

Learning to Manage:
A Substantive Grounded Theory of
Large Bodied Women's Interactions
with Medical Professionals

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Statement of Originality

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Abstract

A qualitative research approach using constructivist grounded theory methodology was used to further understanding and generate dialogue about the experiences of overweight and obese female healthcare consumers. Participants included 22 women, all of whom identified as large bodied. Data was collected from two major sources: semi structured interviews with participants and current literature. The value of this study lies in the documentation of a substantive theory which elucidates the issues facing overweight and obese female healthcare consumers, and the strategies they employ to manage these issues.

The substantive grounded theory of 'Learning to Manage' details what large bodied women viewed as the salient concerns that face them as healthcare consumers, and how they resolve these issues. They identified their interactions with medical practitioners, specifically with general practitioners (GPs) as the most challenging. The women in this study felt extremely vulnerable when they became healthcare consumers. They believed they were negatively branded by their body size which worked to create a one dimensional identity – that of an overweight or obese patient. Once they were labelled their weight became the central focus of the consultation, often obscuring the reason they had sought help. Consequently, the shared social problem of women was identified as 'being defined'. Feeling like 'just a fat body' (as described by participants) was common to all participants, and left women battling feelings of invisibility, shame, guilt, responsibility and fear. For large bodied female patients, being defined by their size was something which had significant ramifications both on the women themselves and on the clinical interaction. Being defined was comprised of three categories – 'feeling invisible', 'expecting the worst' and 'feeling judged'.

In order to manage or counteract the issues and feelings associated with 'being defined' participants developed a range of strategies which have been conceptualised as the basic social psychological process 'Learning to Manage'. Women believed that the weight commentary from medical professionals was usually inappropriate and frequently hurtful; however they felt they had limited recourse because of the power held by medical professionals. Subsequently they learnt to manage their interactions with medical professionals in ways which blocked out or minimised the consequences of embodying the

identity of an obese patient without having to overtly challenge their doctor. They believed that if they openly challenged their doctor they risked further sullyng their already marked identity. Logically women knew that they could not be refused what they needed, however they felt that it was easier to manage from an emotional perspective if they engaged in strategies which pretended compliance or apology for their fat bodies.

This research adds to the limited body of health science literature which has investigated weight through a framework which is cognisant of the multilayered meanings attached to fat female bodies. It also adds to the ever increasing research which recognises the impact of stigma in addressing public health crises such as obesity.

Works Arising from this Thesis

The publications listed below were works developed from this thesis:

Williams, D.M. (2009) 'I am more than an obese body': overweight and obese women talk about their experience of general practice', *General Practice and Primary Health Research Conference*, Melbourne Australia.

Williams, D. M. (2008) '(Re)examining the multilayered meanings of being fat: developing 'new' strategies for working with overweight and obese female consumers of primary healthcare', *2008 General Practice and Primary Health Research Conference*, Hobart, Australia.

Williams, D.M. (2007) 'Learning not to listen: large bodied women talk about their experiences of healthcare'. *Australian College of Midwives Biennial Conference 2007*, Canberra, Australia.

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Dedication



In the words and pictures of both Lennon & McCartney
and my seven year old niece Ruby, 'All you need is love'.

This work is dedicated to my mum Jenni.

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Part One

Prologue

Making the researcher's identity visible

“It’s a funny thing, fat. Even though it is obvious to everyone you meet and may in fact be the only thing people remember about you, admitting that you are heavy or out-and-out obese is often the hardest thing in the world to do” - Shawna Vogel, 2000

My interest in the health experiences of large bodied women began to emerge when I started nursing, and it was during my early years as a registered nurse that several things happened that significantly affected me, and ultimately influenced my decision to undertake this project. The first event occurred whilst I was working in an acute setting, as I helped to care for a woman who was having surgery. She was required to have her height and weight recorded before her procedure; however when I went to weigh her I discovered that the ward scales were not going to accommodate her body weight. I was then instructed to take this patient to a set of antiquated scales used by kitchen and storeroom staff, situated outside the public dining room frequented by staff and members of the public, which can accommodate 300 kilograms. The patient was taken to be weighed by an orderly and when she returned to the ward she was crying. When I asked her what was wrong she said that she was humiliated. When I asked her why, she looked at me and said “you know why” and grabbed her stomach. I didn’t have an answer because I knew what she was saying was true.

Some weeks after that I was looking after a room of patients: three males and one female patient. After the consultant had conducted morning rounds, he rang back to check a detail and by chance I answered the phone.

‘What is the name of that big fat woman’, he asked.

‘Which big fat woman’ I replied.

‘That big fat woman in room 14’.

‘Do you mean the only woman in room 14’ I said.

‘Yes, the big fat one’ he said as he hung up.

This is an extreme example, and the bigotry was not always so blatant. However, it did open my eyes to events and attitudes that seemed to pervade the fabric of that environment. Around the time of this event I also read a book by Charlotte Cooper (1998, 26) who suggested that fat people are vulnerable as targets and super-visible because they deviate from an assumed norm, which in this case is slenderness. This idea caught my attention, and has stayed with me ever since because it resonated within me. Society places high value on physical sameness, and fat is vilified ironically not because it deviates from a large percentage of the populace, but because it deviates from the idealised populace. And to my eyes, this was being echoed within the medical community. What I saw was large patients being treated in a way that labelled them as different and somehow not deserving of the same consideration as thinner patients. It was during those early months that my interest broadened beyond the social experience of fatness, to the experiences of large bodied women as patients. Schreiber (2001) discusses the notion of sensitizing concepts, suggesting that these are ideas that the researcher has in her head before she starts the research. Charmaz (2006) also comments on sensitising concepts, arguing that for grounded theorists they provide a starting point, and that if they do not emerge in the data then we (grounded theorists) discard them. At the beginning of this project, I was sensitised to issues of difference and fat embodiment within the hospital setting as well as to the experiences of discrimination that large people experience in their social worlds. However I used these ideas, as Charmaz suggested, as a departure point through which to look at the data and guide my analytical thinking (2006).

My intent in introducing myself as the researcher is not to create an indulgent space where I air my own views and opinions. Rather, it is my attempt at creating a transparent dialogue about my own place in the research process – and the impact that this has had on the subsequent generation of theory. Early in this project, it was suggested to me that I was undertaking this project because I was unhappy with treatment I had received, somehow implying that the purpose of this research was to gather together a lot of large bodied women who were also unhappy with their treatment from medical professionals. In fact the exact opposite was true. The aim of this research was to call for large bodied women to discuss their experiences of healthcare, in order to begin to create a dialogue in an area that until recently has been largely dominated by discussions of obese bodies as the site of disease and cultural dislike.

I share membership of the group that I research, and because of my own knowledge and experience of the subject matter, I do feel a connection to the women who participated in this research. Because of this shared membership, women disclosed that they shared stories with me that they would not have shared with a researcher who did not also inhabit a large body. However it was my sameness that also caused comment and repeated questioning as to whether I would be able to manage a project where I was interviewing my 'own' people (as described by one participant), without imposing my own stories and opinions onto the findings. Initially, I found warnings about bias and subjectivity to be condescending because it was my understanding that researchers are often drawn to investigate areas that interest them personally. However, as the project progressed, the comments actually worked to create an invaluable inner dialogue that helped create awareness of my own story. These questions have helped me make visible my own meanings and understandings of health and weight and largeness, and through this I have been able to listen more clearly to the stories and experiences of participants, identifying them as unique stories separate to that of my own. I have spent a significant amount of time engaged in a critical reflection regarding why I feel compelled to make visible my own identity. Webb (1992) suggests that whilst all research involves social interaction, researchers using an interpretivist approach both invest and share themselves in the research process (p749). She also advised that researchers should acknowledge both their involvement and inseparability from the research (p37).

As a researcher whose thinking and practice is both informed and shaped by constructivist and feminist thought, it is accepted that the stories and experiences of the researcher are part of the research process. Indeed, they shape and influence the construction of the end research product. That being the case, I have still struggled with my need to declare my own identity. In hindsight, I think that the struggle has been linked to questions from individuals who have questioned whether my identity somehow detracts from the legitimacy of findings. So despite this struggle, I chose to share myself with readers. I acknowledge that my views of overweight and obesity have been shaped by my experience as a health professional, and my own gendered experience of being large. I don't wish to hide the fact that my current research was partly borne from my own experience as a large bodied woman. I consider that it was my own experiences that initially opened my eyes to the experiences of patients.

Being a researcher for a project in which my own journey is intrinsically linked to those of participants is complex and thought provoking. Being large bodied is a significant personal journey – however it is one that is very visible in the public gaze. I acknowledge the inevitability of my own life influencing what I hear and see and eventually write about. I acknowledge that being large bodied has informed thinking behind the conception of this project, and that I have experiences common to those of participants. However, whilst experiences may have threads of sameness, we are not a homogeneous group – and each participant’s story has been unique and valued. I wish to make sure that the story I tell reflects the story of the participants; however I don’t necessarily think I need to do this declaring my own personal identity. I do this through rigorous application of methods and a well-documented decision trail. I do this by encouraging participants to share in the creation of theory.

I have chosen to reveal my identity, to *out* my own fatness, because I think it adds to the richness of this research. Mills, Bonner and Francis (2006a, p9) state that Explicating the place from which the researcher starts provokes a need to reflect upon his or her underlying assumptions and heightens his or her awareness of listening to and analysing participants’ stories as openly as possible. As well, it provides the reader with a sense of the analytical lenses through which the researcher gazes at the data.

With this in mind, I chose to reveal my starting place.

Chapter 1: Introduction

Background

This chapter will introduce the concept of weight and provide an overview of current reporting on obesity. It will also provide a rationale for this research, including why a qualitative approach was used, the research question and aims of this research. The chapter will conclude by presenting the structure of this thesis.

The term ‘obesity’ is of Latin origin, meaning having eaten (Cooper, 1998) and it is the very meaning of this oft-used term that exposes the beliefs and causes that people attach to large bodied people. The terms overweight, obesity and fat have considerable meaning attached to them, acting as an umbrella term for many meanings including sickness, deviance, laziness and unattractiveness. Kulick and Meneley (2005) posit that fat is anything but straightforward, suggesting that fat is a three letter word “larded with meaning”. Obese individuals face issues and circumstances comparable to other disadvantaged groups who both identify and are identifiable as members of a clearly different community (Komesaroff & Thomas, 2007). These groups experience issues which are impacted by the social and cultural structures, added to which the quality of healthcare they receive is also affected. The difference between the obese as a disadvantaged community and other groups, however, is that obesity does not engender the same public compassion or respect drawn by other groups (Komesaroff & Thomas, 2007).

The terminology used to describe excess body weight varies between disciplines; however the terms overweight and obesity is the most common language used to describe excess weight within health science research. This research does not delineate between overweight and obese, and I have primarily used the term obesity when referring to all bodies that are classified as over the accepted medical norm of a healthy weight. Gard and Wright (2005) make reference to this fact, suggesting that overweight and obesity are often used interchangeably when in fact they are regarded as two different classifications of largeness. As the researcher and someone who also identified as a member of the group that I was researching, I wavered between terms. When interviewing, I tended to use the

words that individual participants used, something that I worked out as I developed rapport with participants during interviewing. ‘Obese’ or ‘obesity’ was not a term that I generally employed whilst interviewing participants, however I did use it when searching for literature and when writing, particularly in the discussion chapter of this thesis.

Participants, however, rarely referred to themselves as obese, usually using the word overweight when describing themselves, particularly if they were talking about their experiences of weight in healthcare contexts. One participant described her feeling around the word obese:

I hate it because of the connotations of it. It's almost used like a dirty word. For some reason I would almost rather be called fat than I would obese, because fat is my word that I have reclaimed for myself. And in saying that, there is almost a certain level of pride that I can say that I am a fat woman and I am ok with that. (Stella)

The participants used a number of terms to describe their bodies, referring to themselves as chubby, fat, large, overweight, and big. I prefer the term large bodied however within the majority of literature I reviewed as part of this study the terms overweight and obese were used. Thus, given the diversity of the language used by participants and within the literature, my use of terminology to describe weight throughout this thesis is also varied.

A Normal Weight

A Belgian astronomer in the 1830's was the first to define a normal weight, after measuring the most common weight for height of British and French army conscripts (Staley 2008, p27). Since then normal weight has largely become measured by the Body Mass Index, a tool initially used by Life Insurance companies in the 1940's which relied on data from 25 year old insurance applicants to generate ‘ideal weights’ (Brown, 1990; Stanley, 2008). Contemporarily, the biomedical classification of normal weight is largely reliant upon the Body Mass Index classification which is calculated by dividing weight in kilograms by the square of the height in metres. Obesity is usually defined in adults as BMI above 30, whilst overweight is categorised as a BMI in excess of 25 (World Health Organisation, 2010).

The body is not ahistorical; its shape and weight through time illustrate the social and cultural trends of the time (Lawler, 1991). Being overweight or obese has not always held the negative connotations that it does in contemporary society. Etcoff (1999) echoes this sentiment suggesting that there is no evolutionary precedent for the slim ideal. Throughout history maintaining an above average body weight has been viewed as a symbol of wealth or affluence, or good health. Johnson (2004) suggests that the notion of body size as a marker of the moral character of an individual emerged in the 1940's and 50's from a range of developments in medicine, psychology and fashion. Prior to this period, large bodied individuals were regarded amongst other things as cheerful and prosperous, whereas after this time largeness became a signal of lack of control over "voracious appetites" (p480).

Casswell (1995) and Philipson (2001) have both commented on body size in the nineteenth century suggesting that fatness was a signal of prosperity and stout women were considered both attractive and sexy (2001, p2). Simpson (2002), however, contradicts this by suggesting that the nineteenth century was the period during which thinness and fragility became feminine ideals. Sontag (1978) also emphasises that the nineteenth century saw the popular emergence of the tubercular look, which emphasised thinness and attached glamour to a sickly appearance. Wolf (1990) also suggests that the thin ideal has only emerged over the last century. She argues that the preoccupation with thinness started when women received the vote in the 1920's, suggesting that female emancipation via law is connected to the rapid change in the representations of women at that time. Wolf clearly states that the "great weight shift must be understood as one of the major historical developments of the [twentieth] century", a phenomenon which has emerged as an answer to the issues raised by the women's movement, including the economic and reproductive freedom (p187).

The Obesity 'Epidemic'

The World Health Organisation (WHO, 2006) defines obesity as the "abnormal or excessive fat accumulation that may impair health" and cite it as one of the five leading health risks for mortality in the world (WHO, 2009). According to a WHO estimate in 2005 there were more than 300 million obese people in the world, and this estimate is projected to increase to 1.5 billion in 2015 (2009, p17). They also add that 65% of the

global population now live in countries where overweight and obesity kill more than underweight (WHO, 2009). Given the global increase in body weight, it is little wonder that the weight of populations has now become part of our global consciousness.

Obesity is considered a risk factor for both non-industrialised and industrialised nations. Obesity has been depicted as an epidemic facing modernity in both industrialised and non-industrialised countries, and has been described as a “time bomb” in the rising incidence of diabetes and related circulatory disease (Phillips, 2002). Stewart, Tikellis, Carrington, Walker and O’Dea (2008) describe the health implications of the increasing rates of overweight and obesity as a potential ‘fat bomb’ facing Australians. Wellman and Friedberg (2002) suggest that obesity was identified as an American epidemic twenty years ago, however Crawford and Ball (2002) posit that it is only since the late 1990’s that obesity has been recognised as endemic within Australian populations.

There is a mounting body of medical and scientific reporting that links obesity to significant increases in morbidity, cardiovascular disease and related disorders, and a myriad of other pathologies. The World Health Organisation (2003) indicates that morbidity rates increase with body mass index (BMI) increases, as does the amount of people with one or more co-morbidities. Research also suggests that excess body weight impacts on general health, recovery and disease. Obesity is said to increase the risk of coronary heart disease, type 2 diabetes, ischemic stroke, hypertension, depression, cancers (including breast and gynaecological), and polycystic ovary syndrome (Bray, 2002; O’Brien, Brown and Dixon, 2005; Peters, 2002; WHO, 2009). The presence of obesity has also been said to increase the risk to mother and baby during pregnancy (Nankervis, Conn and Knight, 2006) as well as impairing fertility (Pasquali, Patton, & Gambineri 2007). Stewart et al (2008) suggest that reducing weight, measured by a reduction in BMI, can reduce the risk of developing depression, certain cancers, high blood pressure, high blood cholesterol, and Type 2 diabetes

National data indicates that the last 20 years have seen a dramatic increase in the weight of Australians, with large bodied women constituting an increasing proportion of all obese individuals (Crawford & Ball: 2002; Gill, 2002). Filozof, Gonzalez, Sereda, Mazza and Braguinsky (2001) also indicate that women have a higher incidence of obesity than men. It has been noted that obesity is becoming more common in socially disadvantaged groups,

particularly among women (Catford & Caterson, 2003). In Australia, the rates of overweight and obesity have increased by almost 50% in both adults and children (Healthy Weight 2008 – Australia's Future, 2003). In 2001 self-reported data estimated that approximately 2.4 million Australian adults were obese, and 4.9 million overweight (AIHW, 2003). Measured data between 1980 and 2000 showed that the incidence of obesity in women had increased by 50%, from 8% to 20%. Between 1989 and 1999-2000 the prevalence of abdominal obesity in women increased from 16% to 28% (AIHW: 2003). Australian sources suggest that the number of obese Australian women increased from 27% to 43% between 1980 and 1995 (Crawford & Ball, 2002). Gill (2002) draws on recently published Australian data from the AusDiab study 1999 - 2000, which revealed that 60% of women between the ages 45 and 64 were either overweight or obese, a figure which has almost doubled in the last two decades.

In 2002, the Australian government initiated a national response to overweight and obesity, which saw the construction of the National Obesity Taskforce whose aim it was to develop a national public health strategy to tackle overweight and obesity, largely concentrating on young people and their families (Healthy Weight 2008 – Australia's Future, 2003). The report made brief mention of the fact that being obese can lead to social discrimination and can destroy self-esteem, as well as including the reduction of stigma and blame in the guiding principles for action. However, in the pages of strategies, collaborative activities and planned outcomes that followed no mention was made of any activity that would work to decrease stigma and improve the self-esteem of young people and adults living in overweight or obese bodies. This appears to be a critical oversight in many such interventions into addressing the rising trend of overweight and obesity.

In 2008 obesity was identified as a National Health Priority by the Australian government (Valenti, 2009). In response to this, a Preventive Health Taskforce was appointed and charged with developing a national strategy which addresses, among other issues, obesity. The Taskforce (2009) suggests that obesity, along with alcohol and tobacco, account for a significant proportion of the disparity in health status between advantaged and disadvantaged Australians, and between city dwellers and rural and remote Australians.

The Bettering the Evaluation And Care of Health (BEACH) program is an ongoing national Australian study of general practice activity which began in 1998, and has perhaps

the most comprehensive of data relating to General Practice in Australian history. The BEACH study includes new samples of approximately 1,000 GPs per year, each of whom provide details for 100 consecutive GP-patient encounters (Britt & Miller, 2009). In 2009, in a report which included BEACH data collected between April 1998 and March 2008, analysis revealed that whilst male patients are more likely to be overweight or obese; women are more likely to be severely obese. Consultations with those classified as obese were significantly longer than those with patients who were classified as normal or overweight. In line with international reporting, the collection of data over a ten year period also demonstrates a rise in the prevalence of overweight (from 33% to 35%) and obesity (from 19% to 24%) in adult general practice patients (Britt and Miller 2009, p5).

Many authors point toward the cultural transformations as reasons why obesity has become a global problem. Steinbeck (2002) and Peters (2002) discuss obesity as a social problem delineating the various changes in society, such as an increased diversity and availability of foodstuffs. Peters (2002) suggests that these changes have led to what he describes as the 'obesigenic' environment that has unintentionally promoted a lifestyle that is low in physical activity and high in food and energy consumption. Holm et al (2001) also discuss the global changes in lifestyle, which have led to an increase in the prevalence of overweight and obesity. They suggest that the obesity dilemma extends "beyond the individual" into a global environment which actively promotes a sedentary lifestyle and overeating. Clugston and Smith (2002, p105) concur, and posit that the increased prevalence of obesity is a consequence of "fundamental changes in the world's social structure". Gill, Antipatis, and James (1999) comment on the first World Health Organisation consultation on obesity where it was concluded that "the global epidemic [of obesity] is an unintended consequence of modernization, economic development, urbanization and other societal changes" (p75). Catford (2000) also suggests that mechanisation and labour saving devices have decreased the amount of incidental exercise, which has seen levels of overweight and obesity increase. Clugston and Smith (2002) also comment on the globalisation of the human diet, which has seen the introduction and ready accessibility of a more diverse diet, coupled with a preference for readily available fast foods and a decrease in activity. Allman-Farinelli, King, Bonfiglioli, and Bauman (2006) also suggest that in the past 30 years, great availability and range of foodstuffs combined with a decrease in physical activity has worked to produce an obesegenic environment in Australia. O'Brien et al (2005) in regards to obesity interventions posit that "the bottom

line is that we need to consume less energy and expend more” (p310). This seems a very simplistic solution to a very complex issue.

Philipson (2001) infers that whilst obesity is often viewed as both a public health concern and an issue of individual attractiveness, it is foremost an economic issue. Obesity is seen as a major contributor to disease and disability, thus the economic costs are considerable. Peters (2002) surmises that the augmented incidences of obesity and obesity related chronic disease have generated considerable social costs. Wellman and Friedberg (2002) indicate that obesity is problematic within the health care setting, citing US obesity and overweight budget estimates for the year 2000 as \$117 billion. These figures included both direct and indirect costs. Hughes and Martin (1999) also suggest that obesity creates social and economic problems in that there is a correlation between increased sick leave and early retirement, secondary to health problems. Conversely, whilst commenting on the financial costs of diabetes, Dixon et al (2000) discuss multiple cost accountings within studies that address hospital costing. They suggest that it is problematic to attribute cost to a particular admission diagnosis when patients also have numerous pathologies, such as obesity.

Hospital care, which is linked to hospital spending, of obese individuals is also receiving increased attention. Hauck and Hollingsworth (2010) estimated differences in hospital length of stay between obese and severely obese patients. Their sample included 435,147 inpatient episodes during 2005/2006 with patients over 17 years of age who had stayed one night or more in hospital. Their findings suggested that there are vast differences in the length of stay for severely obese patients, and this is divided between medical and surgical specialities. Hauck and Hollingsworth (2010) suggest that this may be due to the disparity in management of obese and non-obese in patients. One explanation for this is the suggestion that hospitals may transfer patients to another facility post-surgery as a way to shift both the costs and risks associated with managing the complex requirements of obese surgical patients. They suggest that obese surgical patients have a higher turnover than non-obese patients, which could influence the continuity and quality of care.

Rightly or wrongly, the obesity epidemic has now garnered global attention. Current medical and economic reporting paint a very persuasive argument about the dangers and rising costs associated with excess weight. National strategies and guidelines have been

implemented in order to try and combat the increasing weight of Australians. Likewise, other countries around the world have also identified obesity as a threat to individuals, the healthcare system and society as a whole.

Research Rationale

This work is one of very few studies conducted within the health sciences that illuminate the voices of a marginalised group such as large bodied women. This work extends thinking around several issues. Firstly, this research explores and documents the interplay between medical professional and overweight and obese from the perspective of the consumer which remains quite rare in the field of obesity research. Secondly, this research has been conducted using a qualitative approach which remains rare within the health sciences. A significant amount of research that has been conducted has tended to favour quantitative methods, whilst the qualitative studies which have investigated weight stigma and the experiences of women have not been conducted within a health science framework.

Much of the contemporary literature around overweight and obesity has been viewed primarily through two lenses; the biomedical lens, which focuses purely on obesity as a disease, and the social lens. There is a considerable body of work on the medical consequences of obesity, the physiological and psychological effects of stigma and negative body image, and overweight and obesity as a global epidemic. A review of material published in medical journal articles in the last decade revealed that the majority of weight related articles concentrate on weight management, weight reduction or the medical consequences of obesity. Increasingly, the literature now includes a focus on bariatric and weight loss procedures, particularly laparoscopic adjustable gastric banding. Bariatric surgery is becoming the preferred treatment of patients who are significantly obese (Tweddle, Woods & Blamey, 2004) and the research reflects this.

There is a paucity of research that addresses the effect that being fat identified, and recognised, has on women's experiences of healthcare and other services that promote wellness, and on their actual engagement with health services. Excess weight influences the provision and experience of healthcare. It can impact whether individuals fit into hospital gowns; it dictates the use of specialised equipment, and in order to access certain medical procedures some fat bodies have to be thin. It is recognised that individuals living

in large bodies are subject to judgement and negative stereotyping based on their appearance. However to date there has been minimal exploration of large bodied individuals as patients or consumers of healthcare services that are cognisant of the multiple meanings attached to the obese body. Given the increasing urgency to address the obesity crisis, it is timely to endeavour to understand healthcare consumers living in large bodies. Also, given the gendered nature of both health and bodies, it is appropriate to explore being large bodied from a single perspective, which in this research is women. It is critical that researchers be at the forefront of investigating effective ways in which to provide healthcare for large bodied female consumers, as well as identifying ways through which to encourage healthy weight practices.

Women's health is not a new area of inquiry, particularly for nurses, however there has been little investigation into how the social understandings of fat and fat bodies interface with the medical constructions of fat, and what this means for healthcare consumers who are large bodied. There is also little investigation into how large bodied women understand their interactions with healthcare providers. As obesity has now become the domain of biomedicine, as well as a sociocultural phenomenon, it is essential that a new body of work is produced, one which recognises the impact that being fat identified (and recognised) has on an individual's experience and ability to get the healthcare they need and are entitled to. Lawler (1991) indicates that for women, the principal message that she receives from society is that she must remain, among other things, slim. Although men also experience body scrutiny and subsequent judgement, evidence suggests that women are subject to stricter governance in regard to their appearance. Wellman and Friedberg (2002) argue that obesity is not gender specific; however it is indisputable that the experience of living in larger bodies is. There is little denying the fact that women are held to different standards regarding their body size and appearance.

Women have been objectified and judged by their appearance throughout history, and in this society the pressure to be thin is immense (Casswell, 1995). Large bodied women can be and are viewed as persons who are refusing to comply with the social norms regarding thinness, especially women and thinness. Within the westernised world, to be fat and female is not generally regarded as desirous. Lawler (1991) suggests that society is bombarded with messages that promote the ideal body, a projection that for the majority of us is unattainable. To be slim is desirable, as well as moral, healthy and virtuous. Women

are subjected to very different pressures than those of men, particularly in regard to their bodies. Lawler (1991, p97) states that “historically women’s bodies have always been targeted, technologised, pathologised and medicalised much more so than have men’s bodies”. Based on Lawler’s notion, I believe that women’s experiences are vastly different, and thus worthy of individual examination.

The Research Question

Consistent with grounded theory, the initial research problem commenced with a broad area of inquiry. Initially, the research question was ‘what is the process of engaging with the healthcare system for large bodied women?’

The idea was to seek out participants who were both large bodied and female in order to develop a substantive theory about their engagement with healthcare. As with other grounded theorists, I initially set out to work with participants to draw out their stories, and in doing so identify what they considered to be significant. This included a focus on what women considered to be the issues facing them within this context, and the strategies that they used to manage these issues. As data collection progressed and participants revealed what they considered to be important, the questions became more focused. As participant accounts revealed that their main concern was being defined by their largeness, data collection became more focused. The questions sought to understand more about what women considered to be the salient issues facing them as healthcare consumers when they were defined by something negative, what influenced and shaped these problems, and the process through which participants managed the problems they shared.

As is well documented within grounded theory literature, the study was directed by emergent data, so ultimately the research questions were:

- How do large bodied women get the healthcare they need when they feel defined by their large body?
- What are the strategies used by women to overcome and/or manage the barriers and issues associated with being a large bodied female patient?

Research Aims

This research aimed to add to current obesity research, with the intention of generating dialogue about overweight and obese healthcare consumers. Despite the global focus on obesity, and the increasing population of large bodied individuals, the current social and cultural norms surrounding obesity mean large bodied women remain a marginalised population, and at risk of being underrepresented in research.

It was the objective of the research to expand on current understandings of large bodied women as healthcare consumers, through explicating and interpreting women's understandings of their individual health experiences. The study aims were to:

- ◆ Gain insight into large bodied women as healthcare consumers.
- ◆ Develop an understanding of the shared social problem experienced by large bodied female healthcare consumers.
- ◆ Detail the basic social psychological processes used by large bodied female healthcare consumers which details the strategies they use to resolve the shared basic social problem.

Qualitative Research

Despite the surfeit of research that has investigated overweight and obesity, few studies have illuminated the healthcare experiences of large bodied female consumers. Most studies which have investigated obesity, particularly the lived experiences of obese individuals, have used quantitative approaches. Thus, it is important to generate new knowledge which is qualitative in nature. Grounded theory, informed by symbolic interactionism and shaped by constructivism is extremely relevant and suited to this nature of inquiry. The symbolic interactionist underpinning urged me to focus on meaning and the creation of meaning through interaction with others, which I believed was central to the nature of this inquiry. Given my understanding of grounded theory, both methodologically and as a method, I felt that it was the appropriate tool to employ in order to generate rich new information where the focus was on the understandings and perspectives of the women involved. Grounded theory has been extensively used in research with women, is a means of generating new knowledge that is situated both within the context of the field and existing theory (McGhee, Marland & Atkinson, 2007).

Grounded theory methodology is concerned with “the processes and meaning people use to manage their worlds” (Pursely-Crotteau, Bunting & Draucker 2001, p194). Eaves (2001) suggests that grounded theory inquiry is directed by the discovery of social and social psychological processes, commenting that this is an assumption inherent in both the work of Glaser, Strauss and others. Grounded theory was appropriate as it offered a method through which to approach the phenomenon broadly, allowing participants to identify what was important to them, namely the problems acknowledged and shared by participants in the phenomenon under investigation. The ability to study human behaviour within a social context is a widely acknowledged strength of grounded theory (Morse, 2001), which also made grounded theory an appropriate methodology to use in order to explicate participant understandings of their social worlds.

This research was concerned with large bodied women as healthcare consumers, particularly how they managed their interactions with medical professionals. Schreiber and Stern (2001, pxvii) believe that grounded theory was “designed to reveal the human characteristic of change in response to various life circumstances”. They posit that a fundamental element of this is to capture how people understand and manage what is happening to them over time. Morse (2001, p12) also comments on the characteristics of grounded theorists, suggesting that researchers using this method are more interested in how people “create and respond” to experiences than how they “perceive their world”. Crooks (2001) also concurs with this, stating that “grounded theory gives us a picture of what people do, what their prime concerns are, and how they deal with these concerns” need page number.

Crooks (2001, p17) states that:

grounded theory methods allow the researcher to see women as full members of their social, political, economic worlds; to understand the lives and activities of women; to understand women’s experiences from their own particular points of view; and, finally, to conceptualise women’s behaviour as meaningful and as a direct expression of their world views.

Further to this she adds that grounded theory researchers, in choosing this perspective, “give voice to the thoughts and actions of women and establish the importance of women from a woman centred perspective” (Crooks 2001, p19).

Structure of Thesis

This thesis is divided into two parts, and presented over nine chapters. Part 1 of the thesis contains a prologue and four chapters. The prologue provides the reader with insight into the position and background of the researcher.

Chapter 1 provides a brief context for the research, as well as outlining the research aims and research problem. It also includes a brief explanation of why qualitative research was selected as the appropriate paradigm for this research, as well as

Chapter 2 commences with a brief explanation of the use of literature review in this grounded theory study, and will progress to present issues relating to overweight and obesity, large female bodies, the medicalisation of obesity and the new body of literature that questions the obesity ‘epidemic’. Also included are the contextual factors in which the large female body is embedded, including the sociocultural and medical constructions of obesity and how this intersects with gender.

Chapter 3 details the approach to grounded theory that has been used in this research in order to construct the substantive grounded theory of large bodied female healthcare consumers. An overview and evolution of grounded theory methodology is presented, followed by a discussion of symbolic interactionism. Constructivism, which is the theoretical approach that shaped this grounded theory, will also be discussed particularly focussing on the grounded theory approach of Kathy Charmaz, the scholar whose work this thesis draws upon.

Chapter 4 presents the methods that were used in this study, including recruitment and participant selection, theoretical sampling, interviewing and data analysis. Also included is a discussion of rigour, evaluating grounded theory and lastly the ethical concerns that were considered as part of this research.

