vulnerable. (Theresa)

Only two women stated that they felt comfortable to approach their HCP for a personal examination. Angela, whilst confident with her GP, stated categorically that she felt the nurses at her practice were '*uppity and judgemental*' thus stating '*I'm happy to share things with him/her but not them*'.

Summarising the sentiments of many of the women in this study, Maggie stated:

I think when you go to a doc, you sort of put them up on a little pedestal. They're a professional, there to help you when you get ill. A doctor is up here (indicating hand above her own head height), it's like there is a list of people that you rely on in your life, and they would be along the same lines as police and fire brigade – doctor. They have to set a certain standard and if they don't do that, people lose trust, faith in what they're doing, you know, and don't feel safe. (Maggie)

6.4   I want you to know...

At the conclusion of each interview with most of these women, I asked them to tell me how they felt HCPs could make the general practice encounter safe and respectful towards their needs. Their summaries are presented verbatim, to honour this rare opportunity for them to share their experiential advice to the health care community.

I think that is difficult for anyone to walk in somebody else's shoes, but perhaps they could consider that and take into account, like listen to what they are going to say in their head before it comes out of their mouth. Perhaps do some research themselves, so they are up to date with different

reasons for obesity...I think they need to look at everybody's individual needs and a big person, often will have situations going on with them, there are all sorts of dynamics going on and if they can take that into account when they are talking to you and giving you options. (Selina)

I just think we should all be treated as individuals and I believe that large-bodied women have a built-in radar for when people are judging us. Lectures don't work... (Alana)

There is nothing worse, you feel really weird, really self-conscious and belittled when things don't fit. So if a doctor is trying to put a thing on you and it doesn't fit, or any other piece of equipment doesn't fit...just make sure that whatever you have is going to fit. (Laura)

I would like them to just be aware that losing weight is not easy. It's fine for them to <u>say</u> it's not easy – but it's not in the saying of it, it's in the <u>knowing</u> of it. (Theresa)

My expectations of a doctor are, you know, it's going back to what I remember of my family doctor as a little kid...really caring, and I think, is this the new way? Is this the new doctor of today? The whole world just seems in a rush, is this just part of it? (Maggie)

We're all the same, there's nothing different about us. We're a bit more flabbier, but other than that we're just the same, so don't treat us any differently. We've just got fat, that's what it is, get past seeing that. We've not done any harm to ourselves intentionally. We didn't do this – well we did do it, we didn't want it done. But it's done, and none of us want to be here like this. We would all like to be skinny and blonde and look like Barbie, but we're not. And if you are a GP, have a look at yourselves because I think GPs need to be well rounded, they need to not just study the books – but study the people. (Monica)

If only they could realise the implications they're having on people. I'd like them to actually see people for who they are, not for what somebody <u>else</u> has been. They may have had some people that have been 'failures' but they

don't know what's underneath that. I'd like it where they could see us as a
person, an individual – somebody that <u>wants</u> to succeed in life... (Loreen)

6.5   Summary

Trust, the faith and confidence in a person or system to provide for one's needs – especially when a profession confers their expertise and ability to do so, is a fundamental requirement of a therapeutic relationship. The women in this study spoke of their experiences with HCPs in terms of vulnerability, demonstrating an understanding that they entered the general practice environment with a well founded fear that their physical size exposes them to potential exploitation. The women in this study have described the ways in which they negotiate such behaviours – whether overt or perceived, by modifying their level of engagement with the general practice service. Lack of trust and feeling unsafe has lead many of these women to making active choices not to disclose health concerns to their primary health care provider and to avoid potentially lifesaving practices such as cervical and breast screening.

In the following chapter, the implications of these findings for both large-bodied women and healthcare professionals will be discussed.

Chapter 7   Discussion and recommendations

7.1   Introduction

The preceding three chapters have discussed seven themes that reside within the broad categories of 'Living large with stigma', 'Living large negotiating health' and 'Living large accessing health care'. Each of these themes was derived from analysis of the narratives of eight large-bodied women regarding their experiences of accessing general practice services. This chapter further explores the findings from this study and discusses implications for health care professionals' clinical practice and patient outcomes.

At this juncture I feel it is prudent to revisit the substantive research question in this study. In asking 'What are the experiences of large-bodied women accessing general practice services'? I sought to give voice to a marginalised and highly stigmatised group within the community of health care recipients. The fundamental purpose of this study was built on an understanding that in order to provide safe and respectful care to these women, it is important to identify and understand factors which either enable or disable these women's level of engagement with primary health care services. My own assumptions, as I commenced this study, were influenced by exposure to dominant obesity-related teachings within my clinical training and clinical practice experiences. Equally so, a growing awareness of contradictions within these teachings was a fundamental influence on my choice of analytical approach in this study. As outlined in chapters one and three, using a post-structuralist feminist approach enables me to 'unpack' and challenge dominant obesity teachings which currently influence both medical and nursing clinical practice, and socio-cultural understandings about women who are large-bodied. The interpretation that I present is my analysis of the verbal and non-verbal material collected during the interview process. I do not in any way claim my interpretation to be an all encompassing truth, but do present it as a glimpse, a starting point from which to begin to understand these women's experiences of accessing general practice services.