Part 2 of the thesis includes four chapters and an epilogue. Chapter 5 introduces and provides an explanation of the substantive grounded theory of 'Learning to Manage', which provides explanation of how large bodied women understood and manage their interactions with healthcare providers. The substantive theory of 'Learning to Manage' discusses how large bodied women engage in the basic social psychological process of 'Learning to Manage' in order to address and resolve the basic social psychological problem of 'Being Defined'.

Chapter 6 presents and discusses the analysis of participant data relating to the basic social psychological problem of 'Being Defined'. The basic social psychological problem has three categories, which will be discussed throughout this chapter as the sub categories of 'feeling invisible', 'feeling judged' and 'expecting the worst'. Excerpts of participant data will be used throughout to demonstrate how the problem of 'Being Defined' and the sub categories of 'feeling judged', 'expecting the worst' and 'feeling invisible' were reached.

Chapter 7 describes the basic social psychological process of 'Learning to Manage', namely the patterns of behaviour used by participants in order to resolve the basic social psychological problem. 'Learning to Manage' encompasses a range of behaviours used by large bodied women to manage the basic social psychological problem of 'being defined'. The sub-processes of 'Learning to Manage' which have been identified as 'Trying to be Seen' and 'Protecting Myself', explain the strategies used by participants to deal with the challenges which faced them as large bodied healthcare consumers will also be presented. Findings will be supported by participant data which emerged through interviewing.

Chapter 8 presents a discussion of the research findings in relation to current research. The literature that was consulted as part of data collection and analysis will be presented in the discussion chapter, and will situate this research within the broader structure of biomedicine, as well as examining the medical interaction. The basic social psychological problem and the basic social psychological process will be discussed with reference to relevant literature. Stigma, and health and weight related discrimination, which underpins the findings of this study, will be explored. Literature relating to the strategies that participants used as part of *Learning to Manage* will also be presented. Lastly, the ways in which stigma and discrimination can be addressed in clinical practice will be presented.

Chapter 9 provides a concluding discussion which includes the achievement of study aims and the value of using a constructivist grounded theory approach for the current research. It also presents an evaluation of this grounded theory, as well as the limitations of the current research. Lastly, recommendations for healthcare providers, education and research will be presented.

Conclusion

This chapter has introduced the research topic, and provided an overview of the present research. The research aims; question and rationale have been presented, as well as a justification for using grounded theory methods. An overview of the structure of this thesis has also been presented. The following chapter, entitled *Setting the Scene*, presents data that was accessed as part of the first phase of literature reviewing.

Chapter 2: Setting the Scene

Providing a Context

Introduction

The purpose of this chapter is to present the contextual factors in which the large female body is embedded, including the sociocultural and medical constructions of obesity and how this intersects with gender. This chapter commences with a brief explanation of the use of literature review in this grounded theory study, and will progress to present issues relating to overweight and obesity, large female bodies, the medicalisation of obesity and the new body of literature that questions the obesity ‘epidemic’. The chapter concludes with a presentation and synthesis of recommendations drawn from current research relating to this research.

Reviewing the literature

The literature review in grounded theory has and continues to generate discussion. Glaser and Strauss’s seminal work *Discovery of Grounded Theory* recommended that literature not be reviewed; for fear that it would influence the emergent theory (Glaser & Strauss: 1967). In the ensuing years, the debate has continued with many authors utilising grounded theory methods commenting on the timing of the literature review.

Underpinning most qualitative research is the belief that pre-existing theoretical frameworks and ideas should not be imposed on a research investigation (Heath, 2006). Rather, focused reading should occur when emergent theory is well formulated (Heath, 2006).

I elected to undertake a preliminary literature review both to familiarise myself with the work currently being investigated, as well as to meet the requirements of my doctoral program. A preliminary literature review helped to contextualise the issues for clarification of thought and ideas, as well as to identify current gaps in knowledge. I considered it important to garner some knowledge as to what type of work already existed

in the area that was proposed for investigation, in order to avoid potential duplication of work. The initial literature review was also a means of providing a theoretical context for the issues which play a role in the framework of this study. A more in-depth discussion and critique of the research, politics and debates central to obesity and obesity research were explored as part of the discussion chapter.

The preliminary literature review for this research was carried out with particular boundaries in place. For instance, while there is a small amount of research that suggests that overweight and obese women experience shame and discomfort during consultations with health professionals this was not a topic that I searched for during the preliminary review. I endeavoured to avoid issues such as stigma, discrimination and healthcare avoidance, as I suspected that some of these may arise during data collection. The reason for this was that whilst I was sensitised to this issue, I did not wish to approach participants with notions of shame and bias fresh in my mind. Once these studies were identified, I read the abstract, but did not conduct any further reading at that time. During the initial review, I looked for research relevant to my area of interest, namely women as healthcare consumers, overweight and obese women as healthcare consumers, and obesity as a medical and cultural phenomenon. As indicated above, this literature was used to contextualise the study, and will be presented in this chapter. Research that I found which I believed may be of use during data collection and analysis was set aside. The second phase of literature reviewing, which was targeted and in-depth, began when I started data collection. The literature accessed as part of the second phase has been incorporated into the discussion chapter of this thesis.

Considered Bodies

Women and men are not socialised in the same way regarding their bodies, thus how one then lives in a body that falls outside the social norm dictates experience. McDonald and McIntyre (2002) comment on women who ‘... construct their lives or whose lives get constructed outside of societal norms...’ suggesting that for these women experiences of health are “lived in a complex interplay of their social reality and society’s discourse surrounding their reality” (2002, p 262). Kern (1975, px) indicates that the “object body” acts as a determinant for how we experience our lives, and that physical size is one feature of appearance which acts to modulate the “potentialities of different life experience”.

Lawler (1991) echoes Kern's outlook, suggesting that physical form shapes the experience of social life. It is for marginalised women, such as those living in larger bodies, that strong messages are conveyed regarding worth and value.

Consistent with the symbolic interactionist underpinnings of this research, fat bodies have meaning ascribed to them. In other words, bodies house symbolic meanings and are the site for values which reflect the values held by our culture. So whilst being obese is currently being tabled primarily as a medical concern, the social implications of fatness are also just as legitimate. Murray (2009) suggests that in the secular western society "bodily maintenance" has become the most visible marker of morality and an ethical lifestyle. The healthy body, which is usually represented as a thin body within public health discourses conveys the individuals' ability to self-control (Murray, 2009). Maurer and Sobal (1999) suggest that social institutions such as professions, industries and organisations play a significant role in shaping the social responses to issues such as weight. According to these authors society "deals with weight not just as a physiological condition, but also as a set of social meanings" (p7).

Grounded theory, particularly that which is undertaken with a constructivist bent, pays attention to the impact that broader social structures has on the phenomenon. A feature of a 'contextualised' grounded theory as noted by Charmaz (2006), and of particular interest and note to me as the researcher, is the ability to include notions such as power and difference as sensitising concepts, and to then progress to a inductively derived analysis which theorises the connection between the local world of the participant and larger social structure (p133). I think aiming to construct a 'contextualised' grounded theory has allowed me as the writer the ability to take into account gender, the social norms regarding female bodies, and the socio-medical construction of obesity when writing this story. In this case, the combination of the social implications of fatness and the medical connotations of overweight and obesity are in itself critical factors in the problems faced by participants, so it was imperative to identify and examine these issues.

The importance of looking at the broader context of the lives and bodies of women in this study are important features of both a contextualised grounded theory and a grounded theory which is informed by a social theory such as symbolic interactionism. Willis et al (2007) suggest that theories provide a model through which to explore and gain insight into

a problem. Social theory, such as the symbolic interactionist perspective underpinning the current study, looks at “the social context of human actions” and is built on the premise that what we believe and how we act as individuals are constructed both by interaction with each other and other social groups as well as by social structure (Willis et al. p439). With this in mind, I considered it important to examine the context of large bodies within society in the current health and social climate, as well as looking at issues such as power and gender.

Women and Weight

Fatness is something which elicits strong opinions, particularly in contemporary societies. Fatism is almost an accepted part of our culture, a socially accepted form of discrimination. Currently, the majority of reporting on overweight/obesity, including medical and lay reporting, all point toward the fact that fatness is a significant risk to the health of women. Fat people are depicted as comedians, deviants, sloths, and generally as people who defy norms about how bodies ‘should’ look. Overweight and obese women are rendered as abnormal, with women who inhabit large bodies living at the margins of a culturally enforced and medically endorsed ideal of body weight.

Davis (1995) states:

We live in a world of norms. Each of us endeavours to be normal or else deliberately tries to avoid that state. We consider what the average person does, thinks, earns, or consumes. We rank our intelligence, our cholesterol level, our weight, height, sex drive, bodily dimensions along some conceptual line from subnormal to above-average (p23).

Murray (p363) also argues that ‘normative thinness constitutes the ‘universally feminine’ suggesting that this perception becomes part of the backdrop of normalcy in relation to body types. In this way, slender bodies are normal and fat bodies are abhorrent.

Many authors point toward the evidence which demonstrates our cultural fear of fat.

Kipnis (1998, p199) sums up the social, cultural and medical fixation with fat, stating:

Fat. Few topics excite as much interest, emotion, or capital investment. With a multibillion dollar diet and fitness industry, tens of millions of joggers, bikers, and power walkers out any sunny weekend all trying to banish fat, work off fat, atone for fat, health ideologies who talk of little these days besides fat, research and development dollars working overtime to invent no-fat substitutes for

fat, our intense wish is for fat's absence is precisely what ensures its cultural omnipresence.

Women in this research had thought about their fat bodies in depth. Most didn't believe that you could live in a large body, and not have thought about the ramifications of that embodiment - living in a large body was something that had reached into every corner of their lives. McKinley (1999) suggests that because women are chiefly defined through their appearance, beliefs about weight and womanhood are closely connected. She states that "the social construction of the female body as an object to be watched makes the definition and evaluation of women in terms of appearance seem "natural"(p99). Germov and Williams (1999, p118) state that

[T]he social body is a 'gendered body', with significant differences in the normative expectations of female and male bodies as reflected in cultural aesthetic ideals. Gendered bodies are produced and reproduced through discourses of beauty, health, food, cosmetics, fashion, and exercise.

Cooper (1998) describes fat people as a social group who share experiences of oppression and prejudice. Herndon (2002) posits that fat women are doubly disadvantaged – both because of their social experiences of female embodiment and their largeness. McKinley (1999) also discusses the gendered nature of obesity, suggesting that throughout history depictions of ideal women have been linked to weight. She argues that whilst weight is used to evaluate both men and women, weight holds special meaning for women. In 1992, Rothblum argued that women are held accountable for their weight and that they suffer the consequences of this. She argued that beauty standards 'virtually demand' thinness in order to be attractive, estimating that the American diet and beauty industry was worth 20 billion dollars.

Women who had been large for many years believed that their body size had considerably impacted and shaped their lives. Germov and Williams (1999) argue that the female beauty ideal is based on thinness, and that women strive for this in order to be considered attractive, and to avoid the stigma that being overweight carries. Urla and Swedlund (1995) discuss early anthropometric research, where men's bodies were the tacit prototype, and women's bodies were not only under-represented, but also commonly referred to as 'deviation' from the norm. They suggest that the 'normal' body was value laden and

developed within the context of “a race-, class-, and gender-stratified society” (1995, p293).

Women who live in large bodies live in the intersection of a medically endorsed and culturally enforced ideal of body weight and shape. If, as Susie Orbach (2009) claims, “our bodies are the sum measure of our worth” then large bodied women are being bombarded with negative messages about their bodies from a broad cross-section of the community. Urla and Swedlund (2002) argue that it is well documented that women’s bodies have been understood through the lens of her reproductive function. It is also widely recognised that women’s bodies are constructed as objects that are relentlessly sexualised (Lawler, 1991; Wolf, 1991; Greer, 1999). Sands and Wardle (2002) indicate that the ‘prototypical’ woman depicted by Western media is thin, whilst ‘heavy’ women are consistently under-represented. (Silverstein, Peterson, and Purdue: 1986, in, Sands & Wardle: 2002). Wesley (2002) also comments on modern feminist thought which holds that the ideal body image that women strive for is secondary only to the societal construction of women as “objects of [hetero] sexual desire”.

Western culture adheres to the notion that thinner is normal, thinner is better, and fat is abnormal. It is difficult to refute the notion that for women, particularly those living in this culture, a thinner body is regarded as a normal body. For the women in this study there was definitely little doubt as to what they believed their bodies ‘should’ look like. Spitzack (1990) suggests that obesity is culturally constructed as something which not only confronts ‘aesthetic sensibilities’ but also which evidences character deficiencies (p10). Similarly, Orbach (2009, p58) states:

From the outside, we can and do read people’s bodies. Bodies communicate. Often, though, what we read from the body we translate into the terms of the mind.

In western culture, a thinner body is regarded as healthier, more sexual, and more attractive. Women in particular are inundated with images of thinness, distributed by the media who Barker and Barker (2002, p89) indicate possess a significant responsibility in propagating public health information and also in perpetuating the ‘yardsticks’ of measurement against which individual body shape is measured. There has been much inquiry into the role that the media and other industries have played in shaping unrealistic

expectations about body size and shape, however there appears to be little change in the effect that these social organizations have on the consciousness of women. If anything, guilt grows stronger and women punish themselves more to belong to a culture that serves only to oppress them.

In 1991, Naomi Wolf said “ideal beauty is ideal because it does not exist” (p176). Whilst the women in this study did repeatedly reveal their scepticism about the notion of their ‘ideal weight’ or ‘BMI’, it was also evident that they weren’t immune to dominant discourses around ideal weight and the BMI. McKinley (1999) suggests that the construction of ideal weight as ‘healthy’ is problematic because it makes it seem scientific and objective, and thus, difficult to challenge. She suggests that the adoption of the notion of ideal weight is so common that it has become part of normal thinking. She states:

Through the positive construction of ideal weight, the stigmatisation of fatness, and the connection of ideal weight with ideal womanhood, dominant culture creates the desire for thinness, especially in women, and simultaneously controls women’s behaviour (p 107).

Drury and Louis (2002) suggest that given the social addiction to slimness and beauty an individual is only valued if they are ‘aesthetically pleasing’. Within western cultures, being fat does not equate to being beautiful. And the push and longing to be beautiful is a powerful force. Germov and Williams (1999) argue that the ‘thin idea’ is perpetuated and replicated by structures which profit from its promotion. Structures such as the dieting, fashion and fitness industries promote an ideal which is for the most part unattainable, yet the pervasiveness of the ideal is strong.

Naomi Wolf (199, p187) introduced the notion of ‘the beauty myth’ describing it as a “backlash against feminism that uses images of female beauty as a political weapon against women’s advancement”. She suggests that the beauty myth is not about women at all; rather it is about male institutions and institutional power (p13). She says that the female obsession for the ‘ideal’ beauty is not because women are weak, but because they have been set up to strive for that. In her now seminal work Wolf discusses the hold that the beauty myth has over women. Beauty, she tells us, is an elusive quality that women must want to embody, and men must want to possess women who embody it (p12). If as Wolf describes, the beauty myth is a form of social control over women, those who defy it therefore must be seen as women who openly defy the norms, or who are too lazy, weak

willed or stupid. Wolf (1991) also states that “female fat is the subject of public passion”, suggesting that the obsession with female thinness is based on female obedience not on female appearance, but on female obedience.

Wolf also talks about food, suggesting that women have always eaten worse, and differently, than men. Feminist authors have argued that for women, our appearance is a determinant of social life. Inhabiting a body that is bigger than the culturally sanctioned norm dictates that the lens that a large bodied woman is viewed through is coloured. It also dictates how large bodied people view their own life. Wolf is not alone in her discussion around the structures and institutions that have informed standards of beauty. Fat and beauty are not often words that are used together in western culture. The social and cultural context of fatness has undeniably affected the life experiences of people living in large bodies, in particular women. Over the last decade global cultural shifts in thinking have seen the development of health strategies aimed at counteracting the incidence of overweight/obesity. Diet and beauty industries, which now promote thinness as both a social asset and the healthy choice, have continued to thrive.

Culturally, overweight and obese people have been depicted as people who are subjects of scorn and derision. Hatred of fat has seen the advent of practices such as ‘hogging’, whereby men will purposively attempt to ‘pick up’ the ‘ugliest’ or most overweight female they can find in order to win a bet, a game or to have sex. In 2006 Gailey and Prohaska conducted a study with undergraduate male college students and their findings suggested that some men find hogging entertaining because they believe that the women they select are defying “traditional gender norms” by being overweight and thus are not worthy of the same treatment as ‘normal’ women (p 38/39). The following quote is an excerpt of a blog on the website called CollegeStories.com where college students can submit stories about college experiences. There is a host of stories about groups of young men ‘hunting’ down overweight or obese women for sport, or the humiliation of ‘waking up’ with a fat woman. One story, written by a young male, describes a night out with his friends:

When we got to the bar, I started to play pool and lost track of Bob. Halfway through the night, I found him sitting at the bar talking to a rather large girl. When I say large, I'm not kidding. This girl could only get one ass cheek on the barstool. Bob has a reputation for hogging; Mike likes to say he won't hook up with a girl unless she weighs more than he can bench press, but this one was especially big.

Our friend Lana commented to us, "She's not even one of those pretty fat girls." Coming out of a girl's mouth, that's pretty bad. Bob ended up going home with her, and coming home the next morning to hear eight drunk voice-mails left on his machine mostly us just laughing and yelling 'FAT'.

Another college blog, PointInCase, provides another example of hogging:

There are three main types of fat girls, each with a fairly simple designation. Although none of these girls are generally acceptable for relationship purposes, there comes a time in a man's life when he has too much to drink, and the pursuit of the fat chick is inevitable... We've all done it, no sense denying it. Having sex with fat girls is a time-honored[sic] tradition, practiced by males across the country every weekend. Often referred to as "hogging" or "whale hunting," banging fatties dates back as far as the Stone Age, when cavemen obsessed with slaying large animals would sex up the fattest women, hoping for bigger, stronger, and hairier offspring.

These stories demonstrate part of the culture which affects the everyday experiences of overweight and obese females. Whilst these examples might seem extreme, they evidence the sanctioned cultural scorn which is attributed to overweight and obese individuals, especially women.

It is widely acknowledged that overweight and obese individuals, particularly women, are judged in a negative fashion. Research has identified that people who are overweight or obese experience discrimination based on their weight. Brownell and Puhl (2003) suggest that the discrimination experienced by overweight individuals is caused by very strong anti-fat attitudes. Some authors have suggested that anti-fat attitudes are a culturally accepted form of discrimination. Inhabiting a large body has been shown to impact the attributes that others apportion to the obese individual. Brownell (1991) and Smuts (1992) suggest that thinness can be viewed as a sign of 'trustworthiness' because it illustrates that a person has both discipline and control. Barker and Barker (2002, p90) suggest that individuals who 'fit the conventional norms of attractiveness' are liked more, have a better chance of employment and are judged more favourably on 'many personality dimensions'. Miller and Lundgren (2010, p712) undertook an experimental study with college students examining the effect of body mass on their evaluation of political candidates, as well as looking at the effect of weight on the relationship. They found that obese women were evaluated more negatively than non-obese candidates, whilst the opposite was true for male candidates.

Fat female bodies directly confront the gender rules that govern the appearance of western women. Contemporarily, in western culture, fat bodies also defy norms about what is viewed as healthy with largeness representing medical noncompliance and deviance from the *normal* body. The combination of sociocultural and medical norms around female bodies dictates the experiences of fat women some of which this thesis has explored. There exists a cultural phobia around fatness, a 'fat phobia', which Robinson, Bacon and O'Reilly (1993, p467) describe as a "pathological fear of fatness often manifested as negative attitude and stereotypes about fat people". Orbach (1990) believes that western women are vulnerable to pressures to lose weight because we are raised to conform to ideals of womanhood which emphasises the importance of body weight and height. She states "we are taught that we must both blend in and stand out – a contradictory message indeed" (p xviii).

Valentine (1994) posits that a woman's character is judged by her outward appearance, thus influencing how she interacts with the world that she inhabits. Wiles (1994, p33) suggests that being fat is a "more negative and stigmatised experience" for women because of the cultural expectations regarding female attractiveness. Thone (1997) concurs with this sentiment and posits that there are a very harsh rules for women in society and that heading the list of what not to do's is to 'NOT GET FAT'. If as Wolf describes, the beauty myth – which relates to the pressure to be thin - is a form of social control over women, those who defy it therefore must be seen as women who openly defy the norms, or who are too lazy.

Given the understandings of obesity within western culture, it is difficult to reject the notion that individuals who are overweight or obese are treated differently. Herndon (2002) states that fat people are constantly advised and urged to engage in self-modification – to lose weight. Fat women are repeatedly chastised about weight and persistently urged, even when uninvited, that to lose weight is best. Powerful cultural and social institutions advise that losing weight will make you live longer, look better, and decrease your chances of getting various diseases. Orbach (2009) suggests that fat people are seen as outsiders who should both dislike themselves and be disliked and discriminated against by others (p103).

The Medicalisation of Obesity

Medicine has been and is influential in the way that health and illness are socially constructed. Medical researchers have largely looked at obesity within a disease framework. Medical definitions of bodies which are considered normal and acceptable have increasingly shaped how society defines and respond to bodies (Conrad, 2007). In western societies women who are overweight or obese live in bodies that are culturally and medically identified as *abnormal*. Medicalisation is a term that has been coined by sociologists which refers to the process whereby non-medical conditions become treated and defined as medical problems, such as disorders or illness (Conrad, 2007). The medicalisation of obesity has led to a focus on obesity as a disease epidemic and obesity as a medical condition, ignoring the people involved (Herndon, 2002).

At the time of writing Wright (1999, p308) argued that the “medicalisation of women’s fat” was relatively new, but that it was not unlike other areas of women’s bodies which had been subject to medicalisation. Conrad (1992) also suggests that women’s bodies are more vulnerable to medicalisation. The medicalisation of obesity has led to the construction of obesity as a disease, and as a result women who live in large bodies are presumed to suffer from ill health, as well as medical professionals presuming that weight is the root cause of all health ailments. However despite evidence which suggests that obesity may be linked to genetics or that which suggests that obesity doesn’t necessarily equate to ill health, the experiences of the women in this study suggest that fat people are still held personally responsible for what they have done, or let happen to their bodies.

Cooper (1998) discusses medicalisation suggesting that it “ensures that it is the fat on our bodies that is blamed for the problems in which we deal” (p121). Cooper proposes that a social model of health would allow us to look at fat bodies as part of spectrum of bodies rather than as something abnormal. She suggests that some scholars have looked at disability through a social model, and whereas medicine would define an individual with one leg as having a disability the social model would see this as impairment and a natural part of everyday life. Adopting a social model to an analysis of fat bodies could assist individuals to stop blaming themselves for the consequences of their bodily differences and instead focus on the cultural attitudes and beliefs which have cultivated the beliefs that fat bodies are abnormal.

Sobal (1995) suggests that obesity became medicalised through the pervasive claims by medical people, and their allies, “that they should exercise social control over fatness in contemporary society” (p69). He suggests that these claims appeared in medical journals, reports, mass media, and were presented in many forms: including through labelling and defining obesity as a disease (p69). Medical definitions of bodies which are considered normal and acceptable have increasingly defined how society defines bodies (Conrad, 2007). Now that obesity has become medicalised, medicine is another social institution which makes believe that their bodies are abnormal or somehow bad.

Conrad (1992) draws on the work of Foucault in a discussion around medical surveillance, which he suggests is a form of medical social control whereby a condition becomes perceived through a “medical gaze”. When this occurs medical professionals can then lay claim to all activities regarding the condition (p216). Medical surveillance, which is an expanded form of social control, has seen focussed medical attention on individuals who are not sick, but who have become objects of medical interest (Conrad, 2007). As is the case with overweight or obese individuals, individuals who come under the gaze of medical interest are often considered ‘at risk’ and thus are monitored. Conrad (2007) suggests that as social medical control has increased, certain forms of behaviour are no longer solely the responsibility of the individual. However, this has not been seen in how society has responded to obesity. He suggests that the increase in weight loss surgeries such as gastric bypass is an attempt to shape more socially acceptable bodies (2007). Bordo (1993, p166) also comments on social control as it relates to women’s bodies, stating that “the discipline and normalisation of the female body has to be acknowledged as an amazingly durable and flexible strategy of social control”.

Cooper (1998) suggests that the construction of obesity as a disease is not only the result of scientific findings, but also cultural values and beliefs that denigrate fatness. She also proposes that the collective consciousness of people has changed, due to increasing quantities of research findings that act as proof that the overweight body is the source of all manner of ailments from the ‘trivial to fatal’. McDonald and McIntyre (2002) reflect that the contemporary cultural representation of women ‘literally and figuratively’ shape the ‘embodied thoughts and feelings’ of a woman as well as her actual body.

Some authors have also discussed obesity within disability literature. Kai-Cheong Chan and Gillick (2009) draw parallels between fat people and disabled people suggesting that both groups ‘inhabit culturally distasteful bodies’ and dwell on the fringes of “normalcy and normality” (p233). They suggest that both groups experience social isolation and invisibility due to the pressure they feel to find ways of reducing that which makes them ‘abnormal’ (p233). However, the key difference between how society views disability and fatness is that one is seen as something that is inherent, whilst fatness is seen as a consequence of personal choice (Kai-Cheong Chan & Gillick, 2009). Stearns et al (2006) discuss the perceptions held about obesity suggesting that obesity differs from other disabilities in that it is considered to be voluntary or self-inflicted (p241). Herndon (2002) posed the question of situating fatness within a disability context. However she claims that there is resistance to accepting fatness as a disability, she suggests, because people fear that in accepting it we therefore condone it (p125).

Throsby (2007) argues that the present-day “obesity epidemic rhetoric” provides a context in which the fat body is labelled as “lazy, self-indulgent and lacking in discipline” (p1561). Throsby discusses her research with 35 individuals who had undergone weight loss surgery and who were once or were still extremely overweight. The participants in her research echoed the findings of this research in their dichotomised view of their own fatness. Throsby’s argues that whilst her participants sanctioned many of the contemporary constructions of obesity as a problem to be fixed, they at the same time refused to accept the attribution of moral failing to the fat body. They did this, she argues, as a way in which to negotiate or resist the “discreditation of the fat self” (p1562). She also suggests that participants, provided with the opportunity to talk, offered detailed narratives about how and why they were fat. This again resonates with the participants in this research who all talked about their thoughts around being fat, and how they had come to be this way.

Questioning the ‘Epidemic’

The construction of both the ‘war on obesity’ and the ‘obesity epidemic’ have changed how society and medicine address and understand overweight and obesity, as well as changing the way that individuals living in large bodies experience their health and bodies. Obesity is now recognised as a disease, something which has created an interdisciplinary dialogue about whether or not this has been accurately and honestly constructed.

Rich and Evans (2005) discuss the ethical issues associated with the ‘obesity crisis’ discourses arguing that they have been both “socially constructed and public represented” (p341). They suggest that ‘obesity discourse’ is dominated by scientific issues which issue repeated warning, however, there are very few certainties presented. Throsby (2007) suggests that whilst obesity discourses that concentrate on individual moral responsibility, epidemic and crisis are in the majority, there are increasing challenges to these discourses which question some of the key parts of these discourses. These challenges have come in the form of critical ‘moral panic’ works by authors who question taken for granted assumptions about fat individuals, such as the ability to be fit and fat; the fat body as an object of sexual desire, and that constant dieting is harmful to physical and emotional health (p1563). These critical works have also increasingly begun to question broader issues such as the effects of the construction of obesity as a new health problem.

Whilst many would agree that obesity is a disease there is an increasing number of others which propose that obesity in itself does not constitute a disease or an epidemic. Rather, these authors suggest that the obesity epidemic has been borne from moral panic and fear of fat. Rich and Evans (2005) suggest that a central notion of the obesity discourse is that thinness and weight loss is a “universal good” (p346).

Murray (2007, pp362/63) suggests that ‘the clinical gaze’ of medical professionals are grounded in an observation that is never, nor cannot ever be, neutral, but is always already structured in and through the variety of cultural meanings, specificities and prejudices that provide a kind of *lens* through which we perceive others and the world. Murray (2007, p361) states that

In the West, medicine is held up as an objective science, dedicated to healing the sick, unfettered by social prejudices and biases. Medicine is presumed to examine the body of the patient as separate from the self.

Rich and Evans (2005) draw attention to their concerns over the ways in which ‘biomedical narratives’ significantly impact public understandings of obesity, often ‘excluding or marginalizing important considerations around the influence of social structure’ (p342). They suggests that the “scientific evidence” which is used to lend authority to obesity reporting is often tenuous at best, given how much is still unknown about obesity and its impact on health. They argue that the uncertainty and ambiguities

which underpin the obesity epidemic is ethically problematic in the kind of values they foster, as well as the ways in which they contribute to the moral panic around obesity which may not be warranted.

Lebesco (2004) suggests that popular culture would have us believe that fat bodies are 'revolting'. She suggests that fat bodies have been depicted as unhealthy, painted by medicine as the source of all health issues. Despite the obvious trend of the population toward obesity, the 'conventional norm' of beauty, and increasingly of healthy, is still overwhelming thin. It is widely accepted, and actively promoted by certain industries, that overweight and obese bodies are not healthy bodies. Orbach (2009) asserts that global industries, such as diet, cosmetics, food, surgery and pharmaceutical reinforce to women that their bodies are a site for continual (re) construction and improvement.

Weiss and Ramakrishna (2006) suggest that in order to try and stop stereotyping and discrimination influencing the development of health policies, community understanding and social policy need to be informed by science. However, as Gard and others have questioned, there is speculation that 'science' behind the 'obesity epidemic' is not in fact science, but rather part of a dialogue grounded in cultural anti-fat attitudes. Gard and Ward (2005) and others have questioned the science behind the obesity epidemic and suggest that it is this so called science which has added to western commentary around overweight and obesity. Herndon (2002) also suggests that despite the lack of scientific evidence that links obesity to morbidity and disease, the medical community continue to dramatise the effects of obesity which leads to an increase in weight stigma. Rich and Evans (2005) suggest that narratives that critically engage moral and ethical issues around body politics have been excluded due to the primacy of the biomedical narrative in the obesity discourse. The critical narratives, which investigate issues such as the shame and guilt generated through the strength of the biomedical narrative are considered secondary to what is really important – the development of scientific evidence which help us to understand the aetiology and treatment of obesity. They believe this is a problem, stating:

Public representations of obesity do not simply inform us of medical or biomedical 'facts', but create meanings that influence cultural understandings of health, the body and eating (p344).

Rich and Evans (2005) draw attention to the fact that the public discourse of obesity has developed over a number of years through a variety of sources, resulting in understandings that are far from neutral. They suggest that the increasing commentary from academics, researchers and journalists which all come from a biomedical perspective rarely look at the potentially damaging consequences of the obesity discourse, instead focusing again of what can be done to 'tackle' the problem of obesity.

Rich and Evans (2005, p355) recommend that alternative narratives of obesity may offer a chance to for overweight and obese individuals to re (position) themselves within these alternative discourses, which may also contribute to broader sociocultural discussions around understanding of obesity. They suggest that the moral dimensions of obesity discourse have to be raised in the public arena, in order to help educators, health professionals and others adopt more careful attitudes toward the representation of weight and health issues. These authors also suggest that there are a number of discourses that value body diversity and which draw on notions such as the fat body being beautiful, or the fat body being healthy. Whilst these discourses challenge the dominant discourse around obesity, they still remain somewhat marginalised and are criticised for undermining the more important issues of obesity cure and prevention (Rich and Evans, 2005).

Despite the medical research that cites the escalating evidence about the dangers of obesity there is increasing speculation that the 'obesity epidemic' has been constructed by pharmaceutical and weight loss industries, as well as popular media and medicine. Marsh and Bradley (2004) have questioned those involved in campaigning against the 'obesity epidemic', suggesting that there are possible conflicts of interest with who funds the campaigns, and where their interest lie. The institutions which underpin the obesity epidemic are powerful and pervasive. Oliver (2006) discusses the obesity epidemic and suggests that a small group of health professionals, aided heavily by pharmaceutical and weight loss industries, have been working since the 1980's to encourage the idea of obesity as a disease (p37). Many others have also commented on the global weight loss industry, urging individuals not to under estimate the power it has had on the development of the medical classification of obesity. There has also been doubt cast on the intent of weight loss companies, with Oliver (2006) suggesting that the weight loss companies cater to people who want to look thin, not those who want to improve health.

Ritenbaugh (1982) points out the complexity of excess weight, describing described obesity as a culture-bound syndrome. She suggests that whilst biomedicine defines the aetiology of obesity simply as the “positive imbalance between energy ingested and energy expended” this is actually “biomedical gloss” for the “moral failings of gluttony and sloth” (p352). Orbach (2009) draws attention to the issues associated with obesity, asserting that whilst obesity *is* an issue it is critical to recognise the many other layers – including the social, class, nutritional and commercial issues also (p101).

Recommendations from Previous Research

A number of studies have made recommendations relevant to the current research, which supports the need to address issues raised in this research. The following section provides an overview of these recommendations:

- Puhl and Brownell (2001) undertook a review looking at discriminatory behaviours and attitudes toward obese individuals, and identified healthcare as one of three key areas of daily life in which stigma and discrimination occurred. They suggested that the existence of anti-fat attitudes could be both deter individuals from seeking healthcare, as well as altering clinical decision making. They argue for the importance of addressing negative attitudes held by healthcare professionals, because of the damage it creates for obese individuals.
- Puhl and Heuer (2010) suggest that ‘stigma is a known enemy’ in the field of public health (p1040), with obstacles created by disease stigma within recognised within contemporary public health thought. However, despite the attention that other stigmatised practices or diseases have attracted, such as intravenous drug use or sexually transmitted diseases, weight related stigma has not and continues not to be viewed as a legitimate concern. Part of this, they suggest, is the belief that obese persons are responsible for their weight. Puhl and Brownell (2003) suggest that despite the increasing prevalence of obesity weight bias remains the same. They argue that without interventions aimed at reducing weight stigma, obese individuals are ‘left to cope alone with prejudice without assistance’ (p220).

- Drury and Louis (2002) posit that clinicians need to examine their own weight biases. They suggest that non-judgmental communication helps establish a trusting relationship which encourages follow-up rather than avoidance.
- Aronne (2004) suggests that whilst obesity is recognised as a significant chronic health condition, there are barriers which prevent general practitioners from treating it. Lack of confidence and/or expertise coupled with the belief that weight reduction counselling is ineffective and time-consuming presents several barriers for physicians, however Aronne (2004) argues that the major barrier is the belief that patients are responsible for their obesity due to lack of compliance with recommendations for a healthy diet.
- Buffart et al (2008), surveyed 647 GPs about their perceptions and weight counselling practices. Their results suggested that whilst GPs felt weight counselling was part of their role, only a small percentage of them actually provided frequent counselling. Buffart et al (2008) also recommend that given the increasing prevalence of Australian overweight and obesity, there needs to be investigations into GP management of weight and their current practices.
- Bertakis and Azari (2005) conducted a randomised, prospective study of 509 patients to examine how patient obesity impacted on the practice style of primary care physicians. Whilst they found no relationship between obesity and the length of visit, they found with obese patients physicians talked less about health and more about exercise. They suggested more research on communication between physician and patient.
- Thuan and Avignon (2005) suggest that whilst GPs could play a significant role in the prevention and management of obesity, there is evidence which suggests that they don't hold the appropriate skills, thus impacting their practice in this area. In their study of GPs in France they found that whilst almost their entire sample thought that obesity should be considered a disease, only a small amount of GPs found it rewarding to provide weight loss counselling to patients and less than a quarter thought it important to refer on to other healthcare professional such as

dietitians and psychologists. Likewise, less than half of GPs felt they were adequately prepared to treat patients carrying excess weight.

- Puhl and Brownell (2006) offer several recommendations based on the findings of their study. Given the strength of the data relating to the amount of times participants had experienced bias from physicians, they stress the importance of developing education interventions aimed specifically at health professionals, both in training and practising, so that that future generations that provide care which is compassionate and bias free (p1814).
- Thomas et al (2010) suggest that quantitative investigation of obese individuals' perceptions of health and social experiences still have primacy within the literature relating to this topic. They suggest that there is a dearth of qualitative research which investigates both the 'lived experience of being fat' and the coping mechanisms used by obese individuals. The authors highlight the contribution that qualitative research can make to obesity research stressing the importance of anti-stigma campaigns in improving the well-being of individuals who are obese (Thomas et al.2010).
- Puhl and Heuer (2009) suggest that more research is needed to examine more effective ways for healthcare providers to talk to patients about weight, as well as providing more education about the complexity of the aetiology of obesity, the setting of realistic lifestyle goals instead of just weight loss, and the difficulty in achieving long-term weight loss. More education, they believe, may help dissipate the frustration experienced by providers which may unintentionally create negative interactions with patients.
- Thomas et al (2008, p328) state that 'obesity is not caused by culture but arises within and is shaped by it'. An effective intervention, they suggest, has to reflect a variety of both individual experiences and their common themes. They suggest that health professionals need to be encouraged to look to models of care developed for working with patients with HIV/AIDS which were patient directed and community based, and led to partnerships between patients and clinicians.

- Johnson (2004) urges practitioners to consider the terminology they use when referring to a patient's weight. She suggests that for some individuals the term 'obese' is a very insulting and upsetting term, and whilst the practitioner might consider they are helping the client face the reality of their weight they are actually probably contributing to a loss of trust and desire to seek a follow-up consultation.

These studies reflect an international body of work. A synthesis of the recommendations of the above studies echoes the findings of this study. These themes for further research or initiatives include:

- Further research into how to improve communication between physicians and overweight and obese patients.
- Development of educational interventions for health professionals which examine attitudes around weight, and which encourage training in how to communicate in a sensitive manner around weight related issues.
- The development of models of care which account for the cultural underpinnings of weight, weight discrimination and weight stigma.
- Increase in qualitative research investigating issues relating to both physician and consumer experiences of healthcare, specifically in relation to weight.

Conclusion

The aim of this chapter was to present an overview of the literature that was consulted as part of the first phase of literature reviewing of this research, providing also a context for this study. The following chapter will present the theoretical and methodological components of this research.

Chapter 3: Methodology

‘The strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes’. - Crotty, 1998, p 3

Introduction

Grounded theory has come to represent a number of different things. It is not sufficient to offer a definition of grounded theory; rather one must unpack the philosophical perspective of the researcher in order to understand how it is used, and in what context. Whilst it is vital to detail the work of Glaser and Strauss in the development of grounded theory, as well as the advancement and divergence of the method, it is equally important to detail the background of the methodological approach that I, as the researcher, adhere to. Grounded theory methodology, as used in this research, is informed by the theoretical perspective of symbolic interactionism and situated within a constructivist paradigm. I have used grounded theory both as a methodology and as a collection of methodological procedures used to collect and analyse data and to ‘raise’ participant’s stories to an abstracted, conceptual level.

This chapter will detail the approach to grounded theory that I have used in this research in order to construct the substantive grounded theory of large bodied female healthcare consumers. An overview and evolution of grounded theory methodology will be presented, followed by a discussion of symbolic interactionism. The theoretical approach which shaped this grounded theory, namely constructivism will also be discussed, including the work of Kathy Charmaz whose grounded theory approach forms the basis of this research.

Grounded Theory

In 1967, Barney Glaser and Anselm Strauss published their seminal work, “*The Discovery of Grounded Theory*” in which they first described grounded theory as the “discovery of theory from data” (1967, p1). At the time of its release, grounded theory was considered cutting edge within sociological circles. The majority of research methods that prevailed at the time were primarily concerned with testing theories, which Glaser considered ‘arm

chair theorising' (Urquhart & Fernandez, 2006). Paradoxically, Charmaz (2006) comments that while grounded theory was developed in order to counter the dominance of positivist research methods of the 1960's, by the 1990's grounded theory had become known partly because of its positivistic assumptions.

Grounded theory was an intermingling of the work and backgrounds of both Glaser and Strauss. Both were sociologists informed by different traditions who worked together to create the techniques for analysing data that combined both of their backgrounds. Glaser was trained at Columbia University, and was heavily influenced by the work of quantitative innovator, Paul Lazarsfeld. Strauss was from the University of Chicago, which was steeped in the qualitative research tradition (Strauss & Corbin, 1990). Columbia University was very much within the positivist tradition, whilst the University of Chicago had its roots in field research and pragmatism (Charmaz, 2006). Charmaz also comments that Glaser and Strauss both brought positivist underpinnings to grounded theory, despite differences in how they manifested (Charmaz, 2005). Glaser instilled in grounded theory rigorous techniques for coding, and a focus on emergent discoveries, all specified in a language more fitting to quantitative methods. In contrast, Strauss brought his notions of human agency, social and subjective meanings, and the study of action (Charmaz 2006, p7). *The Discovery of Grounded Theory* is still recognised as a seminal text for grounded theory researchers, and whilst this research does not draw on grounded theory as initially described by Glaser and Strauss, and further expounded by both Glaser, and Strauss and Corbin in the decades following, the work of these authors has undoubtedly shaped contemporary discussions around grounded theory.

As a method of inquiry, grounded theory was and is orientated to discovery – meaning the generation of theory. Grounded theory is not a description of the participants' 'voices', rather it is a generated abstraction from both their doings and their meanings which are taken as data for the conceptual generation of a grounded theory (Glaser, 2002). As an intellectual method, grounded theory was established on the assumptions that knowledge is dynamic; people are always changing, and that environment works to impede and assist in the conception of individuals' goals and basic social psychological processes (Benoliel, 1996). In grounded theory, the researcher is orientated to discovering the basic social processes that people use to deal with situations in which they find themselves and that generally are not understood by them at a conscious level. Grounded theory research

uncovers what the sources of concern are, and the processes used by participants to deal with it (Crooks, 2001). Clarke (2006, xxxi) describes “basic grounded theory” as an empirical approach to the study of social life through qualitative research and analysis. The researcher assigns temporary codes to particular phenomena through the process of open coding, and examines the data to assess whether codes appear throughout the data when they are generated by different data sources.

The Evolution of Grounded Theory

Since the release of *The Discovery of Grounded Theory*, the evolution of grounded theory has received considerable comment. Despite the recognition that methodologies reflect prevailing modes of thought at each moment in time, there has been considerable comment regarding the changes that have occurred over time to grounded theory methods. Mills *et al.* (2006a) suggests that grounded theory methodology has been ‘adopted’ and ‘adapted’ by many researchers since its inception, in order to use it with a variety of both ontological and epistemological positions (pp 8/9). They position grounded theory upon a ‘methodological spiral’ which reflects the various research traditions throughout time, and the ontological and epistemological underpinnings of researchers (p9). They suggest that all variants of grounded theory are part of this spiral, with constructivist grounded theory toward the latter end.

Grounded theory has undergone many changes since its inception. Far from Glaser and Strauss continuing to collaborate and expand their theory, they became divided in their vision of grounded theory and lost the commonality that they had once shared. Glaser continued to research using what he believed was the grounded theory that they had initially developed, whilst Strauss collaborated with Juliet Corbin to produce what Glaser saw as vastly divergent from the original method. Since *The Discovery of Grounded Theory* was released, there has been ongoing debate over what *is* and *is not* grounded theory. Much has been written challenging the original grounded theory stance that an external reality exists, one that is observable and something that can be detected through the unbiased lens of the researcher (Charmaz, 2005). Dependant on the background, experience and knowledge of the individual, grounded theory is many things. Many factors influence how grounded theory methodology is used. Dependent on the size of the project,

the researcher may elect to use grounded theory as a framework for qualitative analysis rather than a methodology that has its own theoretical underpinnings (McCallin, 2003).

Many researchers have moved grounded theory away from the method described by both Glaser and the work of Strauss and Corbin (Charmaz, 2006). McCallin (2003) comments on the many variations of grounded theory suggesting that there is 'looseness' inherent in the methodology that may not suit all researchers. She suggests that there are three versions of grounded theory – the original, as articulated by Glaser and Strauss (1967); and the models generated by the work of Strauss and Corbin. McCallin (2003) notes that grounded theorists undertake inquiry to discover group behavioural patterns in specific contexts. She stresses that discovery is a critical part of a grounded theory inquiry, particularly in relation to smaller projects where the aim is not to generate a substantive theory, but to explicate the social processes underpinning interaction and behaviour (McCallin, 2003). Mills and Frederick (1999), who situate 'their' version of grounded theory within the Strauss and Corbin tradition, suggest that grounded theory has become a 'central organising concept', which lends direction to the research process as well as providing a 'heuristic' for collecting and analysing data.

Many other researchers have used grounded theory in ways that remain faithful to the original method, as well as those who have further developed it. In 2006, both Kathy Charmaz and Adele Clarke published books detailing grounded theory as they saw it. Other scholars, particularly within nursing, have played a significant part in the development of grounded theory methods. During the 1980's, a period that Benoliel (1996) has named the Decade of Diffusion, the postdoctoral nurses who had studied grounded theory with Glaser and Strauss organised a conference on grounded theory. The outcome of this was the creation of Chenitz and Swanson's 1986 book on grounded theory, *From Practice to Grounded Theory: qualitative research in nursing*. During this time other nursing scholars also moved grounded theory to the forefront of the nursing community. Grounded theory was made visible by the published work of nurses such as Stern (1980, 1985), Hutchinson (1986b), Wilson (1982), and Pyles and Stern (1983). This decade saw the convergence of nursing scholars skilled in interpretive methods, which led to the formation of an 'invisible' college of nurse investigators (Benoliel, 1996).

Many studies claim to use grounded theory methods; however there is some conjecture as to whether all research that is reported as grounded theory actually *is* grounded theory. Grounded theory studies usually explicate a process (Hood, 2007) and many so-called grounded theory studies do not identify a process, and remain at a purely descriptive level. Another critical assumption underpinning grounded theory is that data collection and analysis occur simultaneously, and that theory is generated from data rather than testing pre-existing theories (Eaves, 2001).

Constructivism

Constructivism informs the process, methods and way of thinking in this research. Crotty (1998, p3) defines epistemology as the theory of knowledge embedded in the theoretical perspective and thereby in the methodology. Milliken and Schreiber (2001, p181) state that ‘the epistemology of grounded theory begins with who is the knower’. The grounded theorist endeavours to understand the social constructions that form participant realities, and the subsequent effect these have on behaviours (Milliken and Schreiber, 2001). Constructivists study why and how participants create realities (Charmaz, 2006). Thus, a constructivist grounded theory has its ‘foundations in relativism and an appreciation of the multiple truths and realities of subjectivism’ (Mills et al. 2006a, p8).

Constructivism was borne from debate about the philosophical paradigms that underpin the basic research questions surrounding the characteristics of research inquiry (Appleton & King, 1997). Constructivists are concerned with the construction of truth and knowledge, and reject the notion of objective truth, believing that knowledge and truth are created not discovered (Schwandt, 1998). In its simplest form, constructivism asserts that reality does not exist in any ultimate, empirical way, but rather is a construction of the person who is viewing or experiencing reality at any given moment (Klugman 1997, p304). According to Crotty (1998), constructivist thought holds that there is no objective truth; rather that truth is created by and through our engagement with the realities in our world. Hence, meaning is constructed through interplay with the subject and the object. A symbolic interactionist perspective, which is the theoretical perspective underpinning this research, also holds that the ‘actor’ in any given scene interprets and interacts with the world based on the meaning that she or he has attributed to that symbol. Constructivism is based on the notion that reality is pluralistic, open to multiple interpretations (Appleton & King, 2002). From the

constructivist perspective, meaning is constructed, as opposed to created. Crotty (1998) holds that it is important to recognise that meaning is constructed, not in a vacuum, but within the framework of the world and the objects within it. Meaning is thus susceptible to the cultural and social composition of the individual.

Underpinning constructivism is the notion that we, as human beings, are “proactive co-creators of the reality to which we respond” (Crotty, p195). Constructivism posits that ‘reality’ is not inherent in objects independent of human consciousness, but that reality rests in the conscious construction and interpretation of objects (Barkway, 2001). As with symbolic interactionists, constructivists share the view that individuals assign meaning to experience, which constructs their social reality. This occurs through continual interaction with others including continual negotiation and interpersonal communication (Appleton & King, 2002).

Appleton and King (1997) have suggested that methodologically, constructivism adopts a “hermeneutic and dialectic approach” (p14). Hermeneutics is concerned with the discovery of meaning and the lived experience of the everyday (Pursley-Crotteau, Bunting & Draucker, 2001). Simply put, this implies that a constructivist methodology is informed both by the interpretative perspective of hermeneutics; and a focus on the contradictions within the data, which dialectic logic holds is an important part of reaching higher levels of abstraction (p15). Francis (2005, p252) believes that at the heart of constructivism is the idea that ‘the world as we know it and understand it is a creation of human intelligence and interests, via practices in and through which that intelligence is realised and those interests defined’.

The current research fits well within Charmaz’s description of social justice research. Inequalities based on gender and class, age and disability are everywhere, and Charmaz (2005) suggests that grounded theory studies can reveal how they are ‘played out at interactional and organisational levels’. Charmaz advises that researchers with an interest in social justice will pay attention to details concerning equity, fairness, status, and individual and collective rights of individuals (2005). Charmaz also advises that the constructivist underpinnings of grounded theory must be developed in order to make grounded theory suitable for 21st century social justice inquiry (2005), a sentiment that I adhere to.

Kathy Charmaz and Constructivist Grounded Theory

The work of sociologist Kathy Charmaz has been very influential in the development of my ideas and thinking around both grounded theory as a research process, and the philosophical and epistemological underpinnings of grounded theory. Kathy Charmaz is a Professor of Sociology who has extensive experience in the application of grounded theory, having earned her PhD under the supervision of Anselm Strauss. Since that time Charmaz has built up a significant body of work, with her recent book 'Constructing Grounded Theory: A Practical Guide through Qualitative Analysis' (2006), providing readers with a detailed guide to her version of grounded theory. In a 2006 interview Charmaz credits the work of Glaser and Strauss, as well as people such as Antony Bryant and Adele Clarke with influencing her work, stating "... I do have that grounded theory emphasis that stems from Barney Glaser. I think I have the fluidity from Anselm Strauss, which is probably as much pragmatism and symbolic interactionism as it is grounded theory" (Puddephatt 2006, p8). Charmaz also suggests that her 'version' of grounded theory is embedded within the assumption that any theoretical rendering offers an interpretive portrayal of the studied world, not an exact picture of what is happening within the given scene (2006).

Charmaz's approach to grounded theory resonated for me as a researcher. From early on in my research, I disagreed with Glaser's position that reality is something that can be observed, but not influenced. For me, Charmaz offered a version of grounded theory that was relevant and extremely applicable to contemporary qualitative inquiry, particularly because of how she situates the researcher into the construction of theory. Charmaz believes that the researcher is a key part of the research process, shaping both the process and outcome of the study. She also believes that we as researchers can use what she identifies as the tools of grounded theory without having to situate ourselves within particular ways of thinking (2006). Charmaz also argues that grounded theories need not, and possibly cannot, be tied to a particular epistemology. In contrast she suggests that grounded theory tools can be used in a variety of ways, and that grounded theories can be viewed as the product of an emergent process that has occurred through interaction (p178).

Kathy Charmaz has generated a significant body of work regarding her approach to grounded theory. A key feature of Charmaz's grounded theory, and in direct contrast to early grounded theory which posits that theories are 'discovered', is her explicit notion that theories are 'constructed', and are an 'interpretative' portrayal of the studied phenomenon, constructed by the researcher through interaction. Constructivist grounded theory, which is how Charmaz labels her grounded theory, steps away from the traditional verification procedures associated with Glaser's grounded theory. MacDonald (2001) suggests that constructivist grounded theory does not make distinction between discovery and verification, viewing the two as symbiotic processes. Glaser describes what Charmaz does as 'descriptive capture' versus the 'conceptualisation' that a grounded theory analysis should produce. Others have also critiqued and criticised a constructivist approach to grounded theory.

A constructivist approach to grounded theory is based in the interpretative tradition and is most closely aligned with the work of Juliet Corbin and Anselm Strauss (Charmaz, 2006). Mills et al (2006a) position constructivist grounded theory as relativist in ontology and subjectivist in epistemology, a relationship that openly transforms the relationship between researcher and participant, subsequently bringing the "centrality of the researcher as author to the methodological forefront" (2006a, p9). In her 2006 book, Charmaz describes grounded theory methods and theorizing as "social actions that researchers construct in concert with others in particular places and times" (p129), adding that the constructivist grounded theorist acknowledges that theories are contextually based, specific to culture, time, place and situation (Charmaz, 2006).

Charmaz also summarised her constructivist stance, suggesting that for her grounded theory research process is a fluid and interactive process in which the researcher plays a role. She also suggests that grounded theory analysis fashions the "conceptual content and direction" of the study, and that this is a consequence of how the researcher engages with and interprets the data, as opposed to any external prescriptions (p178). Charmaz stresses continuously that grounded theory is a flexible method, and that its flexibility is made visible through engagement. In 2002, Glaser stated that a grounded theory is the outcome of constant comparison and theoretical sampling, core grounded theory procedures which, through vigilant employment, generate theory. This is in opposition to Charmaz who

explicitly states that the grounded theory is the conceptual retelling of participant's stories as told by the researcher.

Charmaz (2005) suggests that there are several critical differences in undertaking grounded theory with a constructivist stance. She suggests that adopting a constructivist approach allows a focus on the studied phenomenon, rather than the methods used to capture it. She also suggests that a constructivist approach encourages a reflexive approach to reality, and a focus on how this is represented by the researcher. Mills et al (2006a) also stress that a constructivist approach necessitates that the researcher try and create a reciprocal relationship between the researcher and participant, a relationship which encourages the shared construction of meaning, as well as one which endeavours to readdress power imbalances, and lastly to clarify the position of the author in text. In constructivist grounded theory the researcher is as central to the process as the participant. Mills et al (2006a) stresses the importance of the relationship between the participant and the researcher, and the need to acknowledge that interviews themselves are not neutral social actions. 'Doing' grounded theory informed by constructivist assumptions means that the researcher pays attention to how the participants construct their social world and understandings of their place within that world. This approach to grounded theory emphasises the "subjective interrelationship" between the researcher and participant (Mills et al. 2006b) and "actively repositions the research as the author of a reconstruction of experience and meaning" (p8). For a constructivist grounded theorist, the focus is on both participant perceptions as well as those of the researcher.

Charmaz purports that grounded theory is a term that refers both to the method and product of inquiry (2005, p507). Charmaz's approach to the method sees the constructivist elements of grounded theory developed and advanced, whilst the positivist objectivist foundations of its origins are not adhered to (2005). She suggests that grounded theory guidelines can be used with contemporary methodological assumptions and approaches, in contrast to the original positivist grounded theory developed by Glaser and Strauss. Grounded theory, according to Charmaz, is used as a set of guidelines through which to answer the research question. The data itself forms the foundation of the theory, and the ensuing analysis leads to the construction of concepts (Charmaz, 2006). For Charmaz, grounded theory is not prescriptive and rigid, and she advocates against what she describes as "methodological rules and recipes" (2006, p9). Rather, she sees grounded theory

methods as principles and practices that should be used flexibly. This is in direct contrast to Glaser (1999) however, who suggests that grounded theory is only grounded theory when it follows a specific set of methodological guidelines.

Symbolic Interactionism

Traditionally, grounded theory has been ontologically informed by the interpretivist philosophy, Symbolic Interactionism. In this research, Symbolic Interactionism informs both the methodology *and* method of this research.

Blumer (1969, p47) states that ‘Symbolic interactionism is a down-to-earth approach to the scientific study of human group life and human conduct. Its empirical world is the natural world of such group life and conduct’. Symbolic Interactionism is a sociological theory which Blumer (1969) holds is built upon three guiding principles: firstly, that human beings act towards things on the basis of the meaning that they have attributed to these things. Secondly, that meaning of things is a product of social interaction with other human beings. Lastly, that each human manages the things that she/he comes into contact with through an interpretative process (Blumer, 1969). Charon (1979, p23) believes that Symbolic Interactionism focuses on the “nature of interactions” between individuals, on the premise that the interaction is the key ingredient.

George Herbert Mead initially developed the theory that was later to become known as symbolic interactionism. Drawing on the work of Charles Darwin and the theoretical perspective, behaviourism, and the philosophy of pragmatism he developed a social theory based on the premise that individuals interact with each other based on the meaning that symbols hold for them (Charon, 1979). However Herbert Blumer, a student of Mead, is widely acknowledged as making a significant contribution to the principles initially outlined by Mead. Symbolic Interactionism is a theoretical perspective that illuminates the relationship between individuals and society – as mediated by symbolic communication (Milliken & Schreiber, 2001).

Qualitative researchers take time to elaborate our theoretical perspective so the philosophical assumptions underpinning our research methods are visible. The theoretical perspective is a means through which to view the world and make sense of it (Crotty,

1998). It is important to expand upon the theoretical perspective which informs the methodology because it provides a context through which to view the chosen methodology. By explicating assumptions, the particular view of the human world and social life within that world is given clarity, and the methodology is given a context for the process; grounding its logic and criteria (Crotty 1998, p3).

As humans, we make meaning by interpreting the dialogue we share with other individuals, and it is only through dialogue that we become aware of the thoughts, feelings and attitudes of others. However, as is the case with all things open to interpretation, it is in this interaction that meaning can be misconstrued and misinterpreted. Symbolic interactionism considers human beings as ‘dynamic and active’ participants in the world (Beck, 1996). As active participants, individuals create meaning through their actions and interactions with others, and in turn create and attribute meaning to these actions/interactions. A symbolic interactionist perspective assumes that ‘social life consists of processes’.

Symbolic Interactionism has been an important part of the grounded theory tradition. Milliken and Schreiber (2001) consider grounded theory to be more than the sum of its techniques, suggesting that symbolic interactionism is inherent in grounded theory. Indeed, it is widely recognised that symbolic interactionism is the theoretical perspective underpinning grounded theory. Interpretive methods such as grounded theory, which are embedded in symbolic interactionism, concentrate on aspects neglected by a strictly biomedical view of health. Symbolic interactionism supports exploration of experiences, actions and variations across time and context (Stern et al. 1982). Socially constructed standards of acceptable body weight are in process of constant flux through social interaction. In the context of the current grounded theory study, symbolic interactionism can assist in developing understanding and insight into how women develop ideas and understandings regarding weight and body size in their daily lives, and how structural conditions and cultural environments influence these constructions and subsequent interactions (Maurer & Sobal, 1999).

Methodological considerations and the current research

This section focuses explicitly on the use and value of grounded theory, symbolic interactionism and constructivism in this study. This section will provide an overview of how these methodological and theoretical approaches have shaped the current research, including how these three approaches have worked to explain and understand the experiences of the large bodied women in the current study.

The aim of grounded theory is to discover a core concept, the element of the theory “that illuminates the main theme of the actors in the setting”, and which explains what is happening in the data (Glaser 1978, p94). Despite what version of grounded theory one follows, which in the case of this research is not the classical approach to grounded theory, I still consider this to be true. The strength of this methodological approach was that it enabled a way for participants to identify the salient issues, rather than participants responding to what I – as the researcher – thought were going on for them. Mallory (2001) suggests that whilst Glaser and Strauss’s original grounded theory was philosophically situated in critical realism, most contemporary grounded theorists situate their grounded theory in philosophical frameworks compatible with constructivist or feminist thought. In this instance, deciding to approach my grounded theory with a constructivist bent evidenced a commitment to generating a theoretical explanation of the world as seen by participants. It demonstrated the attention to how and why participants see the world the way they do, particularly focusing on how they have come to create meaning about their social worlds. It also paid attention to what participant’s viewed at the salient issues in the phenomenon under study, and how they managed these issues.

Bryant and Charmaz (2007) comment on grounded theory and symbolic interactionism, suggesting that there are several compatibilities. Firstly, both assume an ‘agentic’ actor, where the author’s comment has a focus on process rather than structure (2007). Bryant and Charmaz (2007) also comment on other compatibilities including the emphasis, of both theoretical perspective and method, on theory development from empirical observations, as well as the development of conditional theories that address particular contexts (p21). When grounded theory is informed by symbolic interactionism, the

grounded theory attends to the variety of contextual variables, including women's perceptions, attributes of meaning, relationships and preferences for interaction in the healthcare field. Constructing and reconstructing meaning, in both grounded theory and symbolic interactionism, is a constant process and is the basis for action by situated individuals and collectives (MacDonald & Schreiber 2001, p35). Crooks (2001) suggests that the construction of a personal biography does not develop directly, but rather through interaction and observation of others, experience and self-reflection (p14 -15). She suggests that *ways of knowing* are significant features of both grounded theory and symbolic interactionism, and consistent also with constructivism. This means investigating not just what the participants know, but how they have developed their understanding. Thus, a grounded theory that is embedded in symbolic interactionism seems to be perfectly suited to this type of inquiry.

Symbolic interactionism holds that social life consists of processes (Charmaz, 2006). So despite the fact that some have questioned whether you can 'do' grounded theory without the presence of symbolic interaction (Milliken & Schreiber, 2001), it is clear to me that symbolic interactionism informs grounded theory. Grounded theory, even as it is situated within a constructivist stance, is concerned with the discovery of processes. Also key to premises of symbolic interactionism is the belief that human beings should be viewed in the context of their environment (Benzies & Allen, 2001) and this idea is a central part of a constructivist grounded theory, particularly in this research. The presence of both symbolic interactionism and constructivism allowed me to develop understandings about large bodied women as healthcare consumers that were situated within a context that paid attention to issues such as gender and social structure. Using a constructivist grounded theory, situated within a symbolic interactionist perspective provided a way to explore the issue of large bodied women within a healthcare context, whilst incorporating conditions such as gender and power into the analysis. Informing grounded theory with a constructivist approach seemed a logical choice for me. Two important contextual features of this study were gender and body size, both of which are socially constructed. Charmaz also stresses the importance of tending to context when generating grounded theory (Charmaz, 2006).

The challenge for researchers is to break away from the biomedical assumptions that bind us and to uncover what women know about their bodies, what women's concerns are, how

women make health decisions, what women count as evidence that supports health decisions, and what health care means to them. Coming to know women as a researcher provides a means to give voice to those who were previously silent (Crooks 2001, p14). Grounded theory research informed by a symbolic interactionist perspective seeks to uncover the world view of women, through investigating the social construction of meaning and action. This is achieved by asking questions about opinions, problem solving strategies and past and present experiences. The focus is on the process through which those views developed, rather than present points of view. The presence of grounded theory subsequently focuses investigation by asking what the salient issues are, and what salient variables are in operation (Crooks, 2001). A researcher using a symbolic interactionist perspective is concerned with ascertaining what women believe about their worlds and experiences (Crooks, 2001). Research informed by a symbolic interactionist perspective seeks to uncover the world view of women through investigating the social construction of meaning and action. Women's experiences are 'situated and embedded in a social context', and this is true for both participants and researcher. The relationship between the researcher and the woman creates a powerful social context, whereby both the researcher and the participant are both transformed through the process (Crooks, 2001).

Charmaz (2006) holds that as researchers, we do not "exist in a social vacuum" and that all our interactions create a context for the research we undertake. I engaged in considerable reflection regarding this notion, believing it to be a critical point in examining the notion of socially and medically constructed bodies. For this reason, and after considerable contemplation and reflection, I decided to adopt a constructivist approach within my research. Constructivism resonated for me personally, and held appeal for me as a researcher. Constructivism allowed for much of what I had initially hoped a feminist approach to this research would do for the structure and action of this research, and was an approach which captured my aims and intentions toward the undertaking of this research. Approaching the research using constructivist thinking, further to the presence of symbolic interactionism, has added further significance to my role as researcher, particularly the way and manner in which I interpret and (re)create the participants' accounts. Applying an interactionist perspective to a constructivist research focuses the meaning on developing one version of the truth – not one single truth.

Summary

The aim of this chapter was to provide an overview of the philosophical and methodological underpinnings of this research. Grounded theory has been discussed with reference to its evolution, as well as the philosophical underpinning of symbolic interactionism and the theoretical approach of constructivism.

Milliken and Schreiber (2001) attest that the epistemology of grounded theory begins with “who is the knower”. In grounded theory the participant is assumed to hold expert knowledge of the phenomenon under study, and it is the researcher’s job to explore how participants’ beliefs have been constructed, and their resultant behaviour (Milliken & Schreiber, 2001). The notion of the participant as expert was particularly relevant to this research. Large bodied women, as a population, are mostly silent within the research literature. Most contemporary studies, conducted within the medical and nursing context, have concentrated on obesity as a disease, the risk factors associated with carrying excess body weight, and increasingly, weight loss surgery. Grounded theory held appeal as it allowed me to explicate the voices of a silent population, giving credence to their experience and understandings of their social worlds, in particular participants’ views of how they manage the studied phenomenon.

Charmaz believes that the reader will interpret any story or piece of writing individually, because each person brings their own life experience and knowledge to a story (Charmaz 1999, p379). She suggests that any conceptual categories that arise do so from the researcher’s interpretation of the data, rather than being derived directly from the data itself (Charmaz, 2005). The position of the researcher within the research process was of particular concern to me, given my own experiences, reflections and notions of how ‘excess’ body weight shapes identity and influences experiences. Because of this, I found employing a constructivist approach to grounded theory both necessary and liberating. I felt that employing a constructivist approach to grounded theory offered freedom in authorship where not only could I legitimately ‘write myself in’ to the research, but that this act was an important and essential part of the construction of theory.