7.2 Discussion

At the forefront of this study, widespread stigmatisation of the overweight/obese, particularly for women as revealed in the literature, was presented as a core contributor to an individuals' sense of self and social positioning. Throughout the interview process it became clear to me that these women were acutely aware of their subordinate location within social hierarchies. They described ways in which they have encountered, negotiated and interpreted their lived experiences of stigmatisation, across a variety of locations and stages of life – persistently aware of not fitting within the socio-cultural and medical cultivated ideals of slimness as a sign of beauty and good health. They disclosed their most personal feelings of shame, embarrassment and humiliation as they recalled their efforts of adaption and negotiation with cultural norms which place the blame of obesity squarely on the individual as a morally and physically flawed entity. Evidently, these women access general practice services carrying a considerable emotional burden and an embodied sense of self which is inherently shaped by their experiences of battles for acceptance and respect.

When the women narrated their own perceptions of health status, there was a distinct disconnect between what these women have been instructed to 'know' about the health impacts of obesity, and their own interpretation of personal well-being. Many challenged the dominant understanding of thermodynamic theory which erroneously reduces obesity to an 'energy in versus energy out' equation. They contested discrepancies by drawing on their own experiential knowledge, recognising that their own journey to being large-bodied was influenced by much more than an assumed lack of sheer will and over-consumption of food. Unresolved physical disabilities, disordered eating patterns, depression, early influences on body dissatisfaction and the physiological responses of a lifetime of yoyo dieting have all been cited by these women as features of their lived experiences of corpulence. Accordingly, social assumptions and biomedical pedagogies that postulate these women as lazy, self indulgent, weak and ignorant are viewed as unfounded personal insults by these women. Many of these women have negotiated both significant social and physiological barriers to participate in regular exercise. They have spent an enormous amount of time and energy throughout their lives battling the pitfalls and pressures of managing diets, the

social censorship of food choices, eating in public, and their food purchasing practices. The absence of obesity implicated diseases is a source of pride and vindication for many of these women, their own bodily act of resistance to omnipresent messages and expectations of the fat body as a site of pathological failure.

This conflict between these women's experiences of obesity and biomedical teachings of obesity, presents a problematic paradox when these women access general practice services. The corpulent body is framed within medical discourse as a disease of epidemic proportions. Accordingly one would assume that this would warrant the overweight/obese to be treated with the same degree of sympathy and care as that given to others who have been afflicted by a 'disease' of some nature. Yet they are not. The overall impression from these women was their sense of being let down by their expectations that the health care system would be empathetic and sensitive to their personal needs. These women enter into the general practice domain with a heightened sensitivity to stigmatisation, and desperate to be acknowledged as individuals and not visual spectacles to be pathologised and unfairly judged. And their fear is justified. The women in this study provided many examples of explicit negative weight bias that they have experienced at the hands of HCPs. Verbal insults, inappropriate humour, negative body language, being ignored and breeches of dignity and respect are features of many of these women's experiential repertoire of both implicit and explicit negative weight bias from HCPs when accessing general practice services. Whilst many of the women described their experiences of social stigmatisation with a distinct air of resignation, 'it's just the way it is', expressions of frustration and anger were palpable within their stories of negotiating the general practice system. There is a sense of confusion and frustration that, whilst they are diagnosed as a 'health concern' and disease (albeit, 'self-imposed'), they are not embraced or respected as legitimate receivers of compassionate and respectful care.

What these women are saying is in direct contrast to the continual rhetoric of medical practitioners being lead providers of non-judgemental, inclusive, and patient-centred/person-focused care. As privileged providers of 'truth' within the health care sector, claims to scientifically based care and authority over the human body is a consistent and socially upheld theme within medical literature.

Increasingly however, medicine has pointedly begun to include claims of authority over the humanist aspects of a health care relationship (Clendon, 2011; Scott-Jones, 2009), an aspect which has traditionally been associated with (and widely respected by the public) as an area of nursing expertise (Carper, 1999; Clendon, 2011; Mackay, 2009; Zander, 2007). A salient example is provided within the New Zealand Medical Association's (2011) recently released consensus statement on the 'Role of the doctor in New Zealand'. Claims of primacy to the individual patient-doctor relationship are upheld by statements that doctors: "are committed to excellence in health care" (p.120), possess strengths of scientific intellectuality, non-judgemental behaviour, compassion and an appreciation of an individuals' context, all of which <u>deserve</u> the trust of patients and their families. In a similar vein, the Royal New Zealand College of General Practitioners (2011) clarify general practice as being:

> ... a unique consultation process that establishes a relationship over time through effective communication between clinician and patient...a patient-centred approach, orientated to the individual...dealing with all health problems...in their physical, psychological, spiritual, social and cultural dimensions...regardless of age, gender, culture or any other characteristic of the person concerned.