The following chapter will detail how the study was conducted. This will include methods employed to recruit, sample and interview participants, as well as the processes used to

analyse data. The ethical considerations, including the concerns of reflexivity and reciprocity, are also discussed with emphasis on the care taken by the researcher to readdress potential power imbalances present within the researcher-participant relationship

Chapter 4: Methods

Introduction

I have written in the first person throughout this thesis as an intentional method of writing myself ‘into’ this research. Mills *et al.* (2006) comment on using the researcher’s own voice within the writing, instead of the more traditional third person. They suggest that this is a way of acknowledging the role the researcher has had in authoring a story of the “shared experience of meaning-making about issues of importance for participants” (p12). Webb (1992) also suggests that it is appropriate for a researcher working within the interpretivist tradition to present their work in the first person.

I have used grounded theory methods in a similar way to that which has been described by Charmaz. My grounded theory methods are shaped by a constructivist approach, and informed by a symbolic interactionist theoretical perspective. This chapter presents my theoretical rendering of the stories told to me by participants, developed through rigorous application of grounded theory methods and guided by constructivist grounded theory methodology. This chapter presents the methods that were used in this study, including recruitment and participant selection, theoretical sampling, interviewing and data analysis. Also included is a discussion of rigour, evaluating grounded theory and lastly the ethical concerns of this research.

The Research Question

Consistent with grounded theory research, the final research question is generated by the research process, emerging during data collection (Jeon, 2004). Grounded theory research usually begins with a phenomenon of interest, rather than a focused interest and should become progressively more focused as the research progressed. This research echoed well documented approaches to grounded theory interviewing. As the interviews progressed it became clear that participants mainly talked about their experiences of healthcare within a

primary healthcare context, namely with their GP. Consistent with the nature of grounded theory, the sampling then had to progress in line with what was appearing in the data.

The aim of this study was to work with large bodied women to identify what they saw as the salient issues for them as consumers of healthcare, and the processes they used to manage these issues. I started by first looking at the sociocultural and medical constructions of women's bodies in order to provide a context, and continued with interviewing women living in large bodies. Lastly I used participant data and literature to generate a substantive theory which explained large bodied women's engagement with healthcare. Consistent with grounded theory, interviews commenced with the very general question 'can you tell me about your healthcare experiences'.

The Participants

A total of 22 women participated in the project, with data saturation reached after sixteen interviews with 16 different participants. Some participants were interviewed more than once, with three women being interviewed a second time to find out more about particular categories that had emerged during analysis, as part of the process of theoretical sampling. 16 women were interviewed and I also communicated with another 6 women via email.

Tasmania is a relatively small island state, and because of this I was able to travel to see all the participants who wished to participate in the research. Participants represented several different ethnic backgrounds, as well as different socioeconomic groups. All participants were over the age of 18, with 29 and 63 being the youngest and oldest participants respectively. Participants represented a number of different professions, with most still engaged in the workforce in some way. Of those who were not in the workforce, one participant was currently on maternity leave, whilst the other was on a disability pension.

Participants represented a wide range of body shapes, with participants reporting that they ranged in size from a clothing size 18 to 24. Clothing size, in this study, was an important factor as it allowed women to identify as being overweight or obese without having to reveal their weight. Most participants expressed that their current size, however, was not a static state, rather they experienced fluctuations in size. Most participants reported a long history of struggling with weight and moving between clothing sizes, with some being

smaller or larger than what they ‘usually’ were. I did not attempt to make any distinctions between overweight and obese in this study. Most women shared quite openly about their size, using plus sized clothing as a symbol of where they fell into the weight range most women fell in a range between size 20 and size 24.

All the women who participated in this study did so because they had a story to tell, or because they wanted to talk. When asked why they wanted to participate some women said they did so because they saw it as an opportunity to support a woman doing research into women’s health. Others did so because they wanted to talk about what it was like to live in a large body and others because they wanted to talk about their health experiences – not necessarily related to being overweight or obese – and lastly, a small group, because they wanted to talk about what it’s like to try and be healthy when you live in a body that society says is bad.

Recruitment and Participant Selection

Purposive or selective sampling drove the recruitment phase of this research. In grounded theory studies, as with other qualitative research it is accepted that participants can be selected based on their ability to articulate and express themselves in a way that will shed information around the topic. In this project, where the initial interest was how large bodied women interacted with healthcare professionals, women who were large bodied were recruited. Sampling in grounded theory is sequential, beginning with selective sampling and progressing to theoretical sampling. Janice Morse argues that all qualitative sampling is dependent on 3 principles, one of which she describes as the necessity to locate ‘excellent’ participants in order to obtain excellent data (2007, p231). An excellent participant, she comments, is one who has experienced or observed the phenomenon under investigation, and one who is able to articulate their experiences in a reflective manner. In this instance, locating participants who inhabited large bodies and who wanted to talk was crucial. And, as is common in studies which are voluntary, most of the participants were reflexive people who wanted to discuss their experiences.

Recruitment was conducted over a two-year period, with advertising for participants occurring sporadically throughout this timeframe. This was not a predetermined timeframe, merely a result of finding participants and then reaching the point where

saturation of the data had been achieved. Initially, I had envisioned that the participants would largely be recruited through the use of advertising in community papers, and noticeboards in medical and health centres. During the early stages of recruiting, I emailed a number of organisations providing them with detail about my research, and asking if they would be happy to distribute the project recruitment flyer. All organisations that I contacted then emailed the flyer out through their internal email networks, and each organisation was asked to extend the invitation to keep passing the email onwards. The response from this was immediate, and from that point all participants contacted me after receiving an email about my research. A number of women did pass on the email to friends or colleagues or family members that they thought might be interested, thus the way that some women came to the research was ‘through a friend of a friend’.

All advertisements for the project invited women to contact the researcher if they were interested in participating in a doctoral research project (see Appendix A). When participants contacted me, which primarily occurred through email, I then sent them the project information pack (see Appendix B, C & D). The information pack included project information and consent sheets, and also, provided background information about me in a cover letter to participants – something which I felt was an important step in attempting to form a reciprocal relationship with participants; a key part of constructivist grounded theory (Charmaz, 2006). During the initial email or phone conversation, where I obtained contact details from the participant in order to disseminate study information and consent sheets, I requested permission to contact the potential participant in two weeks to ascertain their decision to participate in the project. Upon follow-up, all but one participant decided to participate in the research. As indicated earlier in this chapter, 22 women participated in the project, with data saturation reached after 16 interviews with 16 different participants. Saturation occurred when it became clear that the basic social psychological problem for these women was ‘being defined’ as a large bodied woman during interactions with their general practitioners, I then emailed 6 different women who I had talked about the project with, and asked them their thoughts about whether they felt their size changed the way their doctors interacted with them. I specifically asked women who whilst still large bodied, had lost and gained significant amounts of weight. The phenomenon under investigation was large bodied women as healthcare consumers, thus recruiting was specifically aimed at women who could provide detailed information regarding this

phenomenon – namely, large bodied women who had experience in interacting with healthcare providers.

There has been debate about whether a grounded theory study should be gender specific as a point from which to commence. Glaser said that a grounded theory study should commence as gender neutral, warning that if it does not then the researcher may wrongly believe then that the theory is gender related (2002). Glaser stated that “gender does not own a theory” (2002, p789) commenting that when conducting grounded theory research for women, the research does “not have to focus on them specifically” (p786), rather that if gender is pertinent, it will emerge. However, I approached this research with the notion that men and women have vastly different experiences of their bodies, due to the gendered differences in the symbolic meanings attached to living in big bodies. Socio-cultural and health experiences are gendered, and it is widely recognised that women’s bodies have and continue to be the site of much of modern western society’s preoccupation for thinness and the ideal body. The body of literature around this area also supports the notion that women’s experiences are shaped and influenced by both their gender and the experience of inhabiting their bodies. Subsequently, this research called only for female participants, and was gender specific from the onset.

Initial criteria for inclusion in this study were based on clothing size and gender. This project was for women who identified, and who could be identified by the researcher as inhabiting large bodies. Based on this, classification for inclusion was determined using a social classification based on women’s clothing sizes, namely a women’s size 16. Size 16 was commonly the largest size available in women’s clothing at the majority of retail outlets in Tasmania (and Australia) at the commencement of the project, and as such was chosen as the minimum size for inclusion in the study. Being above a size 16 creates inevitable division, as it predicates that women over that size are forced out of mainstream retail outlets and into ‘specialised’ shops or sections, reinforcing difference. Using size 16 as a symbol for inclusion in the study seemed a logical choice as it followed an already established social and practical demarcation. This approach to inclusion was thus initiated as both a way of reducing potential harm to participants and as a way of attempting to decrease mediatization of female participants. It was decided early in this research that the Body Mass Index (BMI), which is a widely used biomedical tool for measuring obesity, would not be used to determine appropriateness to participate. Whilst the BMI is regarded

as one of the most reliable tools for measuring overweight and obesity, it has also been recognised as a benchmark that is not always reliable across different cultures (Germov, 2009). It is also a potential source of discomfort and shame for women, who would need to disclose their weight if this tool was used. Whilst other women who wear clothing sizes smaller than a size 16 may still have a BMI which classes them as overweight or obese, it is less likely than it is for those women who wear a larger clothing size. Finkelstein, Linnan, Tate, and Birken (2007) also support the notion of using different ways to appraise overweight and obese, in contrast to just weight as numbers, because people can weigh the same yet look entirely different.

Milliken and Schreiber (2001) suggest that a grounded theory sample consists of people who are familiar with the area of investigation. They also state that a researcher accepts all people who identify themselves as possessing knowledge pertaining to the subject. In this case, all women who volunteered to participate in the study met the predetermined criteria of being both female and over a size 16 in clothing were included in the study. If participants said they met the criteria, then it was accepted that they met the criteria and they were included. In hindsight, this approach to inclusion could have been problematic if a woman who was smaller than a size 16 but who believed her body was larger wanted to participate, but this possibility did not eventuate. All women who participated reported as meeting the criteria, as well as being identifiable as large bodied women.

I had an idea of whom to sample, but was unsure of the direction of the inquiry. Consistent with grounded theory, the research question was ultimately borne of the participants. Hood (2007) describes the initial sampling in this research as ‘a priori’ purposeful sampling. Using this type of sampling, the researcher begins with participants that she or he wishes to investigate. The sampling then becomes more directed as the research progresses. Consistent with grounded theory research, the final research question was then generated by the research process, emerging during data collection (Jeon, 2004). I commenced by simply asking participants to ‘tell me about their experiences of healthcare’, and it wasn’t until I had conducted several interviews that I began to ask participants specific questions.

Theoretical Sampling

Theoretical sampling, as described by Morse (2010) is when participants are selected on the basis of the emerging concepts or theory. Coyne (1997) comments that theoretical sampling seems first to have been discussed by Glaser and Strauss, and is a process whereby data is simultaneously collected, coded and analysed in order to ascertain what data is needed next. Schreiber (2001) describes theoretical sampling as the process of concurrent data collection, coding and analysis in order to develop theory, stating that it is a complex, changing process that shifts as the categories develop and the theory emerges' (p64). Within grounded theory literature the terms 'purposeful' and 'theoretical' sampling are sometimes used interchangeably, however I note the difference between the two. This is noted because of the critique sometimes offered to grounded theorists who choose a specific population to work with, such as I have done in this research.

Charmaz (2006) delineates the difference between preliminary sampling and theoretical sampling, suggesting that the former is where a researcher begins, whereas the latter guides the direction of the research. Charmaz (2006) also comments that it is not possible to plan for theoretical sampling given that it is a process which occurs in response to emerging ideas. Theoretical sampling is guided by the emergent theory (Draucker, 2007). Cutcliffe (2000) suggests that grounded theory researchers seek to develop additional meaning and depth to concepts by seeking new data sources, which makes theoretical sampling a process fundamental to grounded theory research.

Theoretical sampling of participants occurred as descriptive needs were identified in emergent concepts and the developing theory (Morse, 2010). For instance, as it became clear that participants felt that they were treated differently based on their appearance, I then sought out people who had lost significant amounts of weight – thus changing the way that they appeared to the outside world and to healthcare providers. By purposely seeking out new participants, I sought to understand more about the emerging theory that participants were describing to me.

Charmaz (2003) comments that the intent of sampling is to 'refine ideas' not to increase the sample size (p265). She suggests that whilst researchers often sample individuals, even returning to the same individuals, they can also sample documents, scenes of events.

Theoretical sampling helps to illuminate the categories, ‘fill out’ the properties of the major categories, and assists in the understanding of how basic processes develop and change (p103). Charmaz is emphatic that theoretical sampling is not to be used in order to increase the generaliseability of results or to represent a population; rather it should only be for conceptual and theoretical development (p101). I was constantly following up on hunches that were occurring to me during data collection and the early stages of analysis—a strategy which sometimes worked to ‘prove’ my hunch, or to disprove. This is the process of theoretical sampling. This type of sampling was used in order to further develop ideas and categories that emerged during interviews with participants and the subsequent analysis.

As a strategy through which to ‘test’ ideas or hunches I had about the data, I also maintained contact with three of the participants throughout the duration of the research project. I met with these three women again, after the initial interview, in order to share the theoretical ideas I had developed. This was done so I could check if my interpretations resonated with participants, or whether in fact I was going in a theoretical direction which they didn’t believe reflected what was really happening within the data.

Data Management

There were over 300 pages of interview data generated through the process of this research, so it was important that I had a system in place to manage this. Despite having knowledge and training in computer aided qualitative data analysis software, namely NVivo, I elected to approach data management in a more traditional manner and manage the data manually. Although it was easier to store the files electronically, I found that I was able to code the transcripts in a more meaningful way if they were printed out in hard copy.

I kept hard copy as well as electronic files of each transcript. Each participant had a folder, again in hard copy and electronic, which I worked from. After interviews were conducted, I went through the hard copy of each interview and highlighted words and phrases. As interviews progressed, I started individual electronic documents for each code that I felt was recurring frequently in the data. I cut and paste between transcripts, collating all

similar codes from all participant transcripts into these coding documents. This continued until these documents started to develop and codes starting to collapse into categories.

During this time, I also used diagramming and memoing. Some of these were electronic, however many diagrams were hard copy. I kept these in a folder for memos, unless it was particular to a specific participant and then it was kept in that file.

Interviewing

Charmaz (2006) discusses standpoints, suggesting that how we ask the questions influences what participants tell us. She also suggests that the framework that we give our research influences what we look for, and what we see – as well as what we do not. Our standpoints shape our realities and what we each see as truth. I was very conscious of these points as I began interviewing participants.

Interviews varied in length, however most interviews were approximately 45 minutes long in duration. In this research, I endeavoured to make the interviews with participants a lot like conversations with friends – I wanted to be open and approachable, and I wanted the participant to feel like she had power and the right to share what she wanted, in the way she wanted to. This being said I did also want to elicit as much information as I could, so I chose an approach to interviewing which is what Charmaz (2006) describes as ‘intensive interviewing’. The intensive interview is an in-depth interaction which is intended to encourage participants to share their interpretations of their experiences, in the kind of detail that one wouldn’t expect to obtain in an everyday conversation. The intensive interview can use a loose topic guide as a framework, or a series of semi structured questions. Charmaz (2006) suggests that this kind of interviewing allows the researcher to “go beneath the surface”; use social skills to advance conversation; encourage clarification of certain points, and validate the story of the participant (p26).

I interviewed 16 participants before reaching theoretical saturation, a point at which no new information or categories were emerging in the data that revealed new insights (Bryant and Charmaz, 2007). During data collection, I also re-interviewed 3 participants several times in order to discuss categories that arose in the data. I did so in an attempt to keep my reconstructions of participant data ‘grounded’ in what the participants had

actually said. It has been reported by many that a grounded theory should be ‘immediately recognisable’ to the people who the story is about (Milliken and Schreiber, 2001). My ongoing interaction with the 3 participants, who were part of the original 16 interviewees, who I sought advice from several times during the research process was an attempt at making this research as ‘recognisable’ as possible. I considered this process a form of member checking, methodology process through which the researcher returns to participants with a verbal or written overview of the emergent codes of theory in order to obtain participant feedback (Charmaz, 2006).

In this research interviews were conducted with participants in a setting of their choosing, including cafés, hotels, homes and office settings. I preferred to conduct interviews in my office or the participant’s home; however, in some cases participants were not comfortable with this, or it was not convenient. Commonly in grounded theory research, the direction of the interview is guided by participant responses, which is recognised as encouraging participants to share their personal and private concerns (Wimpenny & Gass, 2000). I employed in-depth interviews, believing that the constructing of theory from participant interviews was a two-way process.

As stated above, I initially commenced interviews by asking participants to tell me about their experiences of healthcare. After several interviews I acknowledged that this seemed to make the participants feel that, as one participant described it, they were ‘about to fail a test’. After that, I then decided to ask participants their reasons for wanting to participate in the study. This seemed to relax participants as some of them said afterwards that they did not feel that there was a right or a wrong answer. This also transpired to be way of leading into the topic of large bodies, being a woman, and being a large, female health consumer. In grounded theory, interviews give way to further interviews, and initial coding then gives rise to ideas and categories for exploration in the next interview.

Once data transcription was complete, data was then a constant comparative method of analysis. Interview questions become more focused as data collection progressed which is considered consistent with grounded theory (Duffy, Ferguson, & Watson, 2004). Charmaz (2003) suggests that grounded theory methods contain guidelines which help the researcher to study ‘social and social psychological processes’. Given that a researcher does not know in advance what the particular processes are, general questions are used in preliminary

interviewing (Charmaz, 2003). Subsequent questions are then developed in response to the issues identified by participants. Participants are then found in order to provide more detail on specific issues raised in preceding interviews.

I did not have an interview schedule as such and strove to let participants 'be experts' as described by Charmaz (2006). With some participants, particularly early on in the process, a simple question at the beginning was enough to get participants talking. Indeed, Charmaz states that sometimes one question will suffice if "stories tumble out" (2006, p 290). However, as the interviews progressed and I did need to ask specific questions, based on findings from early coding of other interviews, I would take several questions into an interview with me. I would sometimes also take brief notes whilst talking with women, mainly to remind me to come back to that point later and sometimes to record visual cues that I noticed. This was done usually because I felt it was a significant point, or because the participant had started talking about something else – all of which are things that one would expect in intensive interviewing. For instance, a number of women talked about feeling ashamed during their consultations with doctors. One participant didn't talk about this during her interview, so I raised it by asking her 'other women have mentioned that they sometimes feel ashamed when they have to visit a doctor. What do you think about this?' She then said *'I feel that way all the time! I can't believe that I haven't mentioned that'* (Lucy). However, it didn't always work out that way. In other instances I asked similar questions, in order to verify a hunch or to come back to a note I may have made, and the participant would respond 'no, I have never really thought about that' or 'no, that's not really an issue for me'. Additionally, as codes and categories began emerging, the questions I asked participants changed. As it became clear that 'feeling invisible' was an issue for participants, I started asking participants how they managed this feeling, and whether this had changed over time, and if so, why and how.

I usually ended interviews with the phrase 'is there anything else that you would like to tell me' or 'is there anything else that I should know that I didn't ask?' This is recommended by (Schreiber, 2001) as a key question for finishing the interview as it forces the participant to reflect on what they have said, which can often lead to more useful data. I then thanked the women for their time and knowledge and willingness to share their stories with me.

Interviews were recorded using digital recording equipment, and then transcribed. I was responsible for transcribing all the interviews, which I did the day after each interview. I titled each transcript with a woman's name, a pseudonym which I appointed to that interview. As I was the only person handling the data, I did this primarily so I could use the pseudonyms within the text of the thesis when writing up results without any participant being identifiable.

Data Analysis

Data was analysed using constant comparative analysis, which is a signature feature of grounded theory methods. In grounded theory the use of comparison aims to further the development of theory. Coding occurred from the outset of data collection and was ongoing throughout the research process, which is also a signature feature of grounded theory research. Data was examined line by line, with beginning level coding directing ongoing analyses between documents.

During analysis I was committed to involving the participants in the construction of theory, in order to ensure that the story that was told 'made sense' to the participants. This was facilitated by meeting individually with three participants, as mentioned earlier, with a transcript of their interview that had analysed for preliminary codes. The women who volunteered to play a continued role in the 'reconstruction' of data were invited to comment on the emergent codes, and to have a 'voice' in the direction of analysis. Those participants were involved on an ongoing basis in helping me 'bounce' my hunches and ideas off them, and this was invaluable to me as the researcher, and for adding credibility to the emergent theory. I choose to do this at several points during analysis in order to attempt to reduce becoming disconnected from the data in front of me, and going off on a theoretical tangent. The participants were really useful in several instances where they felt that I was following something that wasn't important, or advising me to follow another vein of thought. Consultation with participants is congruent with the grounded theorists, who verify with participants that their analyses are representative of the truth of the participant. This being said, it is still 'my' analysis, and Charmaz (2005) claims that all analysis is constructed from the standpoint of the researcher, therefore no analysis is ever neutral. Analysis using a constructivist grounded theory advances both the subjective

experience and social conditions (Charmaz, 2005), issues which were significant both in terms of the subject matter and to me as the researcher.

Constant Comparative Analysis

Glaser and Strauss first advised the use of the constant comparative method of analysis in *Discovery of Grounded Theory*, which was a method widely used in sociology at the time (1967). Constant comparison is now regarded as a signature feature of grounded theory, and what Charmaz describes as the ‘core’ of the method (2006, p178). Holten (2008, p277) also denotes the process of constant comparison as one of the “twin foundations of grounded theory”.

Constant comparison is a key feature and critical part of the coding process (Duscher & Morgan, 2004). Constant comparison, used within a grounded theory framework, is used to assist in developing categories and conceptualisation (Jeon, 2004), the aim of which is to construct a theory which is ‘grounded’ in the data. Charmaz describes constant comparison as a method of analysis that ‘generates successively more abstract concepts and theories through inductive processes of comparing data with data, data with category, category with category, and category with concept’ (2006, p187). Comparison, then, is the tool for moving the analysis forward.

Morse (2001) suggests that one of the strengths of grounded theory is the focus on actively seeking variation in the data through the use of constant comparison of all data segments, coding and verifying. She suggests that if these procedures are followed correctly, grounded theory can provide “rich, dense, comprehensive results” (2001, p11). Codes need to reflect emerging ideas, rather than simply describing topics which are appearing in the data, as these codes then assist the researcher in taking apart the data and developing analytical questions about it (Charmaz, 1990).

Chiovitti and Piran (2003, p 429) discuss their experience of coding in a grounded theory study, stating that “information provided by participants earned its way into the theory when constant comparisons of data revealed the repeated presence of specific content areas in actual participant data”. Likewise, in this study the data that appears in the final rendering is not what appeared at the beginning. An example from the data collected in

this research referred to the topic of mothers. Early on in interviewing, several participants discussed their relationships with their mothers. After I reviewed and coded the first interview, I saw that the participant had talked about her mother in relation to the messages she had received about her body when she was growing up, and how she felt that this had impacted her as an adult. Similarly, in the second interview the participant also discussed her mother, focussing on how ashamed her own mother had been about her body, and how she had learnt from a young age that ‘thinner was better’. After the first three interviews, I started to think that this relationship was going to feature in the theory that I was aiming to develop, even though I could not understand how this would work its way into a research project interested in large bodied women as healthcare consumers. However, as interviews progressed and other women didn’t discuss their relationships with their mothers, I realised that this was an area that was not going to ‘earn’ its way into this theory.

The process of constant comparative analysis was employed from the onset of data collection, through all the stages of coding. By constantly comparing incident with incident, concept with concept, I was able to progress the emergence of conceptual ideas.

Grounded Theory Guidelines

Charmaz (2006) describes grounded theory activities such as coding, and memo writing sampling as ‘grounded theory guidelines’. She suggests that these guidelines can be used in a variety of studies, by researchers who all bring their own background, understandings and theoretical framework. Charmaz (2006) suggests that grounded theory guidelines can be used in conjunction with 21st Century methodological assumptions and approaches (p 9).

Coding

I used two types of coding in this research: line by line and focused coding. Charmaz suggests that there are at least two primary phases of coding in grounded theory: the initial phase where data is examined by segment or line by line; and the second focused or selective phase where large amounts of data is organised by the most frequently occurring codes (2006). These stages of coding were not necessarily all linear, and some codes took time and considerable engagement with the data to emerge. Charmaz believes that grounded theorists call attention to “what is happening in the scene” when they engage in

coding data within a grounded theory framework (2006, p3). Coding is a process whereby data is sorted, and labels are attached to each segment in order to describe the meaning of that segment (Charmaz, 2006). A constructivist grounded theory does not have the same attention to the development of a single core category and its properties as does more traditional, objectivist grounded theory (Charmaz, 2000); however, this being said, there are constructivist grounded theory studies which have done exactly this.

Turning a code into a category occurs through analysing an initial code and defining its properties (Charmaz, 1990). At this stage, the researcher's philosophical position or theoretical interests may influence what questions are asked of the data. For instance, as a researcher with an interest in large bodied female healthcare consumers, I asked questions specific to obtaining more information about participant's experiences with health care services or providers. I asked these questions because the aim of the study was to investigate this subject. Charmaz (1990) instructs that coding for processes and assumptions, instead of topics, leads to a more precise analysis. This method of coding assists in identifying major events and issues, and also assists in detecting associations between structures and events (p1168).

Coding is the process whereby we, as researchers, attach labels to segments of data which portray the meaning of each segment (Charmaz, 2006). Coding should relate to the theoretical questions underpinning the research study. Charmaz discusses the differences between codes and concepts, suggesting that a concept is a code that has been identified conceptually, meaning that it is then part of the researcher's 'larger theoretical framework' in which the researcher can specify conditions and offer explanations (1990, p1168). She also adds that in order to create a concept, the researcher has to make a number of decisions, which again involves the researcher actively interacting with the data. To conceptualise a term, the researcher first has to decide that it reflects an important issue or process within the data, before then including it in future data collection (p1169). In order to transform the code into a concept, analytical process such as constant comparison is used.

Line by Line Coding

Open coding, also referred to as *in vivo* codes or first-level coding, are often expressed using participants' own words and was the initial step in the coding process in this research. Labelling each segment assists the researcher in comparing each segment of data with another. Charmaz discusses coding and suggests that the preliminary line by line coding that many grounded theorists engage in allows them to remain connected to the data. She also suggests that this coding encourages the researcher to ask questions to her/himself about what processes are at play in any given situation, and the subsequent consequences of this process (2006, p51). First-level codes were identified during my preliminary engagement with interview transcripts. Charmaz suggests that examining data in this manner can prompt the researcher to 'remain open to the data and to see nuances in it' (2006, p50). Charmaz (2006) offers a number of strategies for line by line coding check this, including breaking up the data into properties; looking for tacit assumptions; explicating implicit assumptions and meanings; comparing data with data, and identifying gaps in data (p50). She advises to construct theory step by step, remaining grounded in the data, without taking off on 'theoretical flights of fancy'.

Hundreds of line by line codes were identified in the interview data, usually using participants' own words, some of which included:

◆ Not feeling good enough	◆ Avoiding
◆ Feeling responsible	◆ The way he spoke was really harsh
◆ Feeling ashamed	◆ Feeling afraid
◆ Having to apologise	◆ Pretending
◆ I knew he was going to	◆ Complying
◆ discuss my weight	◆ Hiding
◆ Feeling afraid	◆ Expecting a comment
◆ Everything is linked back to fat	◆ It's my fault
◆ Defending myself	◆ She's a feminist doctor though
◆ Preparing for battle	◆ Doctors only see my fat body
◆ I was in tears	◆ Responsible for bad health
◆ Being defined by my body	◆ Eating
◆ My mother felt this way about doctors	◆ I am not just a number
◆ I always feel like I am waiting	◆ Relationships
◆ Avoiding	◆ Not feeling entitled
◆ The way he spoke was really harsh	◆ Feeling invisible

Figure 1. Participant Language

As suggested by Birks and Mills (2011), initial coding continued until codes began to emerge from the transcript data. At this point, I then moved onto the next phase of coding: focused coding.

Focused Coding

Charmaz describes the second phase of coding as ‘focused coding’, in which the numerous and/or significant previously identified line by line codes are used to sift through large amounts of data. Focused coding requires the researcher to make analytical decisions about which initial codes make the most ‘analytical sense’ to categorise the data (Charmaz 2006, p57). Focused coding saw line by line codes grouped together into categories, which resulted in the identification of a number of categories including, ‘adopting specific behaviours’, ‘protecting myself’, ‘being defined by my body’, ‘struggling to be seen’, and ‘living in a large body’.

After major categories were identified through focused coding, I engaged in considerable reflection of the relationships between the categories, particularly drawing on the use of memos and diagramming. Qualitative coding can be difficult because it does not always necessarily follow a linear pathway and Charmaz (2006) echoes this in relation to the transition from line by line coding to focused coding.

Memo writing and diagramming

Mills *et al.* (2006) said that as researchers we have several selves, and for the research to reveal passion and sustainability, the area has to be of great concern to one of those selves. However, they also caution that passion can potentially blind the researcher to subtleties in the data. The act of memoing and the use of diagrams means that the researcher’s thoughts are committed to paper, and that they can assist in explicating what is in the data, both implicit and explicit (Charmaz, 1990). Charmaz (1999) depicts memo writing as the ‘pivotal intermediate step between coding data and writing the first draft of the analysis’ (p376). Memo writing allows the researcher to identify and describe theoretical categories, which subsequently focuses further data collection (Charmaz, 1999).

I used memoing as a reflective tool through which I explored my own ideas and assumption about the data, including what it was that participants were saying compared to what they actually meant. Milliken and Schreiber (2001) suggest that memoing “makes visible the researcher’s internal dialogue regarding the data”. Through memoing, the researcher is in a process of constructing and reconstructing her or his own meanings about what is guiding participant action and interaction as they attempt to resolve the basic social problem. Milliken and Schreiber (2001) suggest that in doing this the researcher engages in a symbolic interaction between the data and herself or himself.

After the first interview that I conducted, consistent with grounded theory, I wrote my thoughts down regarding the interview. This is an excerpt of my thoughts post my first interview:

I strongly feel that Molly is caught between two worlds – the empowered world where she and others discuss feminism and bodies, and where she rejects the images and ideals that suggest that thin is best. However, just as keenly, I feel that a certain amount of her is self loathing, afraid and just wishes she was thin. She told me that she had a great doctor, and that she didn’t get any ‘crap’ from him, but she also told me that the thought of having to ‘get naked’ at the surgery is terrifying, and that she would hate to go through all that ‘weight shit’ again with a new doctor.

I also kept a research journal, memoing when I felt worried or unsure:

I don’t think I am at all prepared for this study. That interview just went for an hour and a half, and was intense. I don’t think I expected that she would tell me so much, share so much of their story with me. It makes me feel very nervous and responsible about how I represent her, and others, in the body of this work. Maybe if I wasn’t so connected to this study I wouldn’t have the same fears about representation?

I also wrote memos relating to my use of methodology, specifically about my methodological decisions. This is a memo from the preliminary stages of my research where I was struggling with feminist research and my own feminist values and how these fitted into the project:

I've been really battling over whether this should be labeled as a 'feminist' research project. However I am unsure whether, methodologically, feminism is the right fit for this grounded theory? A feminist approach would certainly be in keeping with the topic of bodies and women, but I feel that using a constructivist approach more accurately captures my concerns as a researcher – some of which feminism and constructivism both attend to.

Perhaps the most frequent memos were those that I wrote during coding:

I think I have been following a wrong path. From the early stages of data collection and coding I knew that the women, after long term engagement with medical professionals, began to do what they described as 'shut out' or 'shut off' from the advice or dialogue they heard from their doctors. For ages I have visualised 'learning not to listen' as a separate concept, however I think that 'learning not to listen' is actually part of 'Protecting myself'. For these women, actively NOT listening is a defensive strategy aimed at minimising the hurt they feel as a consequence of their engagement with doctors.

Another memo, which I wrote as I was deep in data analysis, captures my thoughts related to the processes that participants were using to manage the basic social psychological problem of being defined:

Memo – Managing or Learning to Manage, or learning to play the game?

Women were constantly in a process of trying to manage the visit with their doc, and their doctors too. They felt that they were constantly engaged in a process whereby they had to manipulate the situation in order to get what they wanted. I think that managing is about trying to get the help they needed, whilst at the same time minimising hurt, and trying to be visible to their doctor as more than just a fat body. So maybe there are two sub processes, and these are self-protecting and trying to be seen? Self-Protecting – this is about trying to protect themselves, which is crucial for participants. They need to develop strategies in order to minimise hurt, shame, guilt, and embarrassment. And I think that learning not to listen to what is being said to them is part of protecting themselves. Trying to be seen – these women use a lot of different strategies in order to try and be 'seen' by their GPs. I think that they role play, apologise for themselves and their bodies. And I think that they act certain ways which they know will get them what they need – maybe this is role playing?

I found memoing and diagramming extremely useful tools. Memoing really did, upon reflection, demonstrate a clear trail of my study – including theoretical ideas, and decisions made or not made. It also helped to piece together my theoretical ideas, and provided a history of what I thought at particular times during the study. These memos do not necessarily appear in the end report, but the ideas captured in them help to capture the journey, and are an essential component of the end product.

Below is a picture of one of the many diagrams I drew during the process which I used to try and establish the issues of important to participants, and to identify what I was seeing in the data:



Figure 2. Research Diagram

Another diagram, which I did using my computer instead of by hand, I did toward the end of data analysis

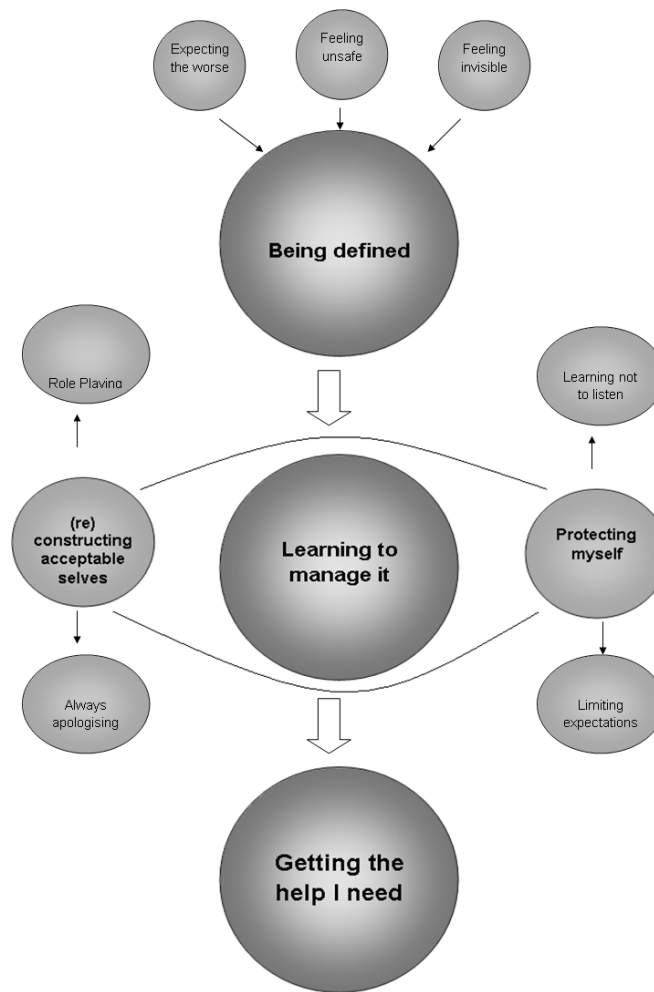


Figure 3. Research Diagram

Rigour

I spent considerable time thinking about rigour in this research, and subsequently making sure that I had taken the appropriate steps to address rigour. Norton (1999) argues for careful consideration of the links between ontology, epistemology and methodology and methods, suggesting that these links are important in developing a grounded theory which is rigorous. I have endeavoured to do this throughout this research, with much time spent thinking and subsequently detailing my version of grounded theory. I think it was and is important for a reader to be able to follow why I have made the choices I have made, as

well as the philosophical and theoretical thinking which guides the methodological framework of this research.

I used theoretical sensitivity, a common grounded theory procedure, as a way in which to address rigour. Schreiber (2001, p60) states that “the personal background of the researcher is the filter of salience through which data are sieved, and each researcher is more or less open to theoretical possibilities contained within a data set; however, we must cultivate this ability”. Schreiber (2001, p60) states that ‘theoretical sensitivity is the ability of the researcher to think inductively and move from the particular [data] to the general or abstract, that is, to build theory from observations of specifics’. Theoretical sensitivity is the ongoing processes of constantly challenging the researcher’s own biases and personal theories against participant data to ensure that emergent theory remains grounded in participant data (Schreiber, 2001). Likewise, McCreadie and Payne (2010) suggest that theoretical sensitivity specifically addresses the role of the researcher, namely the ability of the researcher to create meaning from the data.

Theoretical sensitivity was a reflective process that I engaged in throughout the entirety of the research. This often manifested in memos and journal entries, and forced in me an awareness of what I *thought* was going to emerge from the data. By acknowledging my own beliefs, I was then free to see what was really happening in the data. As part of my commitment to cultivating theoretical sensitivity I engaged in regular meetings with another grounded theory graduate student, where we shared our ideas and issues relating to our projects. We regularly brainstormed ideas relating to what was emerging from coding or writing in our respective projects. These ‘critical conversations’ allowed me to search for all possible explanations of what was happening in the data, and acted as another way through which to safeguard against my own ideas or theories imposing on the theory.

Holton (2007) suggests that theoretical sensitivity requires both “analytic competence” and “analytic temperament” (p275). “Analytic competence” is the ability of the researcher to generate theoretical and conceptual ideas from a wide variety of data sources, whilst ‘analytical temperament’ requires the researcher to “maintain analytic distance from the data, tolerate regression and confusion, and facilitate a trust in the power of preconscious processing for conceptual emergence” (p275). I believe that the attributes described by Holton (2007) are necessary attributes a researcher should have when undertaking this type

of qualitative inquiry – as the researcher, you need to be able to tolerate the, at times, chaotic research journey and “sit with” chaos, and you have to trust that hard work and application of grounded theory techniques, underpinned by a small degree of serendipity, will help the theory emerge.

Glaser (2002) describes bias as ‘just another variable and a social product’, suggesting perhaps that constructivism provides a way for the researcher to avoid tackling the issue of researcher bias. Others, particularly Charmaz, disagree with this sentiment, and indeed use constructivism as a way of explicating the ideas and beliefs of the researcher – choosing not to ignore them, but to make them visible and incorporate them into the research. Glaser, however, suggests that constructivism works to ‘cover up’ bias, instead of incorporating it as just another variable within the analysis (2002).

Chiovitti and Piran (2003, p430) suggested eight research methods for researchers wishing to enhance rigour and critique other grounded theory reports and I have used these extensively as procedural guidelines through which to ‘check’ my own work against. Chiovitti and Piran’s (2003, p430) methods are presented below:

Standards of rigour	Suggested methods of research practice
Credibility	<ol style="list-style-type: none"> 1. Let participants guide the inquiry process 2. Check the theoretical construction generated against participants’ meanings of the phenomenon 3. Use participants’ actual words in the theory 4. Articulate the researcher’s personal views and insights about the phenomenon explored by means of <ol style="list-style-type: none"> a) Post comment interview sheets used as a tool b) A personal journal c) Monitoring how the literature was used
Auditability	<ol style="list-style-type: none"> 5. Specify the criteria built into the researcher’s thinking 6. Specify how and why participants in the study were selected
Fittingness	<ol style="list-style-type: none"> 7. Delineate the scope of the research in terms of the sample, setting, and the level of the theory generated 8. Describe how the literature relates to each category which emerged in the theory

Figure 4. Standards of Rigour

I have constantly referred back to these criteria extensively throughout the research to try and ensure that the theory I was creating reflects participants' meanings as best I could whilst at the same time adhering to rigorous research principles. The participants had a strong presence in this research, as was intended, and the data they proffered guided the study. As the researcher I was concerned that my interpretation and the writing up I offered were clearly demonstrated within the body of this work. Thus it was important to make sure I did as suggested by Chiovitti and Piran (2003) and use the participants' own words to evidence the categories. Using participant quotes brought depth and life to the theory, and it also bought credibility and audibility. Chiovitti and Piran (2003) discuss 'audibility' as a process through which to address rigour. Audibility, as described by Streubert and Carpenter Rinaldi (2011) is the ability of a researcher to follow the methods and conclusion of the original researcher. Using participant data, which were verbatim quotes from interview transcripts, provided an audit trail for the reader of how I, as the researcher, arrived at theoretical decisions, thus demonstrating the credibility and audibility of this research. In their grounded theory study Chiovitti and Piran (2003) described the methods through which they checked that their emergent theory matched with participants' meanings of the phenomenon. They firstly made sure that as each interview was coded questions were changed to reflect participant data. Secondly, as the theory was constructed, they used direct questioning against codes to assert that they captured participant meaning. I also used these methods in this research, considering them part of the natural progression of a grounded theory project.

Part of my plan to address rigour was to ensure that I engaged in a process called 'member checking', a common activity in qualitative and grounded theory research, which refers to taking the transcripts, or summaries of interviews back to participants to validate findings (Birks & Mills, 2011). I spoke to each participant post their interview, in order to discuss the points that I believed had emerged. At this point they then had a chance to inform me if they did not believe what I had identified reflected what they had said. Luckily, this did not happen. I also had an ongoing email discussion with three participants during the life of the study, which I used as a way of testing ideas that I had, whereby the participants could either confirm or reject the hunch that I had had. This was a strategy that I used to try and keep my theoretical re-telling of their story as close as I could to what participants had said. It also provided some interesting insights that participants had not shared during initial interviews.

Norton (1999) suggests interpretive methods look to the interpersonal skills of the researcher when assessing validity, because the researcher is the instrument whereby participant's perspectives are gathered (p37). Whilst validity as a concept is not something I, as the researcher, associate with constructivist grounded theory I have thought about this a lot during this research. While I believe that I have the necessary skills and attention to detail to ensure that this study was conducted in a rigorous manner, potential readers in most cases do not have the chance to meet the researcher, thus, rigour has to be demonstrated in the writing up of study procedures. I have endeavoured to do this in a way that is transparent and which provides the reader with enough information so they can assess this upon reading.

Evaluating Grounded Theory

The classical grounded theory, which is what I regard as the original work of Glaser and Strauss, advocated a number of criteria to assess the trustworthiness and rigour of a grounded theory study. I have found a lot of these criteria to be out-dated and not relevant for 21st century, constructivist inquiry. Charmaz, whose version of grounded theory I have endeavoured to follow, also does not subscribe to the criteria for trustworthiness that Glaser and Strauss originally espoused in *Discovery*. Strauss and Corbin also commented that a 'good' grounded theory can be judged by four criteria: fit, understanding, generality, and control (1990). Terms such as grad, fit and modifiability have all been associated with evaluating grounded theory research within a positivist framework. However Charmaz (2006) also makes reference to 'fit' and 'relevance', describing them as the twofold purpose of conducting grounded theory research. According to Charmaz, a study 'fits' the empirical worlds when the codes and categories that have been developed 'crystallise' participants' experience, and it has relevance when an analytical framework has been constructed which interprets what is occurring and makes visible the relationships between implicit processes and structures (Charmaz, 2006).

Charmaz (2006) proposes criteria for evaluating grounded theory research which include credibility, originality, resonance and usefulness. This criterion resonated for me as the researcher, as opposed to the criteria for evaluating grounded theory research initially proposed by Glaser and Strauss, and I have used these criteria to evaluate the current

research. The headings offered by Charmaz (2006) - credibility, originality, resonance and usefulness acted as something for which to aim when undertaking this research. Charmaz (2003) suggests that relevance is formed through the analytic rendering of ‘actual problems’ and I have endeavoured also to keep this foremost in my thinking. I was mindful of trying to attend to these headings especially in the writing up stages. As I neared the end stages of this research my aim was to generate a story which remained identifiable to participants, as well as developing an analytical rendering of participant data through which practical recommendations could be sourced. The following table provides an overview of Charmaz’s suggestions for evaluating grounded theory research (Charmaz 2006, p182):

Table 1. Charmaz’s Ground Theory Evaluation Criteria

Criteria	Components of Criteria
Credibility	<ul style="list-style-type: none"> • Do the categories include a diverse range of empirical observations? • Is there a strong link between the data and the argument presented in the research? • Is there enough evidence to allow the reader to reach the same conclusions as the researcher?
Originality	<ul style="list-style-type: none"> • Does the research provide and extend current thinking around this topic? • Is there a social and theoretical significance to this work?
Resonance	<ul style="list-style-type: none"> • Has the researcher uncovered both unstable and liminal taken for granted meanings? • Has the researcher identified the links between individuals and larger structures (if in the data)? • Does the grounded theory make sense to participants and offer deeper insights about their experience?
Usefulness	<ul style="list-style-type: none"> • Is the analysis useful? • Will this research help initiate other research into this area? • Does the research propose any generic processes?

These criteria have been addressed as part of the evaluation of this research, and will be presented as part of the concluding chapter.

Ethical Concerns and Protecting Participants

Because of my own engagement with this topic, I placed a significant emphasis on engaging in dialogue around both my research question and my methodology. Appleton and King (1997) posit that “a researcher’s personal and intuitive knowledge of a field can inform and guide the research process” (p17), and because of my own identity, I felt it critical to engage in ongoing reflection during this research. They proposed that a constructivist methodology, such as the methodology selected for this research, urges the researcher to engage in discussion with colleagues before entering the field, as this is an opportunity for the researcher to refine ideas about issues and topics before entering the field (Appleton & King, 1997). I have continued to do this during this research process, and found it to be both a way of further explicating my own beliefs around the topic as well as gathering the knowledge of colleagues and fellow researchers.

Women shared some terrible stories about experiences they had gone through within the healthcare context. Because of this I was conscious and committed to not asking women to open up and then leaving them to deal with the emotions of the interview without support. Once or twice women became upset during the interview, when talking about things that they hadn’t talked about in years, or that they had never admitted to anyone before. Crooks (2001) suggests that when we invite women to share with us as researchers, we ask them to share thoughts and feelings that they might not share with others in their social worlds. Because of this, researchers need to be cognisant of the fact that they may challenge the blind spots that women develop in order to protect themselves from experiencing feelings of loss or pain (Crooks, 2001). During the course of my interviews many of the women admitted that they had either not talked about these feelings with anyone, or had not allowed themselves to think about ‘this stuff’. However, like with any person who has an active listener, once the dam was broken women wanted to talk and talk. And sometimes this was difficult.

Every effort was made during this research to ensure that for participants the research process was as equal a relationship as it could be. Mills *et al.* (2006a) suggest several strategies that can be adhered to in order to try and minimise the power imbalances that can occur in interviewing. These include scheduling interviews at times and in places convenient to the participant, as well as using an informal and flexible approach to

interviewing, which allows participants to feel that they share power in the direction of the interview conversation. Both of these strategies were consciously used during this research, both as a way of attempting to adhere to a constructivist approach, as well as keeping within the framework of grounded theory interviewing. I scheduled all interviews with participants at the place of their choosing, including time and venue. Another strategy I also used was to tell participants a little about my background, attempting to create a shared space where I was also giving something of myself. Whilst I ultimately had more power, simply through the possession of knowledge relating to the purpose of the interview, I tried to address inevitable power imbalances constantly throughout the research.

Charmaz suggests that a constructivist grounded theorist positions themselves within a reflexive framework paying close attention to how participants render their own reality – and subsequently, the researcher’s position within those realities (Charmaz, 2005). Charmaz suggests that in order to discover participant’s meanings, researchers need to be reflexive about their own. She suggests that researchers need to bracket their own internalised views of reality, in order to try and ‘flow with the experience’ of the world under investigation (2006). Because of my closeness to the topic and participants (due to shared membership), I have kept a journal throughout this project in which I endeavoured to explicate my own understandings – particularly about gender, body size and weight, and how I considered these influenced participants’ engagement with healthcare providers.

After writing the research proposal and preliminary literature review I submitted an ethics application to the University of Tasmania’s Human Research Ethics Committee. The proposal specified the design and procedures involved in the study. Once ethics approval was granted I was then able to commence recruiting participants. After I disseminated my research flyers to the chosen organisations, I ensured that all research participants made the initial contact with me before I sent them the study information sheet. Unlike other health conditions, being overweight or obese is immediately visible to others, as well as having considerable stigma attached to it. Because of this I was especially concerned that participants not feel like they had been targeted.

To ensure participant anonymity all participants were given pseudonyms. All participant data was stored in both a locked cabinet and a password protected computer, according to

National Health and Medical Research Council guidelines. Participants, in the initial information and consent sheets which were supplied to them, were ensured about their rights as participants including their right to withdraw, and the right to expect that their information would remain private.

Before I commenced the research I also reflected as to whether the subject matter could potentially be upsetting to participants. With this in mind, I approached a counsellor who agreed to offer participants a counselling session post the interview, free of charge, if they felt like they needed it, none of whom did.

Summary

This chapter has presented an overview of the methods used in this research, including detailing the plans and strategies used to recruit and interview participants, as well as the tools used to collect and analyse data. The ethical considerations, including the concerns of reflexivity and reciprocity, are also discussed with emphasis on the care taken by the researcher to readdress potential power imbalances present within the researcher-participant relationship.

Part two of this thesis, will present the findings of this study, the discussion and concluding chapter. The following chapter will introduce and present the substantive theory 'Learning to Manage'.

Part Two

Chapter 5: The Substantive Grounded Theory

Introduction

The substantive theory of ‘Learning to Manage’ provides an explanation of how large bodied women engage in the basic social psychological process of ‘Learning to Manage’ in order to address and resolve the basic social psychological problem of ‘Being Defined’. This chapter presents the substantive grounded theory of Learning to Manage, and the components that make it up.

The Substantive Grounded Theory

A substantive theory is specific to time and place (Lempert, 2007), and is defined as a “theoretical interpretation or explanation of a delimited problem in a particular area” (Bryant and Charmaz 2007, p 610). Stern (2007) comments that a true grounded theory must always make sense, which she describes as an immediate recognition by the reader that this theory is about people and objects to which they can relate (p114). She also adds that the theory must clearly reveal that it has been generated from the data. With this fresh in mind throughout this study, I have endeavoured to present a theory which:

- clearly illustrates that it has been generated from participant data;
- is situated within a specific context; and,
- identifies what participants viewed as the most important issues in the phenomenon under study and the strategies they used to resolve them.

The diagram below illustrates the substantive theory of ‘Learning to Manage’. This diagrammatic representation of the theory provides a visual for the process of ‘Learning to Manage’ which begins every time a woman encounters a medical professional in a clinical consultation. Each circle represents a part of the trajectory, comprising the components within. The diagram consists of the phenomenon, basic social psychological problem, and basic social psychological process.

learning to manage

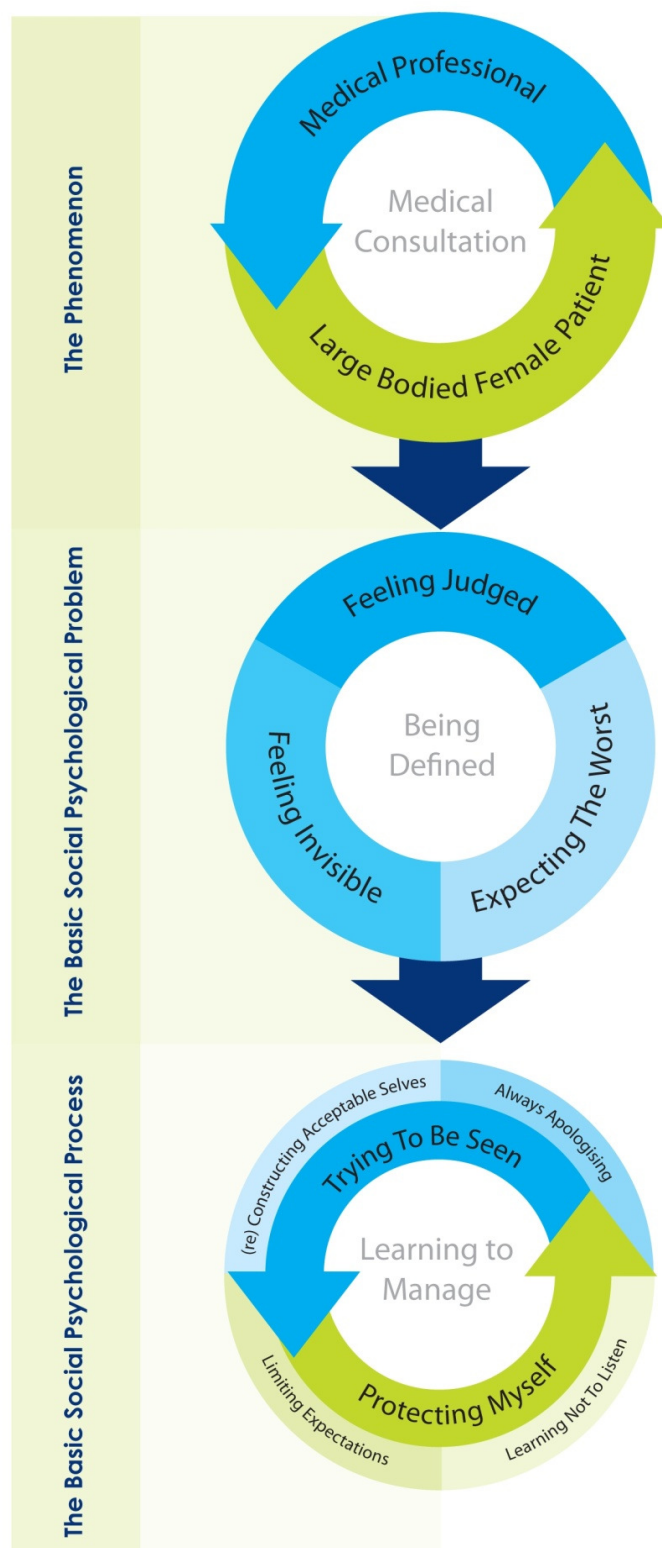


Figure 5. The conceptual model of 'Learning to Manage'

The substantive theory reveals that in order to manage their interactions with medical professionals, large bodied women are in a constant cycle of judging what they need to do in order to increase their visibility and acceptability, as well as trying to minimise the effects of weight stigma to try and feel safe. Large bodied women felt that being overweight or obese healthcare consumers significantly impacted upon their feelings of being *visible* in their interactions with medical professionals. In order to manage feelings of invisibility and judgment women developed a range of specific behaviours in order to try and overcome and neutralise the ramifications of their large body size, and thus be 'seen'.

Medical consultations were an extension of their social experiences of weight-based discrimination and judgment for large bodied women. Notions of healing and care, which are widely and historically associated with healthcare professionals such as nurses and doctors, were not things that large bodied women expected from their engagement with medical professionals. Visiting a doctor was a frequently painful and complex process in which they frequently felt ashamed, embarrassed and frightened of what their doctor would say to them about their weight. In consultations with medical professionals large bodied women always felt they were waiting for comment to be made about their weight. Their vulnerability centred on the belief that being perceived as overweight or obese defined them as patients, creating the primary lens through which they were viewed. 'Learning to Manage' conveys that for large bodied women, the process actively engaging with medical professionals is a phenomenon that they had to learn to manage in order to get what they needed.

The substantive theory explains how when large bodied women become patients, they did so with the knowledge that they would experience discrimination because of their body size. For large bodied women, deciding to seek healthcare was something they did with the expectation that doing so would likely bring with it what they considered was an often inappropriate and judgemental focus on their weight. Making the choice to engage with a medical professional then was always done with some degree of trepidation. This trepidation was generally not associated with the actual environment itself, such as fear of exposing one's body or a gown not fitting; rather it centred on women's interpersonal engagement with the medical professional and the weight related discrimination they believed they would suffer.

It was evident in this research that large bodied women became healthcare consumers when they needed to, not ever because they believed that a medical professional was someone they could turn to for advice or support. However unlike other research that suggests that overweight and obese patients avoid healthcare services, for most of the women in this study making the decision to see a doctor was not really something they felt they had a choice about.

This chapter presents the substantive theory of Learning to Manage. The phenomenon, basic social psychological problem and basic social psychological process are introduced and explained, with a concluding section entitled ‘talking about weight’ which details participants experiences of weight dialogue with medical professionals, namely their GPs.

The Phenomenon

As illustrated by the diagram above, the phenomenon of interest in this study was the clinical consultation between a large bodied woman and medical professional, primarily within the context of General Practice. Women who had increased interaction with healthcare providers, due usually to chronic conditions, also talked about their experiences of seeing specialists. A small number of participants also discussed their experiences of hospitalisation, particularly their fear of potential hospitalisation. However, the small amount of references made about hospitalisation meant that their relationships and interactions with medical professionals, specifically GPs, remained the critical factor for participants, as opposed to their experience of the physical environment.

The Basic Social Psychological Problem

Based on participant data, the basic social psychological problem of ‘being defined’ emerged as the shared problem of the women in this study. Being defined as an ‘overweight’ or ‘obese’ patient was extremely disabling for large bodied women, because in contemporary western society excess body weight is loaded with negative meaning and implications. Being defined by their largeness, and treated in a way which reflected this, was a state that large bodied women experienced in their world external to healthcare; however it was very different when it occurred in clinical interactions with medical professionals. In the healthcare context it seemed like betrayal not only because it hurt

them, but also because it contradicted everything that women expected from their medical professionals. Large bodied women felt that doctors' stock response was to blame all health issues on weight, often before asking any questions or performing any kind of examination.

'Being defined' was a state in which participants felt negatively branded by their body size, which worked to create a one dimensional identity – that of an overweight or obese patient. Participants felt that when they were labelled as either overweight or obese patients that this then became their prevailing health identity, something which they felt they had no part and little power, in constructing. Once this happened, participants believed their weight then became the central focus of the consultation, and resulted in them being repeatedly treated in a contemptuous and dismissive fashion.

Women felt that their 'real' concerns were trivialised by their doctors, if not altogether ignored, because the doctor was often completely focused on weight as the centre or source of all problems. The feeling of being defined purely by their weight was common to all participants, and left women battling feelings of invisibility, shame, guilt, responsibility, anger and fear. For these women, when they became patients the experience of being defined by their size was something which had significant ramifications for them as individuals, and subsequently for the clinical interaction. The severity of bias or discrimination they experienced with from their doctor directly influenced how effective and satisfying the clinical interaction was. Being defined was comprised of three categories – 'feeling invisible', 'expecting the worst' and 'feeling judged'.

Being defined by a large body size within the healthcare context was very disempowering and distressing for participants, however over time the consequences of it had become something which they anticipated. Large bodied women were in a state of constant vigilance when they were in a clinical encounter. This vigilance was maintained in order to try and 'read' the situation in order that they could choose to respond with one of the strategies they had developed based on past experiences. They never felt they could relax, and were always expecting the worst to occur from any encounter with a doctor. They acknowledged the effect that this constant state of anticipation may have on the

interaction, but felt that it was an unavoidable consequence of their experiences of being an overweight or obese patient.

Large bodied women experienced significant amounts of judgement as part of being defined by their large body size, and this resulted in making feelings of shame, fear, embarrassment and anger regular features of their interactions with medical professionals. Being defined was a state that participants felt impacted significantly upon their ability to both be seen as legitimate and deserving patients, due to the fact that they felt that they were constantly being negatively judged and blamed for allowing their bodies to transgress what is considered normal and therefore healthy.

The Basic Social Psychological Process

‘Being defined’ brought with it a host of issues which the large bodied women in this study had to manage as part of their everyday experiences of being a patient. Because of this, they had over time either unknowingly or consciously developed a number of strategies which they used whenever they entered into a clinical consultation with a medical professional. The participants rarely felt like they could question or challenge what was happening to them. For these women the feeling of ‘being defined’ meant that that had to work extra hard to have their needs met. The strategies that participants used to manage or counteract the issues and feelings associated with ‘being defined’ have been conceptualised as the basic social psychological process ‘Learning to Manage’. ‘Learning to Manage’ was a process that was learnt over time and through repeated interactions with medical professionals, namely their GPs.

The strategies, identified as the sub processes, which made up ‘Learning to manage’ served a number of purposes for participants. ‘Learning to Manage’ encompassed a number of strategies that all participants engaged in, and these include the multiple processes of trying to counteract feelings of invisibility; manage the consequences of weight bias, whilst at the same time trying to get their needs met and protect themselves.

The women in this study usually tried to manage their interactions with medical professionals in ways which avoided conflict. In order to get what they needed, which included not just the practical things, such as a prescription or a referral but also a level of

interaction where their body was not the focus, they felt they had to comply with what was being said even if they were not comfortable with how they were being treated. They felt that if they openly challenged their doctor they risked further sully their already marked identity. Logically, these women knew that they could not be refused what they needed, especially if for example what they needed was some kind of pharmaceutical therapy. However they felt that it was easier to manage from an emotional perspective if they engaged in strategies to make their interactions more manageable, such as pretending weight loss compliance or apology for their fat bodies.

'Learning to Manage' was comprised of two sub-processes, 'Trying to be Seen' and 'Protecting Myself' which each had two properties. Part of learning to manage involved trying to develop strategies in which they could be seen as more than 'fat bodies'. 'Trying to be Seen' was the critical concern of all women in this study, and something that they felt rarely happened. Thus, they were always in a process of trying to find ways of being seen as more than someone presenting with an obvious weight problem. Large bodied women felt they were treated just as bodies which were diseased and evidence of poor lifestyle choices or greed. For women to get what they needed, which was advice or medical treatment, they felt that they had to constantly engage in a series of behaviours which covertly encouraged their doctors to view them as individuals presenting with health issues not connected to their weight. 'Trying to be seen' was about trying to control the interaction with their GP so they could be seen as people who deserved proper medical care and attention. There were two sub-processes of 'Trying to be Seen' and these have been explored as '(re)constructing acceptable selves' and 'Always apologising'.

The second social process identified as 'Protecting Myself' occurred in conjunction with 'Trying to be Seen'. For the participants, just as significant as their need to feel like they were being seen and heard was their need to try and protect themselves. In order to try and endure their encounters with medical professionals taking on as little shame, guilt and hurt as they could, women learnt strategies aimed at protecting themselves whilst interacting with doctors. Feeling safe was not something that they really ever felt with their GPs, or with many other doctors that they had seen during their lives. For these women, to have a doctor they felt safe with was a rarity.

Feeling nervous about going to a doctor is not unusual, and would be reflected within many different populations of women. However for the large bodied women in this project it was a fairly common experience. Feeling nervous, though, was part of a much bigger framework of fear, shame and guilt. Because of ongoing negative experiences with medical professionals, large bodied women felt they had to actively develop strategies to protect themselves when they saw their doctor. The women used these strategies both to try and minimise the discrimination and judgement they experienced because of their weight within the consultation, as well as to try and ensure that they retained as little of the consequences of the interaction after the consultation had finished. Participants employed several strategies in order to protect themselves, and these have been characterised as ‘Learning not to listen’ and ‘Limiting expectations’.

Talking About Weight

While not part of the actual grounded theory, it is important to understand participant’s thoughts about how, when and why weight should be discussed. Contrary to what may be popular opinion, not all women were averse to discussing weight with their doctors. What it came down to was *how* it was done. Participants who’d had positive experiences with their GP’s and other doctors, talked about how to discuss weight ‘in a good way’. There were, according to them, reasons to discuss it and ways in which to do it. Several of the participants talked about positive medical consultations which had involved weight, differentiating between whether that was influenced by a ‘good’ doctor; their management skills, or because they had changed. One participant stated that she didn’t get as upset anymore when she got comments from her GP, stating ‘that it’s all age and learning to accept yourself for you who are I think’ whilst another participant stated:

These days, because I feel stronger now in myself self, it’s like I now feel like “bring it on – I am waiting for it, because I have had enough and I am not going to stand for it anymore. (Nicky)

Discussing weight wasn’t always the source of expecting the worst, or feeling judged or invisible, and this is important to note. For the women in this study, it was how weight was talked about and when it was raised which was critical to how they then felt about themselves, their doctors, and the interaction as a whole. Participants walked a thin line between wanting assistance with weight, and not wanting it discussed. However, if they did want to talk about it they wanted practical advice – not just being told to lose weight.