The Health and Disability Commissions 'Code of Health and Disability Services Consumers' Rights Regulations (1996) provides for ten rights of consumers/duties of healthcare providers. Among these rights is that which asserts a patients' rights to be treated with respect, dignity, effective communication and freedom from discrimination and exploitation. Whilst discrimination in this code is defined as that which is unlawful in accordance with Part II of the Human Rights Act (1993) - which incidentally lacks any mention of large body size as an individual characteristic which requires protection, there are implied moral obligations within varying professional standards. For instance, the Medical Council of New Zealand (2008) cites the following standard of clinical competence expected of registered medical professionals:

> You must not refuse or delay treatment because you believe that a patient's actions have contributed to their condition. Nor should you unfairly discriminate against patients by allowing your personal views to negatively affect your relationship with them or the treatment you arrange or provide.

Challenge colleagues if their behaviour does not comply with this guidance (p.11).

The issue of whether these expectations are, in fact, backed up by appropriate 'patient-centred' instruction within medical training programmes, is evidenced within the following statement from Ross and Kenrick (2011):

In our teaching we place a great deal of emphasis on instilling in our students an appreciation of the patient in his or her context; a context which can readily be appreciated from both the cumulative knowledge of a patient and his or her history, circumstances and preferences, and also the trust built up in the long-term professional relationship between patient and GP (p.14).

Whilst there was a paucity of examples of sustained clinical relationships between practice nurses and the women in this study, many did experience brief encounters which formed these women's opinions of practice nurses being 'uppity', 'judgemental' and frequent perpetrators of unsolicited advice. The proclamations of distrust and a lack of willingness to engage with practice nurses is concerning because it demonstrates that, on some level, the focus of holistic care in nursing education has not translated into professional and respectful regard towards these large-bodied women. The nursing profession produces a great deal of literature articulating the unique skills that nurses bring to the health care professional-patient relationship. Claims of non-judgemental care, empathy and respectful partnerships with patients are a core feature of both professional nursing guidelines and legal codes of conduct. Many of the philosophical underpinnings of nursing practice are found within The New Zealand Nurses Organisation's Code of Ethics (2010), which speaks to the moral grounds of nursing as a caring profession which is faithful to the principle of beneficence (to do good). Examples of underlying principles that influence the nurse-patient relationship include justice (fairness): "acknowledging and respecting a client's perception of fairness and perception of what would be an appropriate outcome for them" (p. 16), and fidelity (faithfulness): "promoting trust as an integral component of the nurse-client relationship" (p.17). Supporting the case of nursing as a uniquely holistic discipline, Clendon (2011) identifies several distinctive features of the profession which enables a clearer definition of the role of nursing in the New Zealand context:

The nursing approach is person and people centred, focusing on the whole person and the human response to health experiences, rather than a particular part of a person or a particular pathological condition. Nursing practice recognises that people's response to health experiences will include physical, psychological, spiritual, cultural, social and educational needs and will be influenced by the person's physical, social and cultural environment (P.7).

In spite of these aforesaid proclamations of patient-centred and person-focused care, why is it then that the overweight/obese women in this study have been unable to experience and thus describe consistently positive, respectful, holistically focused, clinically useful and non-judgemental patient care? The mismatch between the rhetoric and the actuality is inherently anchored to the traditional construction of obesity as a self-inflicted condition. Individual blame, as a key 'reason' and justification for the stigmatisation of the overweight/obese, whilst *originating* from the biomedical teachings of thermodynamic theory, is *perpetuated* by a powerful (and lucrative) weight loss industry that relies on the widespread social condemnation and fear of excess fat (Fishman, 2006; Hesse-Biber, 2007; Shugart, 2011). And yet, as revealed in the literature, all these assumptions and 'solutions' of obesity have been initiated and dutifully accepted as 'truths', when in fact, there is no coherent evidence to support these claims (Campos, 2004; Campos et al., 2006; Cogan & Ernsberger, 1999; Gard & Wright, 2005; Monaghan, 2005).

Entangled social and medical assumptions have become virtually indistinguishable from each other – and health care professionals are equally exposed to (and caught up in) the same onslaught of emotive and sensationalised messages that support a panic about obesity. Set against a backdrop of increasingly emotive and fiscally based discussions about limited healthcare funds, messages are constantly given to HCPs of the dire nature of excess adiposity as a significant cost to the health care industry (see for example, Ministry of Health, 2003; World Health Organisation, 2000). Corresponding with this, principles of thermodynamic theory continue to be given primacy within current New Zealand guidelines for the management of obesity in general practice (Ministry of Health, 2003a, 2009), reinforcing the notion that the overweight/obese need to be expeditiously

'educated' and managed as a primary health care issue. This notion of the overweight/obese being a self made burden to the health care system, is as much of a powerful component to the potential for HCP weight bias and stigma as social constructions are.