It was when discussions of weight were conducted without sensitivity or with clear judgement that made women believe that they then had to develop ways of what another participant described as ‘managing the fallout’. In keeping with participant data, there were ways to discuss weight which didn’t require managing:

I have some great doctors in my life now and they are very empowering as they only talk about my weight purely from a functional perspective. (Tara)

Another participant stated:

I want my weight to be treated in the same detached manner that a head-cold would be, or an infection. That’s fine... it is maybe uncomfortable, but not hurtful. (Bridie)

Whilst participants depicted their medical consultations as spaces which they actively had to manage, they were not immune to feelings of satisfaction when they actually did get treated by a doctor in a way which felt positive and supportive. One woman discussed her experience of developing gestational diabetes, and her experience of how this changed her interactions and expectations with medical professionals:

One of the most significant things I have had to go through, in terms of my weight and health, was having gestational diabetes because I knew for the first time in my life that my weight was directly linked to the fact that I had gestational diabetes. Yeah, and telling me that I did a really good job of looking after myself whilst I was pregnant, coz I felt really proud of that. But in a way though, I never stopped looking for validation or approval from doctors. In a way I have always wanted that. To be validated from him, I was almost like a little girl getting a gold star I think. I felt that I had done the right thing by not putting on weight... the Obstetrician that I had was beautiful and encouraging and in a situation like that when you are vulnerable, and you are worried about your baby and you have gestational diabetes you need someone who is going to encourage you and he actually encouraged me and congratulated me for controlling my weight. (Stella)

Another participant, who had had significant experiences with GPs and specialists talked about the changes in her, and how she currently regards herself as a patient:

I don’t feel the same anymore. I don’t feel like I have to apologise as much anymore. I feel that I’m more... I’ve tended to separate my self-image from my body image. I can feel like a whole person now, and quite openly discuss the fact that I am quite overweight, or

significantly overweight, without feeling bad as a person. So I take that into a consultation with me now and I feel more empowered. And for a lot of years I couldn't do that – I couldn't separate my body image from my self-image. I would feel ashamed going into any consultation with any doctor, or any healthcare provider – I would feel ashamed. (Stella)

Another woman stated:

I think I have got more assertive now. I think the thing is I am starting to separate now, and I can go in and feel like a whole person and say “Yep, I am obese, and that's a factor, but that's where it ends. I am not going to take on any of your shit or shame. I am going to take on board what you say about my weight and how it affects me on a health level, but I am not going to take on any commentary on a social level. (Emily)

Another participant said:

I don't worry about it so much anymore, because the issues that I am working through now don't relate to me weight, or there is no direct link there, to my weight. Plus I know my current GP is more likely to see me as a whole person. (Stella)

One participant talked about going to see a new doctor about her arthritis, describing what it was like to see a doctor she liked:

But the second one, he was really gentle, and I knew what he was going to say, I knew that he was going to discuss my weight because, well, it's about joints. And I am big, and it's something that had to come up as far as healing is concerned. And it had been said to me before – years ago. But the way that he said it, was kind and ‘you're a person’. (Daisy)

As well as strong feelings about how to talk about weight, participants also had views about changes that needed to be made and what their doctors needed to be aware of, particularly relating it to the recognition of the stigma attached to large bodied women and the discrimination they had experienced:

I think there needs to be some kind of consideration of the fact that fat people are very heavily – well, excuse the pun, the fact that fat people are very strongly discriminated against in the social world. The thing is it is not the same for a thin person to go to the doctor, for what it is a fat person. (Emily)

Another woman stated:

I think what I admire most, is a doctor that can really see you as a whole person and talk about your weight in terms of a medical issue, and not a social issue. But I really admire healthcare providers that can treat obese people as just everyday people, and talk about their obesity on a somewhat detached level. They can talk about it as in 'well this affects your health on this level' but they still say on track in terms of treating you like a real person – you know what I mean? They don't lose sight of the fact that they are sitting in front of a person; they're not just sitting in front of some fat blob who has lost control of themselves because they eat too much, therefore they have lost the right to be treated like a real person. (Stella)

Lastly, this participant talked about what she thought needed to change in how healthcare professionals manage weight:

You can't separate the provider from their life experiences. I think it has to come through education and awareness, and I think it has to come through some sort of psychological aspect as well... I think that there needs to be awareness that when you are dealing with someone who is significantly overweight, that it comes with a whole heap of other issues attached to it and that it may have taken the person ten years to get the courage to come and see you. I think counseling should be a prerequisite for any doctor, that's what I think... if we are going to talk in terms of how to change the experiences for big people. (Jane)

Participants didn't always believe that weight should be ignored, however it seemed to be the way that it was discussed which made the difference:

Weight is an issue so it should come up, but it's the way that's it's done, and people [doctors] always go to that first, and often just talk about that instead of addressing the actual issue that brought whatever big woman to them in the first place. (Lucy)

For participants who identified that they currently had a good doctor, this was always linked to someone who could see them as a whole person, who treated them holistically, and whose main focus wasn't always weight. This didn't mean that they didn't raise weight; it did however mean that they talked about weight with the knowledge that it could and is a very sensitive issue for many women, as well as conveying the idea that it was not to blame for everything.

Summary

This is a study about experience and interaction, perception and expectation. The women in this research had thought about their fat bodies in depth. Most didn't believe that you could embody a big body, and not have thought about the ramifications of that embodiment in some way. For the participants in this study living in a large body was something that had reached into every corner of their lives. Their beliefs around their body size provided the context for everything else that they talked about because for them the consequences of living in a large body, and managing a stigmatized identity, had played a significant role in their lives.

This chapter has presented the substantive grounded theory of 'Learning to Manage', as well as a section titled 'talking about weight' which described participants' thoughts and feelings about weight dialogue with medical professionals. The substantive theory of 'Learning to Manage' was a continuous process for women and it depicts not just the identification of the problem shared by large bodied women, but also how they worked to resolve these problems. In this research the salient issue was that large bodied women felt that when they became patients they were defined by their body size. As a result they developed strategies to try and deal with the consequences of consultations with their doctors. The basic psychological problem of 'Being Defined' conceptualises the issues faced by large bodied female patients, explaining how when large bodied women took on the identity of patient they felt that they were defined by their body size. The basic social psychological process, 'Learning to Manage' elucidates the strategies, specific to the healthcare setting, used by large bodied women to counteract the issues and feelings associated with 'being defined'.

The following chapters will present the basic social psychological problem of 'Being Defined' and the basic social psychological process of 'Learning to Manage'. Participant data will be used throughout to demonstrate how the conceptual label of 'Being Defined' was reached.

Chapter 6: Being Defined

The Basic Social Psychological Problem

Introduction

The goal of the researcher in grounded theory is to understand the shared social problem of the participants. With this in mind, I set out to uncover what large bodied women viewed as the issues that faced them as healthcare consumers. As described in a previous chapter, I commenced interviews with women with broad statements such as ‘tell me about your experiences of healthcare’. This allowed participants to identify what was important to them, also ensuring that emerging categories remained truly grounded in participant data. I did this by calling for female participants who identified (and were identifiable) as overweight or obese and asking them to discuss with me their experiences of healthcare and interactions with healthcare providers.

After conducting three interviews, I initially thought that the problems experienced by large bodied female healthcare consumers were the broad reaching sociocultural and medical attitudes towards obesity. However through the ongoing process of data collection and constant comparative analysis I then started to see within the data that these attitudes were a critical part of the context of what was happening for these women, not the actual problem. I then pondered whether the problem was managing the stigma associated with the aforementioned attitudes about carrying excess weight. However, as I continued I realised that it was both of these things and more. As I progressed with further interviews and my engagement with current literature deepened I started to realise that these women believed that their appearance, specifically their weight, significantly altered their experiences as patients. With this in mind, I approached the data with fresh eyes, and it was then that I realised that the shared problem of participants was that they felt negatively defined by their large bodies. Subsequently, the basic social psychological problem has been identified as ‘being defined’.

This chapter will present and discuss the analysis of participant data relating to the basic social psychological problem of 'being defined'. The basic social psychological problem has three categories, which will be discussed throughout this chapter as the sub categories of 'feeling invisible', 'feeling judged' and 'expecting the worst'. Excerpts of participant data will be used throughout to demonstrate how the problem of 'being defined', and the sub categories of 'feeling judged', 'expecting the worst' and 'feeling invisible' were reached. Participant quotes have been included exactly as they were spoken and words that have been highlighted in bold font are used to depict parts of the conversation that participants emphasised – either through raising their voice or gesticulation. The literature that was consulted as part of data collection and analysis will be presented in the discussion chapter.

Being Defined

Participant data suggested that 'being defined' was the shared problem of all participants. For women, 'being defined' was something which occurred as a result of interacting with medical professionals. In keeping with the Macquarie Dictionary, (2005, p379) to 'define' is "to state or set forth the meaning of" or 'to determine or fix the boundaries or extent of'.

'Being defined' encapsulated the core issues associated with being a large bodied patient. In clinical consultations, predominantly in the general practice environment, the women in this research felt that they were defined by their body size. They believed that the appearance of their large body established certain beliefs about them, something which they had no part in constructing. They believed that once they entered a consultation with a medical professional they were characterised by their weight, something which ultimately worked to make them feel marginalised and vulnerable. The feeling that they were seen purely as the sum of their weight caused a variety of emotions for these women to manage, and it also worked to create barriers in getting the care they needed:

It really starts to wear you down after a while, you know? It makes me sad that I am seen just as a big obese patient. I feel like that is the least of my problems. I know that being seen this way has stopped me from opening up about things at times, things that I probably should have talked about. (Molly)

The second participant I interviewed talked about an experience which had made her consider the part her body played in her experiences as a patient, and which illustrates part of the problem of 'being defined':

My GP wrote a referral to a specialist and I read it. It was a referral to my gynae, and the first sentence read 'overweight 42 year old woman, otherwise well'. And I really thought about that sentence a lot, you know? Firstly, isn't it rather obvious that I am overweight? I mean, as soon as anyone sees me they can tell. And secondly, I just wonder why that went in that letter? If I am 'otherwise well' then why write that I am overweight? If I am well, and I don't have diabetes or anything else, then why include that in that first sentence? There's something in that. (Sam)

For the women in this study, living in a large body was the most significant part of any interaction with a healthcare provider because from the minute they entered the consultation with their GP, they knew that first and foremost they were recognisable as a large bodied woman, and at times, this felt very limiting:

I am never more aware of my size than when I go see my doctor. I find it so disempowering at times to feel like I have to be consistently trying to overcome this. At when you are a patient, this is hard – you are there for their help, yet I feel like I am the one who is directing the visit, just so I can get the help I need, because he is too bloody busy crapping on about my weight. (Bridie)

Another woman described her experience of being a long term overweight patient:

I have been overweight since I was 8 and I'm 28 now, so for 20 years every interaction that I have had with a doctor since that point and up until the present time, has been interacted upon by how I perceive myself and how I present myself, but also how I am perceived in the eye of the health professional. (Nicky)

For participants, interactions with medical professionals in which they felt defined by their body size created a myriad of emotions. They felt judged, not heard, invisible, hyper visible, ignored, blamed, and responsible again not because of the actual size of their body but because of what they had learnt that their large body represented. In the context of this research, 'Being Defined' was about women's experiences as patients however it was also intrinsically linked and underpinned by their experiences as women in their everyday lives in the communities where they lived. For participants in this study, the embodied experience of living in a large body was the critical point that I kept in my mind when

attempting to do something meaningful with the results. For these women, their belief that their body size had played a significant part in shaping their lives and experiences was noteworthy, and I believe the backdrop to everything else that they talked about. It is crucial then to remember when reading this thesis that the experiences that the women were describing were part of a much larger picture of weight oppression and discrimination.

For the women in this research occupying a body which looked different than a supposed 'ideal' or cultural norm was significant. Their weight, and thus their appearance, was a significant component in the lives of these women and in the context of this research. In clinical consultations, predominantly in the general practice environment, large bodied women felt that they were totalised by their appearance, something which ultimately worked to make them feel marginalised and vulnerable. The feeling that they were seen purely as the sum of their weight worked to create barriers in getting the care they needed as well as significantly affecting how they felt about the progression of the clinical interaction, and how they felt about themselves. They believed that the issues they experienced as patients were because they inhabited large bodies. They maintained that given the overwhelming negative connotations associated with an 'above normal' body size, both within and external to healthcare, medical professionals interacted with them based on what their appearance represented. Women in this study described their bodies in a multitude of ways – they were at times disparaging and at other times accepting. However, the commonality was that all women believed that due to their doctor's inability to see beyond their weight and view them just as '*an ordinary patient*' (Nicky), they became defined by their largeness.

Being defined by weight was problematic for participants as it was rarely the reason why that woman had visited the doctor yet they believed it was all that was ever really seen or focussed on. As one participant suggested:

To some doctors all I've been to them is just fatness.... (Stella)

Women were adamant that their body size changed the way they were seen by medical professionals, colouring the interactions they had with their doctors. For some participants this was extremely hard to make sense of:

I know that I am a good person; I know that I am dedicated to my work, that I'm loyal to my friends. I am good at what I do – and if I'm not I am good at faking what I do. Sometimes I think 'why should it matter what I look like or what size I am, it should be about who I am. But I know it's not – I know it's not. (Lucy)

Another participant described her experience of being totalised by her body:

I know that when they see my size, that they will automatically assume things about me – I know that most doctors will do that. (Bec)

In general, participants talked very candidly about their thoughts and feelings around their bodies. Women believed that once they were defined as an overweight or obese patient they were then treated in particular ways and seen through a lens which dictated that they were viewed as unhealthy or non-compliant. The participants talked about their experiences of 'Being Defined' in various ways. Some felt angry, some were sad, whilst others simply acknowledged the fact that it existed. Some of the women admitted that it was almost a relief to finally have an avenue to talk about how they felt. For participants, one of the critical factors in 'being defined' was that they felt that they had no part in the construction of their identity as a patient. They believed that the clinical consultation should be based on a shared relationship; however their experience was that doctors created an identity about them based on weight, and forced it upon them. One woman discussed this:

I feel like I am seen as someone who is no more than what I weigh... um, by what I look like. I know my body, to some people, may say that I eat too much, that I don't do enough, that I am not very healthy. I think that most of the doctors that I have ever seen have probably made these assumptions about me. (Lou)

'Being defined' created a number of barriers to meaningful clinical interactions for participants. Because of their experiences of judgment many of them spoke of losing faith in medical professionals. In addition, most participants believed that what their GPs offered was pure commentary on their weight, not practical support as to how to lose weight. One woman talked about her experience of being, what she described, 'a fat patient' and how she knew that no matter what, weight would always be raised:

You're afraid of going to the doctor because they are going to say something about your weight, well it's like no shit, of course they are

going to say something about your weight because you're fat and if it's a factor they will say it. Unfortunately there is a lot of inappropriateness on that level too, and doctors do take it upon themselves to comment on your weight whether it's a factor or not - which just pisses me right off. (Emily)

Participants believed that being defined by being overweight or obese was different to being defined by something which is socially and medically accepted or endorsed. They were aware that being big defied the medical norms about what constitutes a healthy body, and thus from the outset of any consultation they were seen as unhealthy or diseased in some way. They also suspected that medical professionals were also partly responsible for the prevailing mindset which says if you are fat then you are responsible for letting your body go past what is healthy and normal. One participant described how she felt with her GP:

I felt like just another in a long line of what she saw as fat people that didn't take care of themselves and then their problems developed into diabetes. That's how I felt – I felt that she just thought 'here's another fat woman', and she wrote in her letter to my specialist that I needed to lose weight and rah rah, and I knew that that was the issue, and I just knew. (Daisy)

Women linked their experiences of 'being defined' to medical professional's fixation with weight. They believed that weight frequently became the central focus of the consultation, often at the expense of other more pressing health concerns. One participant stated:

I have been to lots of doctors, and weight has always been an issue... rather than it being about the fact that I have got asthma or other health problems, it would also be about the fact that I am fat, and that would become the dominant thing of the consultation, and I would be left wanting. (Tara)

Another participant discussed her relationship with her GP stating that she felt that her doctor always tried to pin everything on weight:

It always seems to me that they [doctors] drag weight out. They don't drag out that I smoke... like nothing was made of the fact that I smoke, even when I was being treated for a lung thing, but it was about my weight. I just feel like that's the one thing that they drag out every time... It's not that I eat bad food, which I'm not great with, or that I smoke or drink or do anything like that – it's always weight. (Emily)

Comments were much harder to tolerate, and process, when it related to improving appearance. 'Being Defined' because of the way they looked was demoralizing for participants, especially as they believed their bodies embodied societal meanings of ill health, gluttony and moral failing. Participants felt that the messages they got from their GPs were partly based in social attitudes toward overweight and obesity, something which they felt had no place in a medical consultation. One woman shared her thoughts:

I do not want to be told to imagine how much easier my life would be if I lost a few stone – especially from my doctor. I want to hear that I will give you a referral for your neck pain, or that I will give you some medication for your infected eye. I don't want ANY comments about how imagining myself buying smaller clothes could be motivating. (Bec)

Another participant described an experience she had with her doctor as a young woman, and how this had stayed with her for more than twenty years:

I remember back very clearly with my GP I had when I was about 13 or 14 and all I was to him was just fat... and ironically he was a big man who had this ginormous big stomach himself which I remember clearly, but I feel very strongly that he just saw me as being some young person who was overweight. Not actually as a young person who came with a whole host of feelings and complications and emotional stuff. It's hard enough being overweight when you are young, let alone with someone in a trusted position like a GP reinforcing the fact that you are vulgar or grotesque, which is how he made me feel. He made me feel grotesque. (Stella)

Participants were so used to being totalised by their weight that if they did have a consultation with their doctor which wasn't monopolised by weight they were shocked. Based on participant descriptions, it also seemed that if women did have this kind of experience, then they were more likely to develop a relationship with their doctor.

If the truth be known, I always feel surprised if a GP sees beyond my weight, because I expect it now. So if I actually go to a GP and weight's not the first thing that comes up, or it's secondary, then I actually feel genuinely surprised and I am more likely to warm to them. (Rory)

The experience of 'being defined' changed dramatically when the person lost weight. Several participants in the study had lost dramatic amounts of weight (between 20 and 40 kilos) during the research and I talked to them again nearing the end of this research. Participants talked a lot about how weight loss had changed their interactions with medical

professionals, and their broader lives. The feeling of shame and embarrassment decreased dramatically, they felt more entitled to receive better care, and their self-image changed dramatically:

Losing weight has made a significant difference in how I interact with doctors... I feel much more power. I feel more deserving – and I hate saying it – of receiving top medical care. It's awful, and I hate saying it. You can see why people want this to be confidential.
(Stella)

One woman, who had undergone gastric banding, said that she was terrified that something would happen and that she would have to have her band out:

Now I am a little bit lighter... I don't actually see myself as fat most of the time. I try not to. I try to just see myself as me. But I would be devastated if I couldn't have my band anymore. I would be so scared that I would have to go through everything I have been through again. (Maree)

Below is a diagram of the basic social psychological problem of 'being defined'.

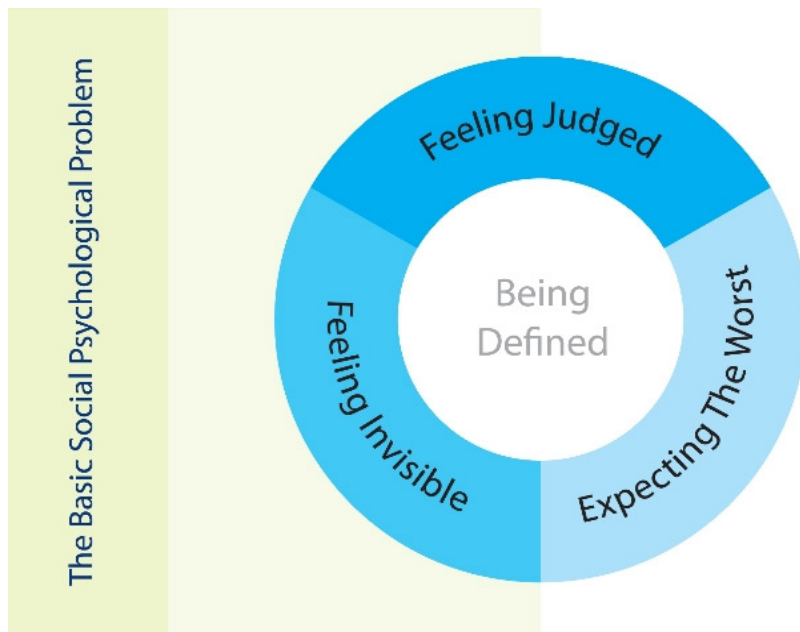


Figure 6. The basic social psychological problem: Being Defined

The sub-categories of 'Being Defined', which have been characterised as 'Feeling Invisible', 'Expecting the Worst' and 'Feeling Judged' explain the challenges and issues which make up being defined and will now be discussed, and supported with participant data.

Feeling Invisible

In this research, feeling invisible is not intended to be understood in the literal sense.

‘Feeling Invisible’, for the purpose of this study is defined as a feeling of not being seen as a unique individual, and instead, being visible only as their excess weight.

For participants in this study, when they became a patient they described a process whereby they felt that all that was visible to their medical professional was their weight.

The Macquarie Dictionary (2005, p747) defines the term ‘invisible’ as something which is ‘not visible; not perceptible by the eye’ or “concealed from public knowledge” and for the women in this study they felt that the primary thing which was perceptible was their body size, not them as human beings with unique characteristics and needs. Within sociological literature Fryberg and Townsend (2008) define psychological invisibility as an absence of any positive representations of oppressed groups and/or individuals. Sesko and Biernat (2010) define invisibility as a lack of individuation of or lack of differentiation between group members.

Feeling invisible as a fat woman was an issue that all women in this study had experienced both as a patient and in their worlds external to healthcare. Feeling invisible whilst at the same time feeling that their bodies were a point of difference was a complicated feeling for participants because it represented a paradox that was hard to manage - because their invisibility was in fact linked to something – their body – which they believed also increased their corporeal visibility. Participants believed that their large body size somehow acted as a barrier to them being seen or heard, thus rendering both them and their concerns invisible. As one participant stated:

I know they [doctors] don't ever really 'see' me... all they see is a fat woman in front of them. (Stella)

Within their social worlds the participants often felt very visible and self-conscious as they felt that they took up a lot more space than women, particularly in contemporary western society, are meant to take up. However they also felt that because of their size they were often overlooked as women who obeyed the traditional norms of western femininity – such as that of being thin. The women in this study considered themselves well experienced in defying cultural norms around female body weight; and increasingly they had started to feel that they were also defying norms of what is considered healthy. They believed that this was because of the intensifying focus on the obesity epidemic and what one

participant described as ‘the fixation on weight as the cause of every bloody thing’ (Nicky). Women felt that because of their size their visibility as a patient was above that of a normal weighted woman. One woman discussed her experience of being a large patient:

It's very dehumanising at times to be overweight in a healthcare setting. Because I think that what happens is that you just end up being treated like a number, after a while. Do you know what I mean? You lose your personality, you lose who you are as an individual, and that has been something that I have really strongly experienced. (Emily)

Women felt that as soon as they entered any healthcare setting they would be identified as someone who was obese or who had a weight problem. The outcome of this for participants was that they believed they were then rendered invisible as anything but what they felt was the obvious ill health caused by their diseased body. They also believed that once this happened they were also only visible by the other things which fatness represents in this culture – non-compliance, laziness and greed. Women maintained that given the overwhelming negative connotations associated with an above normal body size, both within and external to healthcare, medical professionals interacted with them based on what their appearance represented.

I got straight into see this other doctor, who turned out to be a real prick, and all he could see from the moment I walked in, was a fat person. That's the way he treated me – like someone who was fat. (Molly)

I then asked her what that meant, and how she thought that someone who was fat was treated:

*Like a lump of meat – like they are someone who are not worthy of proper medical care or attention, and almost a little bit like I am stupid – like a simpleton. It just... what it reinforced to me was that he was completely ill-equipped to be dealing with someone who is obese, and that he has an old school way of dealing with obesity and that the problem for him was very very medicalised. He treated me like I was a problem to be fixed, and part of that problem was obesity. Um, obviously he could see the size that I was and before he had even asked me any questions he put down on the paper ‘obesity’ and then he asked me about my weight. And he laughed at me, as I told him my weight, because I added the decimal points in and he thought that that was funny and I didn't think it was funny at all. I thought it was f&*king insulting. (Emily)*

For participants, feeling invisible meant that weight always became the central issue in consultations. Part of ‘feeling invisible’ by their large bodies meant that for participants their size was blamed for everything, or depicted as the source of all of their health concerns. One participant described visiting her GP for treatment for an infection:

Well, um, within that biomedical framework everything is about the obese body, so you go to the doctor – like I did – and I had an infection (can I say this) in my vagina, and she [the GP] said to me ‘when you lose weight, everything will get better’ and waved her hand over my fanny. And um, that was a significant experience for me. I had had repeated infections, irritations, because I am sensitive, and I had reactions to sanitary pads and I had been back to see her quite a few times and she said that if I lost weight it would be better. (Stella).

Another woman discussed her thoughts around weight always being identified as the source of all her health issues:

I feel like weight has become this thing that can be blamed for everything. But the thing is, well, I feel like it stops other things. Like I know that my doctor just focuses on weight and that’s all he sees, and it’s hard to put up with because I know that all he sees is this bloody fat. (Lucy)

They felt that once they were seen as a large woman their size then became not only part of their social identity, it became the prevailing and dominant part of their health identity. The belief that everything would always come back to weight was difficult for participants. It made it impossible to take the GP seriously, or to trust them and respect what they said. Participants believed that they were seen as a fat body first and an individual second. Women believed that medical professionals, especially their GPs, found a way to relate every issue to weight, due to the fact that, as one participant stated:

Everything is always linked back into being fat... (Emily)

Women believed that as soon as their doctors saw they were overweight, they used it as an explanation for things which they couldn’t explain, or didn’t want to investigate. One participant describes a follow-up consultation with her GP, after she was diagnosed with a condition by her specialist:

I was diagnosed with Sarcoidosis – and he [GP] didn’t know. He told me to look on the internet, to find out what Sarcoidosis was about, because he didn’t really understand it. But he also said that a

lot of it was probably to do with the fact that I was overweight. Well, if you don't understand something how can you make that call?
(Emily)

Participants believed that their size frequently stopped or impeded legitimate examination by their doctors because all they focused on was that which was obvious as soon as they were seen – their excess weight. As one participant said:

Over the years I have complained of tiredness and feeling drained, and it always goes back to 'you're overweight, you're fat'. (Lena)

This fixation on weight increased women's feelings of invisibility, making women feel quite despondent at times, as well as obscuring the reasons they had sought medical help.

One participant describes an interaction with her GP about her chronic ear infections:

... we were talking about that she had put me on so many courses of antibiotics and nothing was helping and she said that if I lost weight it would improve my ear infections, because I wouldn't get colds so much, in which case it wouldn't flare up and that would solve things. But the fact is I have had them since I was 4 or 5 years old and I wasn't overweight then – I was just a normal kid back then. (Emily)

I asked her how she responded to being told her ear infections were caused by her weight:

I was in shock, but I just felt like completely disabled, like I wasn't even there almost. It is laughable when I am telling you, but I literally couldn't speak. I just let it go, and she barely looked at me and that was that. (Emily)

One of the consequences of feeling invisible was women's fear of not being taken seriously. Because they so often felt overlooked because of their weight, being taken seriously was a real concern for participants. This was borne from the fear that their fatness somehow always overtook the clinical consultations, subsequently making their other health concerns less valid:

I've had good experiences but far more bad. I worry every time I see a new consultant as to whether they will hear me and listen to my serious health issues without becoming preoccupied with my weight. I always feel nervous as to whether they will give me what I need and take me seriously. (Lou)

If these women went to their doctor with a complaint which could be exacerbated by weight, such as a back or knee injury, weight reduction would become the sole focus of the consult instead of what women needed in the moment - which was management of that

injury. In these instances women also believed that weight could be a factor in the management of the injury, simply due to the physics of additional weight equalling additional strain on the injury. However they also believed that focusing on weight reduction did not help manage the actual issue they were presenting with. In many instances like this, women were not referred on for further investigation or not prescribed medication for pain relief; instead they were advised just to lose weight. Situations like this increased the feelings of invisibility experienced by participants. One participant described her experience:

It was the second time that I had been back to my GP for some pain in my knee. She told me that I needed to lose weight, and I agreed that I did – with a knee injury it's a legitimate comment I think. But I also said 'I do need some help now with this knee. And she said 'there is not much we can do really, it feels a bit swollen, and the only thing you can do is lose the weight'. Anyway, so it kept getting worse and I finally went to another GP who sent me for an ultrasound, and sure enough, I had ripped some ligaments around my knee, and that was why there was so much pain and swelling. But how bloody hard did I have to work to get MYSELF sorted out? I told her (GP) that there was something wrong, but it was like she wouldn't listen because it was all just apparently caused by my weight. (Joni)

It was evident in interviews that women had thought about why their bodies had become so subjected to scrutiny within healthcare, and the effect that this subsequently had on people who were overweight or obese. One woman discussed her thoughts on feeling invisible and the medical profession:

It's accepted and promoted within the medical community that being fat is BAD, and I think that is probably happening as soon as people get into med schools... or other health courses. The problem with this is that I think this mindset actually works against really positive relationships with doctors and stuff... because all they see is that fat is bad. So when they see someone, all they see is a very obvious sign that someone is 'sick' - AKA fat - and that becomes the thing which they concentrate on – at the expense of the needs of the patient. (Lucy)

Participants felt that their GPs really only saw a 'fat body' (Stella) and never really saw them as individuals. They believed that 'feeling invisible' ultimately worked to create a barrier to meaningful clinical interactions with their medical professionals. They felt that because they weren't really 'visible' to their doctors as anything beyond their excess weight, very little meaningful interaction occurred. Subsequently they constantly felt like

their presenting concerns were overlooked in favour of focusing on their weight, something that very few of them wanted assistance with.

Feeling Judged

For participants, ‘being defined’ by their large bodies resulted in constantly feeling judged. The Macquarie Dictionary (2005, p769) provides several definitions for ‘judge’ including “to infer, think, or hold as an opinion”; “to form a judgement of or upon”; or to “decide upon critically”. Feeling judged because of their body was something that was felt by all participants in this research – both inside and outside healthcare. All participants had been affected by the cultural and medical stigma attached to the overweight or obese body. Experiencing stigma was a familiar part of the experience of being large bodied – but the consequences of experiencing judgement was something that changed when women experienced judgement as a patient. For most participants, the frustration and disappointment of being judged was clear. As one woman said *‘there is more to me than just a patient who is obviously very obese’* (Lou).

Women believed that ‘being defined’ by anything which was due to a visible difference could be challenging, but that ‘being defined’ by fat was especially difficult because people judged you in a negative and accusatory way. As one participant said:

Let’s be honest, it’s not the same as other things is it? If someone looked really skinny, that is more in line with what people are ‘supposed’ to look like isn’t it, so I don’t think that they would get anywhere near the comments that fat people do. (Daisy)

Participants believed that medical professionals held firm opinions and judgements about patients with a large body size, something which had significant effects on the clinical interaction. The consequences of feeling judged significantly impacted the future behaviour of participants, as well as how they felt after any kind of interaction with medical professionals. One participant stated that:

Sometimes I have felt like when I have gone to see a doctor, I have just been treated like just a fat blob who doesn’t deserve the right to be treated as a real person because you’ve let yourself get so fat. (Nicky)

Participants rarely identified their doctors as people who they felt they could rely on to support them in achieving healthy outcomes, either physical or emotional. They described

feeling this way because they felt that their size blinded their doctors to them as women, mainly because they had allowed their bodies to transgress that which is considered normal. Because of this transgression, they believed that medical professionals somehow thought they had carte blanche to say things which, to participants, crossed the line of what a doctor should say. Participants had strong ideas about their rights as patients. They felt that they had a right to be seen the same as everyone else; to not have their weight commented on at every turn, and to feel safe. However this was rarely the case for the women in this study. One woman discussed her thoughts about being a fat patient:

Well, it's like because you are fat you have brought on some of your health complaints yourself so you don't have the same rights as a thin person does because they – it goes without saying – take better care of themselves. (Nicky)

Women thought that they were judged by their largeness because they had allowed their bodies to transgress that which is considered normal and therefore healthy. Because of this transgression, and because of the power held by medical professionals, participants believed their doctors considered it was acceptable to say things which to participants weren't kind or compassionate or even called for. As one participant described:

Telling me how pretty I would look if I lost a few kilos is really appropriate, isn't it? (Rory)

Another participant added:

I remember when I was recently single, and the GP who had been treating me took the opportunity to say to me 'well now you're back on the market don't you think this would be an ideal time to try and lose some weight? I just couldn't believe it. (Nicky)

'Feeling judged' was something experienced by all participants, and it resulted in significant feelings of shame, embarrassment, guilt and anger. It wasn't something that participants enjoyed, however they were accustomed to commentary about their weight within their social worlds. It hurt them, but they were used to it. But experiencing judgment or stigma from their GP was something that was much harder to manage – and much harder to challenge. It was much easier to brush off the words of a well-meaning friend or relative than it was to ignore the voice of their doctor. One woman talked about fat comments that large bodied women often receive from strangers, revealing that the source of the comment makes a big difference, particularly when it comes from medical professionals:

In a pub with drunken idiots, you can shrug it off... they are just idiots. But a doctor – they shouldn't make you feel that way. They just shouldn't make you feel that way. (Emily)

For the women in this study, being judged for being overweight or obese was something that was always at the forefront of their minds when they had to enter into any kind of consultation. One participant described her experiences with her GP, specifically talking about ramifications of the judgment she had felt:

It makes you afraid. I think probably one of the things is that in some instances it's made me afraid to follow through on things when I know I should have followed through on them. (Joni)

It was evident that participants felt that their GPs were often inappropriate, seldom supportive, and frequently discriminatory. However due to the constant weight commentary in which they were told how unhealthy their bodies were, many women had started to believe or question whether their weight was to blame for the various health issues they presented with. They also questioned whether their large body was responsible for everything they experienced, and if because of their size they had the right to speak up against the discrimination they felt they endured. One participant described her thoughts around this:

Coming from the position of someone with chronic health problems I have struggled to legitimise and validate what I am going through because in so many instances you put it back on your weight and think if I wasn't fat would it be like this and if I was slimmer would I be in a different health position? And honestly I think part of this is because weight is ALWAYS being blamed for everything which is wrong with me. (Jane)

For participants, underpinning the judgements they received about their bodies was the message that their weight was responsible for every ailment or health concern. This belief was based on the language used by their doctors, as well as repeated incidents where weight had been named as the source of the issue without any examination or follow-up. Constantly being told to lose weight, regardless of what they were there for, had significant effects on participants. One woman talked about the outcome of being constantly warned and advised to lose weight above all else:

I become less receptive to doctors saying I should lose weight because it just makes me angry. And none of them are giving you solutions, like how to do it. They just say you should lose weight. Well, that's

great – and if it was as easy as saying, I am just going to lose weight, that would be great. (Emily)

For participants, traditional experiences of the power imbalance between doctor and patient were always present in their consultations with their doctors. Participants found it difficult to challenge their doctors when they felt that they were making inappropriate weight comments, or making judgements about them based purely on the weight of their body. If women chose to confront what they felt was unfair treatment on the basis of body size, they risked being mocked and hurt further, and none of the women in this study seemed prepared to want to face that. Another participant stated:

Um, I think it's mixed in with fear. I definitely think there's fear because even no matter how much you... well, even if you have an academic perspective on the healthcare system, and I have taken a slightly more academic perspective on it now, on doctors and seeing them within this limited biomedical scope, I still have this intrinsic and inherent belief in me that comes from years of being socialised into that mould that doctors are in a position of power and authority. (Sam)

I asked her to describe what it meant to her as a patient to see doctors in that light:

I still feel afraid. I still feel that if they say something to me, I still feel that what they are saying to me is right, even though you know it's not. So I guess I still struggle with this... it's like your belief system is dichotomised, so to speak, it's like you've got your new belief system that's based on a more learned perspective, but then you've got your old socialised stuff which comes out and I think I still struggle with that. I know stuff... I know stuff intellectually, but I still feel like a little girl on some levels. I still feel sometimes that when I go to the doctor, I go to the doctor with my tail between my legs and cower a little bit. (Sam)

A critical part of feeling judged, was that it had led to deep feelings of shame and guilt. Participants had endured so many experiences of being judged that they had learnt to feel deeply ashamed of their bodies when it related to their experiences as patients. Some of these were long held, and had played a significant part in women's use of healthcare services, and in how they felt about medical professionals. One participant described a memory from when she was a teenager:

Like the doctor I had when I was 14, I was having period problems, and he grabbed my stomach in front of my mother and actually physically lifted my stomach up, stretched it out, and told me to lose

weight, and said to my Mum “Don’t kid her – if she just loses a stone it’s not gonna make a difference. She’d need to lose at least 2 stone’. Now for a 14 year old that’s being given absolute pure living hell at high school and is absolutely self-loathing at that point in her life, that’s destroying for a doctor to say that to you. Doctors need to have some responsibility for how they deal with young people that are overweight. (Stella)

The feeling of being negatively judged and blamed by a doctor impacted participants deeply:

It scares me to, um, think that my doctor might think I am doing the wrong thing. If I have to go back after a week and be weighed, even if I have done the best I can, I am petrified. (Maree)

Participants worried about the appearance of their bodies, and at times they felt ashamed of how far away from normal they had let their bodies become. And whilst they felt that this was something that they were reminded of in everyday life, feeling ashamed and guilty as a patient presented challenges different to those in everyday life. Based on past experiences, women got scared of going to the doctor if they suspected they were going to be weighed. One woman said:

I do get self-conscious when I go. Even if I have put on even half a kilo, which could be from anything... I am scared that they will think I am doing the wrong thing. (Maree)

Participants constantly talked about feelings of guilt and shame about their weight, and health, based on their interactions with their doctors. Even for those who questioned the notion that obesity is the cause of all health issues there was still the deeply ingrained fear, and guilt, that they were somehow to blame for whatever was happening to their bodies. Overall, participants felt that they were being unfairly judged because of their weight. However they were also aware that the construction of obesity as a disease has become so embedded within our culture that women felt a sense of responsibility and shame about their bodies even before they entered into any clinical consultation. One participant stated:

When I think back though I could honestly say that I have been very scarred by some of my interactions with doctors. They have always mentioned my weight, even when I went for a completely unrelated issue. They never missed an opportunity to push their own agenda. They have made me feel very guilty for not wanting to lose weight. (Bec)

Women often spoke of feeling less entitled to receive and seek healthcare because of their body size. They believed that the combination of being continuously judged by their doctors, about their weight, had worked to make them feel that they did not have the right to seek additional information or question comments or statements made by their doctor. One participant talked about being openly judged by her doctor and how this made her feel:

I have felt disempowered. I have felt that I haven't had as much right to seek out care, or I should feel ashamed having a sore back because I am fat... it's a horrible way to feel, because in your own mind you start to question 'am I deserving of this. (Daisy)

Another participant talked about how the constant messages she received about losing weight worked to make her feel disempowered:

Um, if my psychological side is being undermined, if I am being told that I am not doing what I should be doing – always the should – or that I am carrying too much weight, or your body height ratio {what is that}, then that sort of comes back as a negative loop to yourself. (Jane)

One participant described a memory of something which had happened to her in hospital. Although this experience was not related to an interaction with a medical professional, it demonstrates that for large bodied women feeling unsafe because of judgment about the size of their bodies was an experience which happened to them even in settings where they least expected it:

Its little things you know ... I remember they got me up to walk me – and this is digressing, but it colours your judgment of the setting – they got me up to walk me in the hospital the second day after I had had my ovary out, and I was walking up and down the corridor and I heard someone whistle, mocking me, from one of the rooms, and that kind of just reinforces the bad experience. You don't expect someone to do that to you in a hospital setting. (Stella)

I asked her how she thought about this and she stated:

I thought the last bloody place that I would be mocked would be trying to walk after I just had a big operation, and because I had a short nightie and a dressing gown, and it's just ridiculous – even in a hospital people are still kind of... I suppose I had this expectation, this idea that in a hospital that you would be safe. But I don't think that's true at all. I think sometimes in a hospital you are the most

unsafe, because they see you as just a body, you are separated from who you are and seen just as being... just, fat. (Stella)

Being large bodied meant that women never felt safe within a healthcare setting. A consequence of being judged by the size of their bodies was that women felt extremely vulnerable to attack. The women in this study felt extremely unsafe when they became healthcare consumers because they were constantly being told that their body was unhealthy, or having other unrelated health issues blamed on their weight. They also felt unsafe because they believed that medical professionals treated them with contempt because of their weight, which given the authority held by medical professionals, was difficult for participants to deal with. Subsequently, participants felt constant feelings of shame, fear and anger during their consultations with medical professionals. Most women in this study had come to associate going to the doctor with one of these emotions. It didn't usually stop women from trying to get the help they needed, but it did totally change the experience for them – as well as the outcomes:

I feel so scared sometimes of not what is going to be said, but how it's going to be said. I had one doctor who just kind of looked me up and down and the said in this sniggering kind of way 'I'm not sure you realise but you are very overweight' and then just stared at me. It made me feel so awful, because it just seemed so mocking. Doesn't sound like much now, but it was awful. (Bec)

Another woman described her experience of being judged and how it resulted in her feeling unsafe:

I know that most doctors think about fat patients with disdain. I feel it, even when they don't say anything directly to you. And having that constant feeling inside of you puts you off going sometimes, and it also just means you are scared every time you have to see your doctor. So then the whole thing becomes about trying not to let your blood pressure go through the roof, instead of actually talking about what you wanted to talk about. So it's kind of awful actually. (Lucy)

Participants also talked about how being judged was about having to potentially reveal their bodies to people, and the shame that this would cause them. One participant talked about the idea of getting weight support from a healthcare professional:

It is confronting. You gotta go to somebody who is a nutritionist, for example, who knows all about food and who is probably quite skinny and sporty and all the rest of that, and you will have to say to them... and they are going to weigh you and do all these things... My weight

is something that I don't share... there is very, VERY few people that I would share my weight with. I would feel quite embarrassed about it about it. Embarrassed I suppose, and a bit of a failure. (Bridie)

The fear of being judged was also something which played heavily on participant's minds, particularly if it related to going into hospital:

I was devastated about having to get in a gown and thinking that they are going to have to lift me onto the operating table for surgery and stuff, and it's going to take 12 people to lift me on, as opposed to a skinny person who someone could lift with their little finger you know. (Molly)

Another participant stated

I would be so upset if I had to have some sort of operation around my stomach – which I hate with a passion – just so so upset. I would just be mortified that people would see that and know how fat I am. Coz I try to hide it as much as I can. (Emily)

Participants talked about their fear of being judged whilst undergoing operations, which was primarily the only time they discussed the acute environment. One woman discussed her thoughts around surgery, and instead of being afraid of the actual surgery or of something going wrong, she talked about her body:

I have been in to watch people have surgery and I see the way you are treated like a body, and I have heard comments made about the body – and to not be even aware and awake and able to defend yourself against people saying things about your body, just makes me feel really sick, you know. (Lena)

Feeling afraid and powerless was a recurring theme amongst participants, primarily because of their experiences of being judged. Participants described feeling afraid of what their GP would say; afraid of having to reveal their bodies; afraid that their concerns would not be heard and afraid of how all of this would make them feel. All of the participants discussed feeling afraid and guilty when they had to access healthcare. One participant described feeling more and more empowered about her body as she got older yet she also described putting off routine health checks for up to five years at a time, because of the fear and shame she felt about her body and the fear of comments from her GP. Fear was also a common feeling experienced by participants – fear of being judged, of what would be said, and how it would be delivered. One woman talked about how her fat always became the central concern in all of her consultations with her GP:

Frequently. All the time. Um, so much so that it has made me afraid of going to see new doctors. Coz I know inevitable it's always going to be something that comes up for discussion – my weight. I'm not afraid of it, but it makes me uncomfortable on a certain level. (Maree)

Participants talked a lot about the shame and embarrassment associated with feeling judged. They described feelings of shame so powerful that it was like they believed they were not entitled to seek and receive healthcare, particularly that they were not entitled to receive the same healthcare as thinner women. One participant talked about what she had learnt about going to the doctor over the years:

There was almost like a shame attached to it. Going to the doctor, you know, as a fat woman you are not entitled to have the same power as a thin person would have. (Rory)

I asked her then what she meant by that:

I just mean that I have felt ashamed because I know that when you are fat people think you are kind of responsible for health things that happen. And that actually makes you feel pretty bad at times... Particularly with doctors. (Rory)

The product of feeling ashamed was that women felt they had less power to ask for what they needed, or to question their doctors about why they were or were not being recommended specific treatment. One participant stated:

I let them judge me in that way, because I judge me in that way. I have grown up thinking that it's okay to do that. (Bridie)

Participants often used the term 'responsible' when describing their bodies. One participant said that she felt extremely negative about her health outcomes, because she had internalised the messages that she had received from health providers about her body. She talked about feeling incredibly responsible for every kind of health ailment, every time she had a consultation with her GP, because of her weight. She described an experience of having to undergo surgery as a hospital inpatient

With some things I have felt guilty – guilty for being overweight. Like when I had an ovary removed when I was 25 I almost felt guilty about it. I remembered being weighed at the hospital and it was that moment of absolute dread before I stepped on the scales before I had my operation, and you almost feel like you are sort of responsible for what's going on internally, because you are overweight. (Stella)

Another of the participants reflected on her feelings around having to prepare for an operation questioning whether it was the organisational issues (such as inappropriately sized gowns) or her own feelings of shame which made it ‘an awful experience’

... but I think it was actually my own feelings... first of all the gown that they give you wouldn't fit. Okay. It's kind of like 'can you get the larger size' and I felt embarrassed and I was getting up... and just because I am fat, I felt embarrassed. (Jane)

For some participants, their feelings about being judged were easy to express and pinpoint:

I don't feel bitter, I feel angry. I feel like I am just plainly restating the facts. I don't feel bitter at all, I just feel angry at the way fat people are treated. I feel very, very, very angry and I feel deflated over the fact that I would have been validated more, and my pain would have been validated more had I gone in there and been thinner... and I absolutely think that. (Stella)

Experiences of being judged ran deep and had significant consequences. Women believed that ‘feeling judged’ was a central part of ‘being defined.’ Feeling continually judged created significant obstructions to meaningful or supportive clinical interaction which had resulted in very little genuine interaction between patient and doctor ever occurring. Most of the women in this research had very little rapport with their medical professionals over the years, primarily because they had always felt that they were being judged because of their weight. Feeling judged also severely limited the potential for any weight loss support as it had created distrust for medical professionals.

Expecting the Worst

There was a sense of expectation that accompanied all participants into an encounter with their GP. When asked, most participants couldn't articulate what had made them come to expect that something would always be said about their weight. One woman said she couldn't be sure what had come first – was she scared of her GP because of past experiences, or because as a ‘*fat woman living in the world*’ (Stella) she had come to expect commentary on her body.

Participants past experiences of ‘being defined’ by their bodies had changed the way they expected to be treated. For participants, whenever they entered a consultation with a healthcare provider they were always anticipating some kind of negative outcome or

interaction. Expectation played a significant part in how women in this study experienced their interactions with medical professionals. One woman described her expectations of medical professionals and the way they think about fat patients:

Doctors look at somebody who is slim, who is at a good healthy weight and it's almost like – you have got a problem, we have got to fix it. Whereas, I feel from my perspective, that doctors look at you and go 'you are a fat beast - you are bringing this on yourself'... And it shouldn't be that way. It shouldn't make you feel that way. (Emily)

Participants discussed feeling like they were always waiting for their doctor to bring up their weight. Through years of experience, participants had come to expect commentary about their bodies – in particular, their body size – and they were rarely wrong. More than one woman referred to this, discussing the inevitability of weight always being raised. And whilst the women did convey a sense of acceptance that this was always going to happen, their anger was also evident:

Doctors to take it upon themselves to comment on your weight whether it's a factor or not and that's happened to me all too much, which has made me afraid, which is what used to make me feel afraid, and that why I got into the habit of explaining and apologizing for myself. Because I knew you would go to some f&king prick who would comment on you, even if it wasn't the case, even if it wasn't a factor. Just because they thought they could. Because they thought 'we've got someone sitting here who is significantly overweight, well whilst she's here we may as well kill two birds with one stone. (Bridie)*

Expecting, which is defined as “anticipating the occurrence of coming of” was a state in which participants were constantly engaged in (Macquarie Dictionary 2005, p496). Anticipating can be a good thing, especially when one is anticipating the coming of something positive. However when what you were expecting was something which they knew was going to embarrass them, confront them or make them feel bad, then it changed everything. For participants, a significant part of the problem of ‘being defined’ was that it had created in the women an expectation of poor treatment, based on weight. For some participants, being subjected to years of judgement and weight bias had created a cycle of expectation of what was going to happen. Many participants had come to expect that accessing their GP, or other healthcare providers, was going to be in some way painful or problematic, and they knew that this was happening. A criticism often directed at large bodied women are that they are overly sensitive about their weight. The women in this

study made reference to this, suggesting that the sensitivity was borne from years of being totalised by their weight. Because they had become used to being treated like just a fat body (participant term), they had come to expect it. One participant described her experience:

I think honestly that up until my latest GP my weight has been a factor in every interaction I have ever had with any healthcare provider. I have gone into every interaction with my GP with awareness, or, well I could call it an awareness, but it's been sensitivity at times. I am very very sensitive that something would be said about my weight. (Bridie)

For the women in this study, the system that was supposed to be helping them was instead something that they felt they had to prepare themselves for and defend against attack in order to survive. For participants, being judged created a cycle of anticipation. Many participants had come to expect that accessing their GP, or other healthcare providers, was going to be in some way painful or problematic, because of the judgements made about their weight and large body:

I definitely think that our culture idolises thin people and doctors take that into their interactions with big people. So whether it's an issue or not, inevitably your weight will come up I think they can't help but comment, and that's how I've felt. (Stella)

Another described her experiences with her GP as a waiting game, one in which she was constantly waiting for whatever health issue she was presenting with to be linked back to her weight. For participants, there was almost an expectation that their size was always going to be commented on. As one participant stated:

I think the strongest message that I have gotten is 'come to expect commentary on your body.' If you are overweight... then expect people to comment. (Lucy)

Another participant related her experience to what she had learnt about her body from external sources, namely her mother:

I was afraid, that weight would be an issue, because when my Mum would take me to the doctor when I was young she always pre-empted it for me in a way. Because she was fat herself then she always pre-empted this fear on us that you have got to prepare yourself that it is going to come up, your weight will be discussed, you know it's just inevitable. So in a way I learnt to dread it. (Stella)

Several participants talked about the feeling of expectation in a different way, referring to it as the feeling of ‘knowing’ that they were being judged because of their body size. One participant called it her ‘fat sixth sense’ (Stella) whilst another talked about it in more depth:

It's a feeling that comes with being overweight for as long as you can remember - you know that when you walk into that room that what they see first is your fatness. So you are being listened to, but you know that they can't separate it. You know that it's this inherent, I don't know how to describe it, it's in instinctive feeling that you have, that you know that you are being judged on your weight. (Maree)

Another participant described it in this way:

I know with every doctor that I've ever seen, that when I walk into that room they will, I know the first thing they are thinking is 'oh we've got a really big girl here'. I know they are thinking that. And it doesn't come through me being thin skinned or sensitive to it, what it comes through is through years and years of my senses being heightened and being made aware of how people perceive fat people in a medical setting. (Stella)

One participant described ‘always feeling ready for battle’ (Stella), ready to defend herself against the comments she knew would follow. Because of the context of their social worlds, namely the sociocultural bias against obesity, they were used to feeling that their bodies were abhorrent and that they might create negative comment. However to feel that they were constantly waiting for their doctor to say something to them was worse, and so much more painful. Primarily because they expected to be safe with their doctors, and in this study, they rarely were. The knowledge that their doctor was most probably going to bring up weight meant that for most women, going to the doctor was often something they felt they had to somehow emotionally prepare for. However, it wasn't for reasons that health professionals may expect. Not all women were scared to talk about weight. However, in their experience, they had found that when weight was raised it was usually done so inappropriately and secondly that it then became the sole purpose of the consultation. One woman talked about feeling sad because of how she had learnt to anticipate that her doctor would judge her negatively based on her weight:

I am sad that I have that attitude and feeling inside of me. I am expecting everybody else to react the same way, so I see it that way. Or is it me that's seeing it, or are they just being themselves? (Emily)

Participants rarely felt safe when they had to see their GP, because they knew they were going to be judged because of their weight. The knowledge that they were going to be judged by their GP meant that for most part going to the doctor was often something women felt they had to somehow emotionally prepare for. Women were consequently always waiting for a comment to be made about their size or weight – and they were usually right. This resulted in never finding a space where they felt secure. As many participants stated time and time again, visiting their doctor was rarely an occasion where they felt safe. For most participants, during or after consultations with their GPs they had to manage feelings of shame, guilt, fear, embarrassment, and apology. One participant stated:

It's like everything is linked back into being overweight and um it's just that you know that there is an inevitability with any new doctor that your weight will come up So you are kind of waiting for it to come up, and if it doesn't come up then you are surprised. But my expectation with any new healthcare provider will be that my weight will come up for discussion. That's my expectation and that's been my experience. (Maree)

Another participant talked about how the fear of not being taken seriously was related to her constantly expecting the worst:

Being overweight has stopped me from going to the doctor a lot over the years particularly in relation to having lower back problems. I've been very reluctant to go to the doctor because I knew that, well you know that if you have any extra weight on that it's going to be an issue with back problems. I have worried that I wouldn't be taken seriously, so um, that prevented me. (Stella)

The process of engaging in this project raised questions for participants, some of which they articulated during the interviews. In particular, they questioned whether their experiences as large bodied women had created an expectation of poor outcomes with their doctors which actually worked to create a bad outcome:

I get scared sometimes that what I fear is going to be said to me actually changes the way I act with him [GP]... and so then it automatically becomes a bad situation because I am in some way making that happen with my attitude. (Lou)

Participants acknowledged that it was possible that their constant state of anticipation could impact upon their interactions. One participant said:

I don't know it's me, if I am bringing an attitude in with me, or whether I am on edge because I just know that something is going to be said. Perhaps I should ask myself why I care so much. I don't know. (Rory)

The participants also talked about how their past experiences of healthcare had worked to change and influence the way they felt now. They discussed how incidents where they had been actually being judged had on what they felt and perceived:

There is that sort of feeling inside that perception about how people react... you respond to small things, perhaps in an adverse way. If I am feeling sort of uncomfortable about my size and I see someone grimace – they may have stubbed their toe – then their grimace is because 'there's another one... another big person. (Lena)

They were always expecting the worst. Women felt that they could never relax when they went to their GP. They felt they were always on edge waiting for the first comment about weight. One participant, when talking about her weight said:

I don't care as much anymore. But still, you are always ready for someone to make... the fat comment, any sort of fat comment. (Joni)

Participants talked a lot about how they felt that they had to be 'on guard' at all times when they were in health settings, largely because of their weight. One woman discussed her current GP who she believed wasn't focused entirely on her weight:

My GP is so good that I don't have to worry about it; I don't have to sit on the edge of my seat. (Lena)

Participants acknowledged that their experiences with their GPs not only continued to impact upon their consultations, it had started a cycle of negative anticipation. Because of the experiences they had had related to living in a large body and as a large health consumer, participants had grown to expect comments about their weight. Participants' past experiences of bias and discrimination and feeling judged because of their body size impacted significantly on their ongoing feelings relating to healthcare.

They had also learnt to expect that their fat would be blamed for whatever was happening in their bodies. As a result, they were always waiting and ready to be criticised or judged because of their weight. One participant described waiting for the judgement she knew would come as always feeling ready for battle, ready to defend herself against the

comments she knew would follow. Another described her experiences with GPs as a waiting game - an environment where she was constantly waiting for whatever health issue she was presenting with, to be linked back to her weight. One participant said '*I am very rarely surprised where weight is concerned*' and this statement was echoed by a lot of women in this research. Another participant said '*Doctors don't like to treat people who aren't doing something about their weight*' (Stella), and it was this common belief amongst participant.

There was a sense of expectation that accompanied all participants into an encounter with their GP. Most participants couldn't initially articulate what had made them come to expect that something would always be said about their weight. However, once they started talking they gained confidence in being able to express their thoughts. One woman said she couldn't be sure what had come first – was she scared of her GP because of past experiences, or because as a '*fat woman living in the world*' she had come to expect commentary on her body. The experiences of always expecting the worst had created in women a feeling of distrust, which gradually eroded the trust and faith that women placed in their doctors.

Summary

The aim of this research was to identify the main concerns of large bodied female healthcare consumers. The basic social psychological problem, identified as 'being defined', occurred when large bodied women engaged with medical professionals in clinical encounters. 'Being defined' by being overweight or obese posed considerable challenges for women when they became patients because they believed that their large body worked to create an interaction where their weight became the primary focus. Additionally, 'being defined' by something which has so many negative meaning embedded within it had numerous consequences for women. These consequences have been explored as the sub categories of 'feeling invisible', 'feeling judged' and 'expecting the worst'.

Participants had grown to expect comment and judgement about their body size, and as a result they were constantly waiting for comment and certain behaviours. For women, experiences of being judged ran deep, and they had significant consequences. For

participants, being judged manifested in a number of ways. For some, part of the experience of years of judgement was the expectation of what was to come. Many participants had come to expect that accessing their GP, or other healthcare providers, was going to be in some way painful or problematic, because of the judgements made about their weight and large body.

Relationships with medical professionals can be extremely powerful, or extremely damaging. Either way, they can have significant outcomes, or evidence of this was visible in participant data. Because of constantly feeling judged and invisible, all because of their weight, women described a loss of faith and lack of trust in medical professionals. I asked one participant if she could sum up her experiences of healthcare and she said:

Always lose weight; always you are better off thinner. (Emily)

Participants rarely identified their doctors as people who they felt they could rely on to support them in achieving healthy outcomes, either physical or emotional. They described feeling this way because they believed that trying to get health advice or treatment was problematic for large bodied women. They viewed their interactions with medical professionals, particularly their GPs as difficult and rarely a positive experience.

Participants believed that being defined by their bodies in the way that they currently experienced had actually worked against them on countless occasions. For many women, consulting their GP was often an exercise in damage control because of all that they felt they had to manage. Out of all the participants, only one woman was happy with her current doctor. In the opinion of the participants, GPs linked every issue back to weight, including things which made no sense to participants at all.

In order to manage the issue of 'being defined', the participants developed several key strategies, identified in this research as social processes, which helped them to manage the issues associated with being defined. The following chapter will explore the strategies that participants used to cope with and /or counteract the basic social psychological problem, which have been identified as the social process 'Learning to Manage'.

Chapter 7: Learning to Manage

The Basic Social Psychological Process

Introduction

This chapter presents the findings of the basic social psychological process ‘Learning to Manage’ which emerged from this study. This process encompasses a range of behaviours used by large bodied women to manage the basic social psychological problem of ‘being defined’ which was identified and explored in the previous chapter. The sub-processes of ‘Learning to Manage’ which have been identified as ‘Trying to be Seen’ and ‘Protecting Myself’, explain and present the strategies used by participants to deal with the challenges and manage the basic social psychological problem of ‘being defined’. Each sub-process has two categories, which will also be explored. Findings will be supported by participant data, which is used exactly as it occurred in interview transcripts.

A basic social psychological process is something that occurs in order to resolve or manage the issues of main concern identified by the participants. In grounded theory the researcher endeavours to uncover the basic social processes that people use to deal with situations in which they find themselves, and that generally are not understood by the individual at a conscious level. The basic social psychological process should encapsulate the patterns of behaviour which are fundamental to the phenomena (Jones, Kriflik & Zanko, 2005). According to Glaser (1992), there are two types of basic social process: the basic social psychological process which refers to change in the individual or group, and the basic social structural process, which refers to changes in social structure arrangements. In this research, analysis of interviews with participants revealed that for these women the processes they used were at an individual level, thus making it a basic social psychological process.

There is debate around the identification of social processes which centres on the discovery of one versus multiple processes in a grounded theory. Morse (2001) posits that a theory can have more than one core category or basic social process, however suggests that this is not common. Clarke (2006) also comments that there is pressure within grounded theory circles to analyse for a single social process, rather than allowing for the identification of multiple processes. Others claiming to use a constructivist approach to grounded theory have noted their discovery of a single core category and/or a basic social process. Charmaz (2006) suggests that most constructivists don't adhere to the notion of only discovering one basic social (psychological) process but rather assume an approach to the world which recognises diverse realities. This research did however identify one basic social process which was comprised of two sub-processes which coexisted with each other, and which participants used at different times during their interactions with medical professionals.

The possibilities for social processes at play in this research were limitless. What I have reported is the processes that I saw, and which were visible to me through my engagement with participants. If I were to revisit this study again in ten years time, perhaps I would see something different. If someone else looked at the data, they also might see something that I didn't. I have written about two social processes in this study. The two processes which comprise 'Learning to Manage' are the processes that I have identified, through being grounded in the data, as salient processes at play in the phenomenon.

The following section will introduce and describe the basic social psychological process 'Learning to Manage'.

Learning to Manage

The process of engaging participants in interviews formed the basis for developing a theoretical understanding of large bodied women as healthcare consumers. In keeping with grounded theory methodology, my first goal was to immerse myself in interviews with participants and identify what I thought was the shared problem of the participants. Once done, I then concentrated on looking at the social processes, namely the strategies, that women developed in order to manage the concerns encountered by them in that context.

Whilst participants were able to articulate their experiences of healthcare they were, at first, not generally able to articulate the strategies they used as part of the basic social psychological process of 'Learning to Manage'. It was only through the course of in-depth analysis of interviews and literature reviewing that I identified that what participants described as 'all part of it' were actually critical parts of the process of managing the basic social psychological problem. 'Learning to Manage' describes the behaviours used by participants during their ongoing interactions with medical professionals to manage the problem of 'being defined'. This eventually made up the basic social psychological process of 'Learning to Manage'.

Taking on the identity of healthcare consumer or patient, as participants usually identified themselves, brought with it a host of issues the most critical of which have been identified and discussed in the previous chapter as part of the basic social psychological problem. In order to deal with the challenges associated with 'being defined' participants engaged in the basic social psychological process of 'Learning to Manage' which encompasses a number of behaviours and strategies. This process was specific to their experience of being a healthcare consumer, particularly as it related to their interactions with medical professionals. 'Learning to Manage' is the conceptual explanation of these behaviours and for the purpose of this study is defined as:

The strategies and behaviours used by large bodied female health consumers in order to manage their engagement with medical professionals and counteract the stigma and discrimination they experienced.

The Macquarie Dictionary (2005, p870) states that to manage is to "to take charge or care of" or "to dominate or influence a person by tact, artifice". For women in this study, their interactions with medical professionals were complicated. They felt that they were judged by their body size, which resulted in them feeling demeaned, ashamed, and angry. They felt like their health and illness experiences were trivialised because everything always seem to concentrate on weight, thus making them feel ignored and invisible. Consequently, they believed they had to learn ways of managing the interaction which worked to combat or try and neutralise both the stigma and discrimination they felt, as well as increasing ways of being seen.

‘Learning to manage’ was essentially comprised of developing strategies through which managing the interaction with their medical professional would give them the best outcome – minimise stigma and hurt, manage judgement, and try and be seen. For them the best outcome usually meant one of several things: that weight would not be discussed, or if it was it would be discussed in a way they thought was appropriate. Successfully managing the interaction also meant that they would be seen as more than what they weighed. Learning to manage their interactions with their doctors was also about trying to reduce opportunities for hurtful comments, by employing strategies which neutralised or somehow made their largeness less offensive to their doctor.

Coping with negative stereotyping and managing stigma were both things that participants felt they had to do in all aspects of their life as large bodied women. However, having to engage in these strategies with doctors and other healthcare professionals made it seem so much worse. Because of the context of their social worlds, namely the sociocultural bias against obesity, participants were used to feeling that their bodies were somehow abhorrent. For participants in this study the process of actively managing their interactions were a fundamental part of their experiences as healthcare consumers. The processes associated with ‘Learning to Mange’ were something they needed to do in order to manage the stigma they felt and the discrimination they experienced. These strategies were essential as they served as a way of what one participant described as ‘surviving the system’:

I just do what I need to do to get what I need... and what I need is not to feel bad about myself or like there is something wrong with me. My purpose is to get out [of medical consultation] as unscathed as possible. (Lou)

Participants discussed how time and getting older had changed their experiences of how they managed the problems associated with being a large bodied healthcare consumer:

I suppose through my own work as I have got older I have become more empowered in how I deal with doctors. I don't feel anymore that I have to feel like I am less of a person - just because I am overweight – when I am talking to a doctor. (Lou)

Conversely, another younger woman talked about what she thought would help change some of the experiences she had endured:

I think – more than anything – doctors need to be responsible in dealing with young people when they are at such a vulnerable point in their life. Coz when you are young what you look like is pretty much your whole identity... and I suppose the thing is, is that if you want to change that, and make it more positive then doctors need to have some training on that level in knowing how to talk to young people, and understanding the experiences of being young and overweight. (Stella)

Another woman talked about how her experiences of weight discussion with her doctors had changed through the generations:

It's how it's delivered. You know, how they tell you. The doctors that are around now are more sensitive to a woman's sensitive side. Years ago they were different... you can talk to them more now. My doctor now though, he is good. He said 'it's fine, it's just a number' and he doesn't embarrass me. He talks about healthy as a bigger concept than just weight... however he also manages to still encourage me to lose weight. (Maree)

Part of learning how to manage was seeking out the doctors who were going to treat them in a way in which they felt like a whole person. One participant talked about this:

So I think that it then comes down to the person, the fat person – so to speak – seeking out a good doctor or healthcare provider, someone that is more holistic and sees, you know... I don't want someone who is going to blow smoke up my arse. I don't want to go to a doctor, and if I've got a long term problem, like I've got problems with my back, I don't want someone who is going to fib to me. I want someone who is going to be real with me. It just all depends on how the person does it. (Molly)

Women were in a constant state of trying to counteract feelings of invisibility; trying to manage discrimination; trying to be seen whilst at the same time trying to get their needs met. The women in this study felt like they had to work hard to get their needs met, and if they chose to reveal their anger or their hurt or their disapproval at how they were being treated, they took the risk that they would be labelled (by their doctor) as non-compliant; that they would be denied appropriate treatment because of lack of interest on the behalf of the medical professional, or that they would be mocked or further judged.