Yet, guidelines are just that – guidelines. They do provide room for professional discretion, respect for social determinants of health and knowledge of the individual patient's context to enter into the clinical decision-making process. It is in the individuals HCPs capacity to either demonstrate their professionalism and humanist qualities by modelling resistance to prejudicing practices/beliefs, or choosing to uphold stigmatisation and further disengage these women from primary health care. 'Better, sooner, more convenient' primary health care (Ministry of Health, 2010) for these women will continue to be nothing more than rhetoric if resistance is not encouraged, because the status quo of increased social and medical surveillance has seemingly backfired. Constant calls for body vigilance has effectually shut these women out of the very locations of health that they are 'encouraged' to attend – including socialising and exercising in public, screening opportunities that require bodily exposure and accessing first point of care health services. Even if one was to blindly uphold claims that these obese women are at risk for a multitude of weight-related conditions, this result of disengagement renders current practices as wholly ineffectual.

7.3 Recommendations for health care professionals – a way forward

The fundamental aim of the patient-health care professional relationship is that it fosters preventative health care practices and efficiently resolves or manages health problems in a way that is appropriate for the individual. This requires not only patient-centred care, but also a person-focused approach. The former shapes the way in which HCPs manage and negotiate the needs of patient's in the presence of a disease(s) or current condition, whilst the latter conceptualises the HCP-patient relationship as a process of accumulating contextualising knowledge about the patient, independent of disease focussed conversations and visits (Starfield, 2011). The utilisation of these two approaches in the care of these large-bodied women begins with consideration given to patient-centred care.

In the absence of patient-centred care, as demonstrated in this study, these women have experienced and continue to experience unmet health care needs. One example is that several of the women have actively chosen not to pursue such procedures as pelvic exams and cervical smears because of previous humiliating experiences. This is simply an untenable outcome of inappropriate HCP behaviour when one considers that obesity is cited as a significant risk factor for endometrial cancer in both the pre and post-menopausal woman (Fader, Arriba, Frasure, & von Gruenigen, 2009). Likewise, many of the women also admitted to feeling disempowered within the HCP-patient relationship, selectively disclosing their health care concerns according to their perceived level of risk for dismissal of their concerns as being weight focussed. The women in this study made it clear that the element of trust was a significant modifier to their level of engagement with their primary health care provider. Trust for these women, was inherently based on their faith and belief that their HCP would be sensitive to their needs - not abuse/belittle/'joke' or chastise them for their body size. Those that spoke of 'good' or 'great' partnerships, said they felt like their GP 'really knows' them, respects their attempts of health seeking activities and encourages them in a kind and respectful manner. They feel they are being listened to by their HCP because their needs are met in ways that do not always reduce the problem to that of their body size. In return, those women that feel respected, seek screening opportunities, disclose health concerns and feel safe to access care freely. In essence, they become engaged with the health care system and thus become partners in health.

It is beyond the scope of this study to comment with certainty about the implicit attitudes held by those HCPs who have established trustworthy relationships with their large-bodied female patients. The ubiquitous nature of fat vilification may or may not be an issue of significant contention as they negotiate their daily lives, but what is clear is that these HCP have shown that despite pressures to conform, holistic patient-centred and person-focussed care is possible.

Mutual positive regard is an essential component of the person-focused provider-patient relationship, establishing a foundation for trust and respect and encouraging future access (Starfield, 2011). This positive regard can be in acted in several ways, such as the language we use, the behaviours we express and the

physical environment we provide. Acknowledging one's own attitude and bias towards weight and obesity is a logical and useful first step towards addressing these issues. The Yale Centre for Food Policy and Obesity suggest such introspective questioning as: What assumptions do I make about people that are based solely on their weight? What stereotypes do I believe to be true of overweight/obese persons and what examples in my life have challenged these beliefs? Am I comfortable working with people of different body sizes and if not, how might this impact on my interactions with my patients? Do I have fixed views on what a 'good' patient should look like or act, and how does this affect my communication styles with different patients? (Yale Rudd Center For Food policy and Obesity, 2011).

Being aware of one's verbal and non-verbal communication is essential to establishing rapport with all patients, thus ensuring a communicative style that is respectful towards all kinds of marginalised groups, including large-bodied women. The burdens of stigma can render corpulent women sensitive to any nuances of language that reflect negative weight bias. Non-verbal communication can evoke just as strong messages of stigmatising attitudes as the spoken word. Time *is* pressured in general practice but this is no excuse for discourteous behaviour. Simple social cues such as making eye contact and body language which demonstrates active listening encourages and promotes respect. Answering questions and asking questions about their social and physical health – not just their weight, demonstrates to these women that they are being seen as more than just a large-bodied woman. There was no intention from these women to claim that the topic of weight should be avoided in all circumstances of patient contact. In fact, these women welcome respectful discussions about their body size IF it is clearly indicated as a contributor to their presenting complaint and IF it is done from a perspective of legitimate concern. These women have enough health literacy to know that blaming weight for migraines, viral illnesses and period pains is tenuous at best and most likely completely irrelevant. These principles also apply to being weighed – ask permission and respect their wish to decline if they choose. Wadden and Didie (2003) observe that the subject of weight, if necessary, is best received by large-bodied patients when presented as an invitation to talk. It takes just as much time to say 'you need to do some exercise and change your

eating habits' as it does to ask 'how would you describe your current eating/exercise level/habits', but only the second approach is likely to evoke any respect and clinically useful information. Consider also, that many of these women have spent an enormous amount of their lives battling with diets and weight loss practices. Their experiential knowledge should be viewed as an opportunity for learning - they probably know more about the intricacies and pitfalls of weight loss programs than the HCP does.

Another strategy that HCPs can use to eliminate weight bias and foster person-focused care into their practice is to ensure space for alternative obesity discourses to be heard and considered. Many of the women in this study demonstrated resistance to dominant teachings of obesity by negotiating their health within the discourse of 'Health at Every Size'. The irony of this is that, had their 'not so respectful' GPs and practice nurses allowed these beliefs and health seeking practices to be heard, they would have discovered that these women *do* in fact exercise regularly, eat healthfully and seek health - and that they did this for well-being, regardless of weight loss. Recognising that obesity is a complex, often poorly understood and socially-constructed disability (Carryer, 1997) fosters patient-centred communication. This means being prepared to listen to a patient's values and beliefs about their health and well-being, seeking out areas' of common ground and moving forward with a mutual understanding and agreement of plans of care. It also means publically educating others about the complex causes of obesity – being prepared to rectify the common assumptions and misunderstandings of obesity in daily conversations. An essential part of this is choosing not to participate in 'jokes' and insulting comments about the overweight/obese.

In addition to the spoken word, implicit messages of respect and acknowledgement can be communicated through ensuring that there is provision for size sensitive clinical tools/equipment and furniture (Aramburu - Alegria Drury & Louis, 2002; I. Brown et al., 2006). Providing chairs without arm rests was a common request by the women in this study, many speaking of the discomfort and fear that comes with being wedged and potentially stuck. Ensure scales are situated in a private room and that the numbers are not publically announced for others to hear. Consider the physical dimensions of the facilities, such as

bathrooms and consulting rooms and seek to mitigate any issues where space may compromise these patient's dignity and safety. Equipment such as large blood pressure cuffs should be readily available and used without comment. Many of these women found it uncomfortable to breathe when lying flat during cervical smears, consider offering extra pillows or elevating the head of the examination table to support their upper body. Another way of ensuring the physical environment conveys an attitude of respect is to resist conforming to social pressures to portray slimness as a feminine beauty ideal. Consider the reading material and posters in waiting rooms – actively seek materials that encourage healthy eating and exercise but don't portray the large body as a failure or weight loss as the ultimate goal of a healthy lifestyle.

Whilst the aforementioned practices may provide a challenge to some HCPs, one must not forget that these principles are grounded within the tenets of what HCPs claim to be extensively trained experts of – patient-centred and person-focused care. It is imperative that HCPs understand that for women, body fat is not just a physiological state but a burdensome signifier which influences other's responses to them on a very personal level. HCPs can contribute to the reduction and elimination of unjust weight prejudice by modelling appropriate behaviours, not only to their patients, but their colleagues, future HCPs and wider society.

7.3.1   The role of nurses to affect a culture of change

Over and above the previous recommendations made, I believe nursing has a particularly important part to play in the reduction of stigmatisation for large-bodied women. For over three decades nursing has both articulated and integrated holism into the development of professional nursing knowledge and practice. What began as an act of resistance and professional severance from the biomedical tradition of reductionism (Zander, 2007), has since resulted in a strong and unique nursing epistemology which views the individual as a whole entity, unified by mind/body and spirit (Watson, 2010). Core to many definitions of holism in nursing is that of Carper's (1999) four ways of knowing: the science of nursing (empirics), ethical knowing, esthetics (the art of nursing) and personal knowing (awareness of self and others). Nursing is thus regarded as a caring profession, and the foundations of our discipline must inform our professional practice. It is antithetical to nursing

philosophy that one would condone and/or allow the perpetuation of prejudicial acts towards any individual or group, particularly when the justifications of such behaviour are so arbitrary.

Nursing is an inherently feminised profession, and as revealed in the literature, women participate within the discourses of slim/healthy and slim/beauty in several ways – as receivers of these messages and as active participants of reinforcement. It is as the latter that nurses can begin to resist and challenge cultural feminine ideals of slimness by becoming ethical role models and advocates for women of all body sizes. I agree with the sentiments of Aston, Price, Kirk and Penney (2011), who posit a post-structuralist approach as an effective strategy for nurses to reflect upon and challenge current nursing practices with marginalised populations such as large-bodied women. As a person-focussed profession, it is imperative that we create opportunities for other discourses to be heard: "When a person tells their story and we pay attention to the way they talk and feel, and how power relations affect them, we can see how discourses affect or influence their beliefs and practices" (Aston et al., 2011, p.4). I offer my own experiential knowledge of this approach as an example of how this may take form in practice.

The ripple effect of changing attitudes has certainly been demonstrated and immensely satisfying in my own clinical practice since the inception of this study. Through my own immersion in the topic, and as the evidence of stigmatisation in health care mounted, I was spurred on to discuss and encourage self-reflection of our own beliefs and practices towards large-bodied women in the practice. By taking on an advocacy role for these women, it became inherently easy and satisfying to 'see' ways in which the subtleties of stigma were injected into daily practices. Discussion amongst us nurses, as those usually responsible for opportunistic health screening and lifestyle 'chats' within the clinic, began to focus on how our approaches may differ between people of differing body sizes. Did we assume that the thin were 'obviously' active with healthy diets and that the overweight 'needed' some education? Did we take opportunities to screen for cholesterol levels and diabetes as readily with the slim as we did with the overweight/obese? Did we speak with – or to patients? What barriers do women face and what are our own experiences of body size and stigmatisation?

This act of raising awareness of these issues means that we have begun a conscious and ongoing effort to think about how we can ensure safe and sensitive care of our large-bodied patients, and address the particular barriers for large-bodied women. But even bigger than this change, is using our voice and social positioning as health care professionals to articulate and disseminate the problems, paradoxes and positivity's that we have learned to our colleagues, friends, families and beyond. A ripple effect that can reach many, but need only start with one.

7.4   Study limitations and opportunities for further research

At the outset of this study, I declared my professional experiential history of practicing within the dogma of thermodynamic theory and the consequences I had witnessed as a result of this practice. I entered in to the study, aware and critical of the stigmatisation of large-bodied women. Acknowledging my belief that negative assumptions and weight bias was present within the general practice sector, I openly questioned the value of the medical model of obesity as facilitating the safety and respect of large-bodied women accessing general practice services. Post-structuralist feminism supports the notion that one cannot simply 'bracket off' these beliefs and thus I consider that my positioning on the subject will have influenced the interpretation of findings in this study. However, I also controlled for this by actively ensuring that there was adequate space and opportunity for the inclusion of positive and constructive vignettes from these women in order to produce a fair and balanced representation.

The women in this study were self selected, and as such, volunteered for inclusion on the basis of having a story to tell about their experiences of accessing general practice. There is an inherent risk with self selection that those making contact only do so because they recognise that their experiences are sufficiently 'dramatic' or 'unusual' to be of interest to the researcher. Whilst this method of sampling can skew the findings to a particular slant and be considered a limitation, this was not, I believe, an issue in this study. The majority of the women volunteering for inclusion were identified through social networks (snow-ball sampling) and often pre-empted the interview with claims of having nothing particularly important to say.

Despite opportunity to do so, there was a limited input of stories about these women's experiences with nurses and nursing services. The focus of these women on their relationship and interactions with general practitioners may, in part, have been due to my positioning as a nurse-researcher practicing within a small locality, creating a situation of social desirability bias. However, it must be noted that many of these women admitted that they do not have the opportunity, or have never even considered the option of directly consulting with a practice nurse. Thus their limited interactions with practice nurses necessarily reduced their experiences from which to draw on for inclusion in this study. On reflection, and with experiential knowledge, I believe that the construction of local general practice services may have been a significant contributor to this issue.

The women in this study were not homogeneous on any other factor other than identifying as a woman who is large-bodied. However, it must be noted that these women were all Caucasian and all lived within a small, well defined and urbanised locality. As a post-structuralist feminist study, the experiences and lived realities of these eight participants must be read as a starting point. These narratives have been socially-constructed subject to the context of the individual and thus represent only partial knowledge of this topic. The findings of this study cannot, and should not be generalised as representing the experiences of all large-bodied women. One must acknowledge however, that within this study there are areas of coherence with other women's experiences from previous studies across different time periods and geographical locations. This tentatively indicates that some elements of these women's narratives may resonate with the experiences of other large-bodied women within the community.

To facilitate further diversity and representation, further studies of large-bodied women's experiences accessing general practice services across ethnic groups, geographical locations and differing general practice systems would be useful for the New Zealand context. Furthermore, to the best of my knowledge, there has been no study that has specifically measured or explored New Zealand health care professionals' attitudes towards obesity and obese individuals. In view of Ministry directives for clinical leadership in the management of obesity, having HCP attitudinal data would be a beneficial tool to ensure that clinical guidelines and policies are not being widely undermined by biased opinions and practices

towards the obese. This would also potentiate the identification of training and knowledge deficits of HCP, thus ensuring that appropriate support can be implemented into HCP training and clinical programmes.

7.5 Conclusion

Obesity is a highly stigmatised physical attribute, especially so for women. Medical and social constructions of obesity have converged to create a powerful cult of thinness that has made women particularly vulnerable to the pressures of adhering to highly prescribed norms of aesthetic beauty and health. Overweight/obese women experience stigmatisation across multiple sites of daily living – and they are acutely aware of their marginalised positioning within society. Yet despite theses constant challenges to their confidence and self esteem, these women can, and do, possess an amazing strength to resist imposed assumptions about their femininity, health and sense of self. Their interpretations however, are sometimes in direct conflict with those reinforced by the biomedical discourse of obesity which dominates current understandings of obesity in the health care sector. The power and pervasiveness of blaming the individual for their overweight/obese body renders other obesity discourses silent. In this respect, not only are these women's beliefs about health and their own subjectivities marginalised, but so too are their bodies. They are the 'other' to the normal, thus silenced within vociferous biomedical debates about 'claims to truth' surrounding the 'problem' of obesity.

This study has given voice to the perspectives of eight large-bodied women, most of whom could cite either isolated or frequent episodes of stigmatising practices during their interactions with general practice health care providers – behaviours of which defy the standards of professional practice set by regulatory bodies and professional organisations. Whilst this study does not support the ability to directly comment or measure the actual attitudes of the HCPs in the locality, it does indicate evidence that negative weight bias is both present and palpable within the general practice domain. Furthermore, when these women did describe experiences of positive health care partnerships, they cited trust, acknowledgement of their individual context and a willingness of the HCP to see past their weight, as key facilitators to having their health care needs met.

Drawing on literature which posits nurses and medical practitioners as leaders in patient-centred care, it is imperative that HCPs reflect upon their own attitudes and beliefs about large-bodied women. Recommendations have been made to encourage HCPs, in particular nurses, to question and challenge tensions that can be found when space is made available for alternative interpretations of obesity to be explored. There lies an opportunity for HCPs to 'practice what they preach', shifting from a position of blaming the individual to a focus on the individualised health care needs for this marginalised and oppressed group.

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Appendix A – Ethics approval

MASSEY UNIVERSITY

17 August 2010

Nicola Russell
225 Gala Street
Richmond
INVERCARGILL 9810

Dear Nicola

Re: **HEC: Southern A Application – 10/57**
       What are the experiences of large bodied women when accessing General Practice
       services?

Thank you for your letter dated 17 August 2010.

On behalf of the Massey University Human Ethics Committee: Southern A, I am pleased to advise you that the ethics of your application are now approved. Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Professor Julie Boddy, Chair
Massey University Human Ethics Committee: Southern A

cc   Prof Jenny Carryer   Prof Steve LaGrow, HoS
     School of Health & Social Services   School of Health & Social Services
     PN371   PN371

Appendix B – Advertisement

Are you a large-bodied/overweight woman? Do you have a story to tell?
Do you have an hour or two to spare?

I am conducting a study as part of my Masters of Nursing degree. The study is called
'What are the experiences of large-bodied women when accessing general practice
services?'

My aim is to ensure health care professionals become aware of how it feels to be a large-
bodied woman using general practice services.

If you are interested in sharing your stories please contact

Nicola Russell (Registered Nurse)
(03) 2176036
or tn.russell@hotmail.com

Appendix C – Editorial

Published in the Southland Express (2010, 7 October).

Study looking for 'large-bodied' women:

Invercargill practice nurse Nicola Russell wants to hear the stories of women, good or bad, about the topic 'what are the experiences of large-bodied women when accessing general practice services?', as part of her Massey University Masters of Nursing degree.

Nicola is seeking around ten females who would like to take part in the study, which would entail an anonymous interview with self-identified volunteers about their individual experiences.

The aim of the study was to "ensure health care professionals become aware of how it feels to be a large-bodied woman using general practice services", Nicola said.

Once completed, her study would be published in the New Zealand Journal of Primary Health Care, she said.

If you are interested, contact Nicola on 03 2176036, 027 231 9155 or email tn.russell@hotmail.com.

Appendix D – Information sheet

What are the experiences of large-bodied women when accessing General Practice services?

INFORMATION SHEET

Thank - you for showing an interest in this study. Please read this information sheet carefully before deciding whether or not you would like to participate.

My name is Nicola Russell and I am a Registered Nurse working in General Practice in Invercargill. I am currently studying towards my Masters Degree of Philosophy (Nursing) at Massey University.

Why is this study being done?

The purpose of this study is to gain an understanding of how it feels for large-bodied woman when accessing general practice services. The results of this research will help ensure that health professionals are aware of approaches that may improve health care services for large-bodied women.

Who is eligible for this study?

You have received this information sheet because you have either replied to an advertisement in the local newspaper, or have heard about this study from someone you know personally. Any woman who considers herself to be large-bodied may be eligible for participation in this study. Eight to ten women will be asked to share their experiences for this study.

What will happen during this study?

During this study the researcher will ask you to share your experiences of accessing your general practice/family doctor. With your permission, the interview will be audio-taped. The audiotapes will be destroyed at the conclusion of the study. However, if you wish, you can have your audio-taped interview returned to you.

Where will interviews take place? And how much time will this take?

The interviews will either take place in your own home or in a private room at the Primary Health Organisation building. The interview will take approximately one to one and a half hours. One interview should, in most cases, be all that is required. However, the researcher may wish to contact you after the first interview in order to ask a few more questions. Your availability for further contact is your choice. If you would prefer not to be available for further contact this will not affect your eligibility to participate in the study.

Are there any physical/emotional risks to me if I participate in this study?

It is not expected that there will be any physical risk of harm if you participate in this study. Some participants may experience slight emotional discomfort when speaking about personal experiences. If this should occur, you have the right to stop talking about that experience if you choose. The researcher will also have information regarding support services if required.

Your choice to participate or not participate in this study will not affect your ongoing health care.

Who will benefit from this research?

There is no direct benefit for you to participate in this study. However, your participation will help to ensure that health professionals are aware of how service delivery may be improved for large-bodied women.

The researcher has no financial interest in this study. The researcher is undertaking this study as part fulfillment of an academic qualification.

Who will have access to my personal information?

The researcher and her supervisor will be the only people who will have access to your personal information. If a transcriber is contracted, this person will be required to sign a confidentiality agreement. Your personal details (such as your name or occupation) as well as other identifiable information (such as medical history or details about your general practice) will <u>not</u> be recorded in the draft and final results documents. You will be given a pseudonym (false name of your choice) at the beginning of the interview. It will be this name that will be allocated to your data.

Your audio-tape and any interview notes taken by the researcher will be stored in a secure location prior to disposal.

Can I see the study results before completion?

All participants will be offered the opportunity to view the transcribed copy of their interview. This is to provide an opportunity for you to ensure that your stories/experiences have been accurately recorded.

You will also be offered a summary of the findings at the conclusion of the study.

What if I am a patient in the researchers' workplace?

You are under no obligation to participate in this study. Your choice to participate or not participate will not affect your ongoing access to health care. The Registered Nurse/researcher is obligated to maintain confidentiality regarding your participation in this study.

What are my rights as a participant?

You are under no obligation to accept this invitation.   If you decide to participate, you have the right to:
- decline to answer any particular question
- withdraw from the study at any stage
- ask any questions about the study at any time during participation
- provide information on the understanding that your name will not be used unless you give permission to the researcher
- ask for the recorder to be turned off at any time during the interview

Who can I contact if I have more questions?

Researcher: Nicola Russell RN, BN
225 Gala Street
Richmond
Invercargill 9810
(03)2176-036 or tn.russell@hotmail.com

Supervisor: Professor Jenny Carryer
School of Health and Social Services, Massey University.
Palmerston North
(06) 356-9099 extn 7719
J.B. Carryer@massey.ac.nz

Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application _10_/_57_ If you have any concerns about the conduct of this research, please contact Professor Julie Boddy, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 350 5799 x 2541, email humanethicsoutha@massey.ac.nz

Appendix E – Participant consent form

What are the experiences of large-bodied women when accessing General Practice services?

PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read the Information Sheet and have had the details of the study explained to me.

My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded.

I wish/do not wish to have my recordings returned to me.

I wish/do not wish to be available for follow-up contact if required.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: .... **Date:** ....

Full Name - printed ....

Appendix F – Authority for release of transcripts

What are the experiences of large-bodied women when accessing general practice services?

AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

I confirm that I have had the opportunity to read and amend the transcript of the interview(s) conducted with me.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research.

Signature: .... **Date:** ....

Full Name - printed ....

Appendix G – Confidentiality form for transcriber(s)

What are the experiences of large-bodied women when accessing General Practice services?

TRANSCRIBER'S CONFIDENTIALITY AGREEMENT

I .... (Full Name - printed) agree to transcribe the recordings provided to me.

I agree to keep confidential all the information provided to me.

I will not make any copies of the transcripts or keep any record of them, other than those required for the project.

Signature: .... **Date:** ....

(empty)

Appendix H – Interview guide

What are the experiences of large-bodied women when accessing General Practice services?

Semi-structured interview guide

- Participants will choose a pseudonym (false name) at the beginning of the interview.

Tell me a story, one you will never forget, about going to your general practice (GP) clinic.

Can you describe to me what is it like for you to be a patient in the GP clinic?

Describe your relationship with your GP/practice nurse/clinic reception staff.

Have you ever hesitated or delayed going to your doctors' surgery because of your body size?

What sort of things would you change about your general practice experiences?

When visiting your GP, what sorts of things have contributed to a positive experience?

What sort of positive things would you like to see retained at your GP clinic?

What is it like for you, to be a woman who is large-bodied/overweight?

How would you describe yourself and your body?

What else would you like to say about your experiences with your general practice clinic?