For the women in this study, interacting with a medical professional was something they did because they felt they had little other choice; it was rarely a choice that they made gladly. To get the help they needed, women learnt a number of ways in which they could

counteract or deflect the attitudes and bias which they felt they were subjected to as a patient. Over time and through repeated experiences, women learnt to manage their interactions with medical professionals in ways which blocked out or minimised the consequences of their experience of embodying an 'obese patient' identity without having to overtly challenge their doctor. They felt that if they openly challenged their doctor they risked further sully their already marked identity:

I know it's going to make it worse if I react. It's easier sometimes to just let the comments slide on past me. If I react I know that I then become the angry fat woman; the defensive fat woman; or the fat woman who is in denial and responding badly when reprimanded about it. It's a no win situation. (Rory)

Learning to Manage is comprised of two sub-processes which participants used to manage their interactions with medical professionals, and to deal with the problems associated with 'being defined'. These strategies were used by everyone, usually simultaneously, but not necessarily as part of a formal trajectory which had phases that could be delineated. As noted above, whilst a grounded theory process can, and has in classical grounded theory studies, have identifiable phases I did not identify a series of actions or strategies which I felt could be slotted into a process that changed over time, and I think that this is very important to note. Rather, the processes I identified were strategies which women developed through their experiences of managing the phenomenon, the social problem of 'being defined'.

Below is a conceptual rendering of 'Learning to Manage' which reveals the basic social psychological process; the sub-processes 'Trying to be seen' and 'Protecting Myself', as well as their respective properties of '(re)Constructing Acceptable Selves', 'Always Apologising', 'Limiting Expectations', and 'Learning Not To Listen'.



Figure 7. The basic social psychological process: Learning to Manage

The sub-processes of ‘Learning to Manage’ which have been identified as ‘Trying to be Seen’ and ‘Protecting Myself’ explain the strategies used by participants to deal with the challenges which faced them as large bodied healthcare consumers. Each sub-process has two categories: ‘Trying to Be Seen’ is comprised of ‘(re) constructing acceptable selves’ and ‘always apologising’, and ‘Protecting Myself’ is comprised of ‘limiting expectations’ and ‘learning not to listen’. The subsequent sections will discuss and present the sub-processes and their categories, supported by participant data.

Trying to be Seen

For the participants in this study, one of their critical struggles was trying to be seen. Whilst their struggle to feel seen as patients has been explored through the concept of ‘feeling invisible’, their strategy for trying to manage and overcome this has been identified as ‘trying to be seen’. ‘Trying to be seen’ had two properties: ‘(re) constructing acceptable selves’ and ‘Always apologising’. This was a continuous process of trying to be seen as more than just a weight problem, and as someone who was clearly responsible - or irresponsible – for letting her body become so unhealthy.

To “see” is to “have experience of or knowledge of” or “to observe, be aware of, or perceive, with the eyes” (Macquarie Dictionary 2005, p1280) and women felt that in order to ‘be seen’ they had to employ a range of strategies – or social processes – which forced their doctor into ‘seeing’ them. Part of ‘managing’ their clinical encounters involved developing ways through which to manipulate their doctor into seeing beyond their weight, and viewing them instead as an individual presenting with an issue unrelated to weight. If they could do this, they then felt as though they had been heard and legitimately examined.

For women in this study, the process of being a patient was complicated. They believed that presenting as a ‘fat patient’, as described by more than one participant, changed everything. They never felt that they were seen as just a ‘patient’, they always felt like they were seen as a fat patient. And the problem with being seen as a fat patient was that it created a number of issues that participants had to manage. Participants believed that it was medical professional’s reactions to their body size, and subsequent interactions with them, that contributed to their feelings of invisibility as healthcare consumers. In this context, they believed it was actually which was the issue. To be visible to doctors as more than just a large body was what participants wanted for themselves. In this context, being seen was about trying to become more than a fat body, which as described by participants, was not a good thing to have. In order to do this the participants then somehow had learnt strategies which made their bodies more ‘acceptable’ to the healthcare provider. One participant talked about acting in particular ways in order to try and manage her relationship with her doctor:

To be honest, I don’t even know when I am doing it half the time anymore... well, maybe I don’t know.... It has just become kind of so ingrained in me that I just try and do whatever I think will make my GP treat me better. (Emily)

Participants were continuously reminded that in order to try and be seen as anything other than an overweight or obese patient, they had to actively employ strategies in order to try and be seen. Participants found that employing the range of strategies they had developed made clinical encounters easier for them to manage because it helped to neutralise, minimise or overcome the issues associated with being an overweight or obese patient. For some women the use of these strategies was conscious, however for most it wasn’t.

Trying to be seen also involved learning ways of trying to avoid conversations about weight. In some instances it was important to participants to do this because through using strategies which deflected the conversation away from their body size they felt they became more visible:

I feel like if I sense the conversation going in the direction of weight talk, then I will quickly search for something else to say, or ask a question or something. (Bec)

I asked her why, in relation to trying to be more visible, she did this:

Well, it just makes it easier if I can try and distract her [GP] with a question about something else, or feign interest in something. (Bec)

Participants felt they had to develop compensatory measures in order to try and neutralise the damage done by their overweight or obese body, and thus make themselves more acceptable. Part of the management strategies that participants had developed were in order to compensate for being overweight or obese. Compensatory strategies, such as pretending that they had started a diet or apologising for their size, were commonly employed so that they would get the treatment or the help they ‘really’ needed instead of the consultation focusing primarily on their weight.

In order to try and be seen, participants felt like they constantly had to monitor the way they acted, communicated, and appeared in order to get what they wanted from their doctors. One woman talked about how she felt she was always trying to manage the fact that everything always came back to her weight:

I know I'm not a doctor, but I just do not believe that me being fat is the cause of everything that has ever happened to me in my life. I feel like I am always trying to get my doctor to see past my weight as the cause of everything that is happening to me. (Daisy)

I asked her how she did this:

I don't know... that's really hard. I just probably say what I think they want me to say. (Daisy)

For participants, ‘trying to be seen’ was essentially a process that participants engaged in to try and be viewed as more than just a weight problem, or more than a medical problem where everything was about or somehow was traced back to their weight. If they could work out ways to make their GP treat them as a patient, instead

of just a ‘fat patient’, they believed that they would then increase the likelihood of interacting with their GP in a way where weight was not the sole focus. If this happened, the women indicated that they were much more likely to feel that they were being treated appropriately. It also created a space where participants felt that their actual medical concerns were listened to; not just issues that the GP attributed to weight.

Always Apologising

‘Always Apologising’ was the first category of ‘Trying to be Seen’. The process of constantly apologising was a deliberate strategy employed by participants in order to try and be seen by their doctors as more than a fat patient. The act of apologising has been defined “to offer excuses or regrets for some fault, insult, failure, or injury” (The Macquarie Dictionary 2005, p62) and for participants, apologising was a key strategy in managing the issues associated with ‘being defined’. Women knew that how they talked about weight impacted the course of the consultation:

I know that how I act about my weight affects the type of conversation I will have with my doctor. (Nicky)

This category explains how these women felt that they had to compensate for the fact that they were presenting to their doctor in an overweight or obese body, which they did by apologising for their size. They felt that if they did this they were more likely to be seen, which for these women meant that they would be taken seriously:

I have struggled so much with the idea that I wasn’t being heard or taken seriously by my doctors. Because I have had such bad problems with two discs in my back, weight has always been an issue. And I get it, I do. But I also know that I have been actively manipulating my doctor for years – and I know that sounds bad but I don’t mean it in a bad way. (Lou)

Women also believed that if they apologised for their size, they were less likely to be judged and ultimately that they would be seen as more than someone with a disease that they weren’t responsible for:

I don’t know about other people, but my struggle is in trying not to feel so bloody guilty about everything. I feel like every time I see my doctor she tries to tell me that everything that is wrong with me is because I am fat.... But I don’t think I am THAT fat. So I kind of hedge around my weight and, well I guess I sort of apologise for

myself... which sounds sick doesn't it? I'm not ashamed of myself, but I just know that if I act sorry then she is nicer to me and more likely to help me. (Lou)

Learning to apologise was also a way in which participants had found enabled them to get treatment. They often felt like because they were fat, the same treatment options weren't offered to them. One participant believed that she wasn't offered pain relief when she had an injury because of her size:

I know that if I somehow apologise for my failure to lose weight or something like that, they will be sympathetic to me, So if I can just eat humble pie for a bit, then not only do they listen to me but they will also be more likely to treat my pain. (Joni)

To be seen as just a fat patient was not something that participants wanted, because it created judgements and it changed the way that their doctor viewed them. They believed, however, that if they apologised for their weight they would be viewed more favourably by their doctor, and more likely to be seen as a whole person – rather than just a fat person. One participant described how she felt that she had to apologise for herself, and her fat body, in order to try and be treated more favourably:

I don't think that thin people have to jump through hoops like fat people do... I feel, in my experience and other people I have talked to, that fat people almost have to be apologetic in any interaction they have with a healthcare provider. That's how I feel. I feel that you almost have to pre-emptively apologise for being overweight, to make it more palatable for the person treating you. (Stella)

Participants felt that even though they knew their large body portrayed one thing, they felt that the doctor still listened to them more if they said that they were trying to lose weight, or even better, that they had just started a weight loss program. Being a large bodied woman was something that participants felt worked against them in a health setting. They felt that the more repentant they acted, the more likely it would be that they would get the help that they needed from their doctor. If they weren't, they felt the consultation could become hostile:

I feel like if weight comes up and I tell him that I am actually not too worried about it – and this has actually happened - then he becomes all snide and sneering and the appointment gets this nasty feel to it. So it's just easier to pretend that I feel bad about it. (Bec)

Participants described feeling like they always had to apologise for their body at the beginning of any consultation, to try and make the doctor aware that they know they are fat, so the doctor doesn't have to raise it first. For participants, to admit that they were happy with themselves as a large bodied woman was something that they felt worked against them in a health setting. One woman described her experience:

I remember this one time with a newish GP, and he raised my weight and I told him that I was pretty happy and I didn't even think about it. Well, he bawled me out, and told me that I had to stop lying to myself, and how could anyone be happy being the size I was. So the next time I saw another doctor, and when weight was raised – as it always is – I just said 'I know, and I feel bad about it. I know I really need to do something about it and have been thinking about the best way forward' or something like that. (Daisy)

Another participant said

I know that I have to apologise for being fat and going to the doctor. (Lucy)

I asked her why she felt this way and she said

Well, I know that if I don't apologise for my weight in some way then the whole appointment will keep coming back to weight, and I don't want that. If I wanted that I would make an appointment to see someone who could actually help me with my weight. (Lucy)

Women also discussed the concepts behind 'always apologising' in relation to the timing of when they initiated it within the consultation. Some of them believed that if they apologised for themselves as soon as they entered the consultation it would somehow make the doctor listen to them. One woman felt that if she acted quickly and openly acknowledged her fat as a problem then the doctor would take her more seriously. She said:

I haven't had really bad experiences, but I know that what I do is this... I talk about it (my weight) first before they can say anything. I do that to let them know that I know, and that seems to somehow work. (Bec)

Another woman talked about her experiences of using apologising as a strategy, suggesting that by declaring yourself as a fat person as soon as you entered the consultation and then apologising it somehow improved the way she was treated:

Sometimes that's what you do, you pre-empt and you get people at the post. You pip' em at the post. If you go into a doctor's room, and you are not just 5 or 10 kilos overweight, you're more like 30 or 40 kilos overweight, then you go in there and you almost get them before they strike at you. Do you know what I mean? (Stella)

I asked her to tell me more about this concept of being 'pipped at the post' and she said:

Well, pip at the post, you are going to pre-emptively strike before they strike. You are going to say blah de blah de blah... So you say to them "I know my weight's a factor". I find myself tagging that onto so many things that I say, over the years. You find yourself almost apologising in advance, or even excusing yourself in advance, for being overweight. (Stella)

Participants believed that if they apologised for themselves, either for their body size or for the behaviour which they assumed would account for their body size, they would somehow be taken more seriously; would have their experiences validated more, and would thus be seen.

(re)Constructing Acceptable Selves

(re)Constructing acceptable selves is a continuous process of self-management which participants engaged in when they entered into medical consultations. The self-management was in regard to how they presented themselves within the consultation, specifically ways they could present or mould the self they were presenting in order to manage or neutralise conversations or negative attitudes about weight.

For the women, part of learning to manage their interactions with healthcare providers in a way that was useful to them was centred on learning ways of compensating for their size and constructing an identity which they considered was more acceptable to medical professionals. For participants, engaging in a continuous process of trying to construct a self that participants felt was acceptable to the GP was a set of behaviours they learnt in order to try and counteract their body size, which lessened their feelings of invisibility, and of judgement. Being able to continuously (re)construct themselves occurred by learning certain ways of making themselves more acceptable to the doctor treating them. The most common compensatory strategy used by these women was saying that they had started a diet, or had started losing weight. If they did this, they believed that this decreased the focus on weight, and made their weight seem less abhorrent.

The participants were engaged in a constant cycle of assessing what they needed to do in order to manage their fatness and then adapting how they presented themselves in a way which they considered would be ‘acceptable to their doctor’. Being acceptable meant that they would be seen as a patient deserving of full medical attention and investigation, rather than someone with a diseased body. The constant cycle of judging what to do, and who they felt they needed to be required constant watchfulness, and it was tiring. Participants were in a state of constant vigilance when they were in a clinical encounter. This vigilance was maintained in order to try and ‘read’ the situation so as to respond with one of the strategies they had developed based on past experiences.

Participants felt like they received very little validation regarding health issues. So in order to do this, they felt that they had to play certain roles and play up or down certain parts of themselves.

I know what I need to do – I just have to play the game. It sucks, and I hate it – but if I want to get what I want to get without having to listen to all the shit about how bad my weight is, then I just play the part I have to. (Tara)

I asked her to tell me more about this, particularly what she meant by playing the game and she said:

Um, you know, I do what I feel will make him like me, and what will get him off my back. I KNOW I’m fat, he knows I’m fat, and he keeps going on about it. I get it. I need help with what I need help with NOW. So I just play along – if he is concerned, I act concerned too. If he is condescending, I just pretend I don’t notice and act contrite. I don’t know... I just do what I have to. (Tara)

For these women, a critical part of being engaged in trying to continuously reconstruct an identity they felt was acceptable was to do it in a covert fashion. Women found it extremely difficult to challenge their doctors, particularly using a strategy such as direct confrontation:

I would never do anything about weight stuff directly, not with my doctor anyway. Maybe if someone in the community... but with my GP I just try and find little ways of doing things so we can move past weight and talk about other stuff. (Maree)

For participants, a significant part of ‘trying to be seen’ consisted of what they described as playing the part of the dutiful patient. They believed that playing this role projected the part of someone that doctors could relate to. Acting the part of the obedient patient, they believed, helped their doctors to be able to overcome their size and treat them like a patient who wasn’t overweight or obese:

I know that by acting a certain way that it definitely makes the appointment more comfortable. I have a friend who absolutely refuses to pretend she is uncomfortable with her weight or anything, and I know that she has had bloody heaps of instances where she has had doctors almost sneer at her. And I just don’t want that... so I guess what I am saying is that if I act like ‘yes doctor-no doctor’ then it’s more likely that they will see me as someone who is nice and not disgusting for being fat. (Emily)

Whilst often women thought their treatment from medical professionals was unwarranted and unprofessional, the fear that in some small way their size *was* actually connected to whatever health issue they were presenting with also worked to stop them from reacting when their doctor said something to them.

I don’t think I would ever say something to the doctor directly. I just don’t think I would have the courage because I know it would make him angry. (Jane)

I asked her why she was afraid of making her doctor angry:

Well, I don’t know. I guess it’s because I already feel like I am on the back foot – being big and all - so I have to try extra hard to please him. (Jane)

A lot of the women in this study also had very little self-esteem when it came to how they felt as healthcare consumers. One woman said:

Being significantly overweight can do... can affect your self-esteem and whether you feel like you can speak up for yourself, and all of that. (Emily)

Another participant questioned the notion of whether her experiences as a healthcare consumer had caused more lasting damage:

I don’t know if doctors have directly impacted on my self-esteem as it is fairly hardy but I have often left a consult feeling very upset, a bit like I’m a non-compliant and naughty girl. (Stella)

Because of the social censure around obesity and weight the participants felt they had to adopt different identities in order to make the doctor listen to them. These identities were temporary and based on what they thought would serve them in the best way, and which would minimise the issues. They felt that if they adopted an identity that was suitably ashamed and remorseful about the state of their 'deviant' bodies; that their doctor would listen to them, and that their health concerns would be met.

Trying to be seen dictated that participants looked for any ways that they could be seen as a patient who could be liked, and who deserved treatment:

I would like to be more than obese - which is what a GP wrote in her computer when I saw her for the first time – and I know that in order to do that I have to try and strike up some kind of rapport with her, or create some kind of connection which means she will treat me properly. (Bec)

Participants also believed that playing the part of the passive or 'nice' patient, as described by one participant (Lucy), helped to avoid conflict or them feeling hurt, ultimately making things easier:

I try and be as nice as I can, even when I feel she [GP] is saying stuff to me that I think is crossing the line. Like, a few months ago she said to me 'if you could just lose 10 kilos I think you would feel so much better, and you would just look so much better'. And I just felt so pissed off, but I didn't say anything. Not because I felt like I couldn't, but because I knew that it would just be easier. It's easier if I just pretend that that's an ok thing to say to me. (Sam)

I asked her what she meant by easier and she said:

I don't know... look, maybe I should say something, but I know that it will just create all this drama and I can't be bothered because then I just get upset. I don't want her lecturing me, and I just want for once to be seen as just me. (Sam)

For the women in this study, part of the process of (re) constructing acceptable selves was to try and become a compliant patient, and a compliant patient they believed was one who was seen as trying to lose weight. And, according to them, someone who was trying to lose weight was likely to become more visible to their doctors. One participant described a very conscious process through which she believed she sidestepped the issue of weight and got her doctor to focus on her:

I've worked it out now. I used to try not to do it because it felt like I was ashamed of myself, but now if they bring it up I just say that I have started at WW [Weight Watchers] and I have lost a kilo or two, and these are my plans. (Lucy)

One of the most commonly used strategies that participants used to try and present a more acceptable self to their doctor was to play the part of the compliant patient. They found that in adopting a role in which they pretending they cared about their weight and were willing to do whatever it took to lose weight, could actually decrease the conversation about weight and concentrate on what they wanted to talk about:

I feel like I consciously adopt this different role when I go into that room. My doctor is really nice, and I like her, but every so often she will start in on my weight and when she does that I know that I need to somehow steer her back to me, and the reason I'm there. (Lou)

I asked her how she tried to steer the conversation back to her and she said

Um, well... I don't know. I guess I act in certain ways. Like I pretend that I care about my weight, or that I have joined the gym so then we hopefully can move on from talking about weight. (Lou)

Another woman talked about her use of different roles in order to get her doctor to listen to her so she would feel seen and heard. One participant said:

I almost feel like I have to perform every time I am with a doctor or be extra good with my answers to keep the doctor on my side. (Maree)

Other participants also used discussions of weight loss or dieting as a way in which they seem or feel more acceptable to their doctor. One of the participants summed up why she did this:

It's like the only way doctors can deal with us fatties is for us to say we are actively dealing with our weight problem. They cannot understand a person's choice to stay the way they are. And if they can't understand it, they won't respect you, and you won't have a very pleasant time. (Sam)

Another participant, when I asked her if she had used weight loss as a way of making herself seem more acceptable to her doctor, laughed and said:

Oh this is an old trick, and one in which I think every overweight person has done. The ironic bloody thing is that I doubt that they believe it anyway. It's like it meets two criteria's – I raise it so we can

bypass it and move on to something important, and two, the doc can check it off their list for having raised weight as an issue. It's such a joke. (Stella).

Another participant talked about how sometimes being a patient was hard work and how she managed this by trying to tell her doctor what she thought he wanted to hear:

Sometimes I wish going to see my GP was less like hard work. Maybe if I was thinner it would be... I wonder if thin women have to work as hard as I do? I feel like I am always waiting for a comment, and I don't feel like I can ever be myself for fear that I will be categorised as a 'typical' fat patient. I feel like I overcompensate telling them that I actually DO exercise and that I try and eat well, and that I don't eat shit food... Funny thing is, I never feel like they believe me anyway. I feel like I have seen that little smirk that doctors give when they don't believe you – do you know the one - - just once too often. I don't know. (Rory)

Participants felt better about accessing healthcare services if they had a regular doctor, because they felt that they had been through the initial weight conversations and had actually moved to a space where they were seen as a *normal person* (participant term), which meant they didn't have to worry as much about constantly trying to keep the consultation on track:

My old doctor moved to Queensland, and I was like 'I know what's coming'. Whenever you see someone new you have to retell your whole story, and I know that in a medical way they need that, but it does always include weight, and I just find it so boring. So I go to my new doctor and he says 'So you know that you are significantly overweight don't you?' and I say 'Yes' and I know I looked embarrassed, and he said 'So what are you going to do about it?' and I just felt so rank and guilty and awful that I said that I was watching my weight and that I was trying to exercise and that I found it really hard to lose weight. And then he seems to soften, and I kind of felt like it was going to be ok then. (Jane)

Through the course of interviewing, participants sometimes came to realise the measures they went to in order to try and be seen:

Because I know that I eat healthily, I feel like I always have that to fall back on. And then to try and get my doc on side I say, but 'I know I don't exercise' and that is such a challenge for me and I just don't know how to get started'. I have said that a number of times, and whilst I have meant it for some of them, I haven't really done anything about it. I feel like, and I haven't really thought about this until now, but I feel like that is part of my 'act'. I try and present

myself as someone who tries to be healthy, but who isn't living in complete denial too – and that way, you seem to be able to get help without all the judgment. (Tara)

Women were resolute that they had to take measures in order to try and project an image of someone who was concerned about health and who deserved to be seen. Participants felt that even though they felt their large body portrayed one thing, their doctor still listened to them more if they said that they were trying to lose weight, or made some reference to the regret they felt about living in a large body. I asked one participant about her coping strategies for when she felt judged:

And that's happened to me all too much, which has made me afraid... well which is what used to make me feel afraid, and that's why I got into the habit of explaining and apologising for myself. Because I knew I would go to some prick who would comment on my weight, even if it wasn't the case, even if it wasn't a factor. Just because they thought they could. Because they thought we've got someone sitting here who is significantly overweight, well whilst she's here we may as well kill two birds with one stone. So I just say conciliatory stuff you know, and somehow it makes me seem less offensive or something. (Rory)

Additionally, some women felt they had to be compliant because they genuinely didn't feel that they had the power or courage to speak up. For some participants, they tried to compensate for their largeness by being as compliant as possible, even if they were aware that what they were saying might appear as false:

Because I am fat I have always wanted to be as compliant as possible, so that they wouldn't have any other ground to get me on. And it was quite clear you know, I would say that I was doing this and I am eating healthy food, it was quite clear that if I was having several interactions with them and my weight wasn't changing, that I wasn't doing those things, but I still felt the need to perpetuate that image that I was being healthy. (Molly)

Another woman talked about how she felt when they talked about weight and she stated:

I feel shame. Feeling ashamed. Not wanting them to... If somehow you were as compliant as possible, then they wouldn't bring your weight up, or that they would be kinder to you about it. (Lena)

(re) Constructing acceptable selves was a constant cycle of action, a process of continuously constructing and reconstructing themselves in order to try and negate their fatness and get their doctor to see past their weight. For women to get the help they

needed, they felt they had to actively manage the process of interaction in GP consultations, in order to get what they needed.

Protecting Myself

The second process that women were constantly engaged in was trying to protect themselves against what they saw as the consequences of their large body size, specifically the size of their bodies within the medical setting. ‘Protecting Myself’ is defined as “to defend or guard from attack, invasion, annoyance, insult, etc.; cover or shield from injury or danger” (Macquarie Dictionary 2005, p1141). For the purpose of this study, ‘protecting myself’ is defined as:

the deliberate use of strategies employed by large bodied healthcare consumers to try and guard themselves against weight related discrimination, and the subsequent emotional damage this caused.

The dichotomy of not wanting to ‘go to the doctor’ combined with the knowledge that there really was no other avenue in which they could get help, was a very disempowering experience for participants. A lot of the things that women felt in relation to their healthcare experiences they could relate to other areas of their life. However, there were critical differences. Women expected to feel safe with their doctors, and expected to be healed or helped. When they did not experience this, the fallout was significant. For participants, being in consultations with their GPs meant being in a constant state of trying to defend and shield themselves against a situation in which they felt very threatened and vulnerable. The critical part of this process was that it was essentially about women trying to feel safe.

Even when participants were discussing their interactions with medical professionals and their need to try and protect themselves, they revealed that it was intrinsically linked with outside commentary from family and that part of surviving this was by developing ways in which to protect themselves:

I think this would be a common thing for other overweight women, but I think you have to develop a thick skin. For some reason, people feel like they can say whatever they want to you when you are fat – like my Nan, who said she would give me a thousand dollars if I lost weight. I wondered why it meant so much to her you know? It’s the same with doctors, and I know it’s different because weight is linked to how healthy you are, but sometimes the way they say it is just

blunt you know? So I have tried just to get tough and block it out. Do you know what I mean? (Emily)

A key part of the act of protecting themselves was that large bodied women learnt to manage their interactions with medical professionals in ways which blocked out or minimised the consequences of embodying the identity of an 'obese patient' without having to overtly challenge their doctor:

As empowered as I feel I am in my life, I don't know whether I could challenge my doc around this stuff – coz I am just not confident enough. (Nicky)

A large part of trying to protect themselves was to employ behaviours which protected them from further comment. For participants, learning to protect themselves was something they did to in order to minimise the consequences of weight based discrimination and commentary that they were subjected to in their interactions with medical professionals, and whilst they all did it, they didn't enjoy it:

The thing is, I don't feel like it matters why I am overweight, why I have or haven't lost weight, - I don't think I should have to consciously think about how I am going to get through my appointment. I don't feel like other people are sitting in the waiting room thinking 'what will he say to me this time and more important' blah blah. Maybe they are, but not in the same way I don't reckon. Weight is different; it's not like other things. It's so personal, but it's so medical now too. (Sam)

Participants expected to be safe with their doctors, and they rarely were, and this was difficult for participants. They felt that somehow their bodies were stopping them from getting the treatment they deserved. The equitable and just treatment that they believed were held up as a fundamental part of the healthcare system was something that they didn't seem to think applied to them as large bodied healthcare consumers:

It shits me – don't I have the same bloody rights as everyone else? Why do I have to work so hard to get what other people seem to get just by being thin? (Emily)

The women in this study learnt that if they protected themselves they could stay safe whilst getting the help they needed. They realised they would still probably get the help even if they didn't employ these strategies, but knew that if they didn't they would potentially take on board a lot of hurt and shame in the process.

Learning not to Listen

All of the women in this study indicated that they had learnt not to listen as a way of managing their encounters with medical professionals. ‘Learning not to Listen’ was a both a survival and defence strategy aimed at minimising the hurt women experienced as a consequence of their engagement with medical professionals. Participants found that by consciously deciding that they wouldn’t listen they could choose not to hold onto the often hurtful comments and insinuations directed at them from medical professionals. This then meant they could block out the negative messages, both verbal and non-verbal, that they received.

Learning not to listen was a clear strategy employed by participants to manage the feelings of shame and apology they felt during their interactions with medical professionals. Some women consciously employed this strategy because they believed that it stopped them from getting hurt, thus protecting themselves. One participant described learning to ‘switch off as a way of ‘surviving the system’:

...and I reckon I do that with doctors and the people who talk about it. I just kind of switch off. You block yourself from feeling about it, so you don't feel it in your subconscious. And then you don't get hurt... If that's how you feel, and if someone says you are fat and you let it get into your heart and feel it, then you get really hurt and depressed. (Sam)

Many of the participants describe ‘tuning out’ or ‘turning off’ to a lot of the advice that GPs provide – because of the backdrop, the context of years and years of commentary about weight, which was a constant even when they were going to the doctors for complaints ranging from ear infections to tinea. Part of not being demoralised by their experiences was learning not to listen. One participant described her strategy as ‘tuning out’ to a lot of the advice that her GP provided because of the backdrop of many years of weight related remarks:

I just get so bored with it always being about my weight. Like, really – it's boring. And I can say that it doesn't hurt me, but it does really. It makes me feel like there is something wrong with me. So I guess I try and tune out to a lot of what they say. (Tara)

Some of the participants really only uncovered that they has developed this strategy during the course of interviews. The participants in this research suggested that accessing

healthcare as an overweight or obese woman, was oftentimes emotionally damaging and rarely a positive experience. Participants depicted learning not to listen as their coping strategy against the shame and pain they felt. However, the downside of these coping strategies were that the participants, who were often already at risk for health isolation, were often further isolated from advice and support. One woman described what she felt had happened to her as a result of constant comments about weight:

I become less receptive to doctors saying I should lose weight because it just makes me angry. And none of them are giving you solutions, like how to do it. They just say you should lose weight. (Emily)

Another participant talked about how she managed the constancy of weight related remarks:

For me, I try and face it by telling myself that it doesn't mean anything and that they are just saying it because they are just so blinded by anything to do with weight that they blame it for everything. So I just don't take it on board. (Stella)

Participants did not feel like they were ever really heard or seen by their GPs, which stopped them from feeling like they ever got any validation regarding their health issues. Most women indicated that they were either learning not to listen, or had stopped listening to health advice that they had received – mainly because it was all about weight. And for some of them, they worried that this actually had negative consequences:

I know that I am doing the right thing in taking on all the shit they [GPs] tell you about your body. But sometimes, more as I get older, I wonder whether I am actually overlooking some advice that might actually also be true? (Emily)

For participants, learning not to listen was both a conscious and subconscious strategy. Some women consciously employed this strategy because they believed that it stopped them from getting hurt. Basically, most of the women in this study indicated that they were either learning not to listen, or had stopped listening to health advice that they received – because it was always tied in with commentary about their bodies. The participants in this research suggested that accessing healthcare as an overweight or obese woman, is potentially damaging and rarely a positive experience. Participants depicted learning not to listen as their coping strategy against the shame and pain they felt during and after consultations with medical professionals, especially their GPs. However, the downside of these coping strategies were that the participants, who were often already at risk for health

isolation, were then often further isolated from advice and support. I asked one woman how she had coped over her years of having negative experiences with her doctor:

What do I do when things happen which make me feel bad? Um, I try not to think about it after I step out that door. I have my antibiotics, and I don't need you, so I just leave what you said in your room. I feel like I have enough on my plate trying to manage my own body image shit without having to feel bad and guilty about my body from some doctor. (Molly)

Another participant talked about her experience or consciously deciding not to listen:

I think that if I hadn't of turned it around for myself I would have always been that person who tried to hide and who felt ashamed and always had a chip on her shoulder. So now I just let what they say wash off me because I know what they are saying is wrapped up in all this cultural hate about fat... and not really about me. (Stella)

Learning not to listen was part of a defence mechanism that stopped participants feeling like 'just a fat body' (participant term), which for most of them had negative connotations.

By learning not to listen they could remove themselves from what was being said:

I can feel myself going somewhere else when my doctor brings up weight. I just don't even listen. I don't want to feel bad. Like just a fat person. (Molly)

One participant talked about how her way of dealing with the experience of being discriminated against was to deny it, and act like she was not living in a large body:

I reckon I do that with doctors and the people who talk about it. You block yourself from feeling about it. So you don't feel it in your subconscious, and you don't get hurt.... coz if someone says you are fat and you let it get into your heart, and feel it, then you get really hurt and depressed. (Lou)

Participants did not want to feel like they were less deserving than a thinner person, so for these women actively not listening to commentary about their weight was a way to protect their self-esteem:

I don't want to feel like someone who doesn't deserve respect. I feel like I deserve it as much as the next person and what I weigh shouldn't come into it. So I refuse, well I try anyway, to listen to anything they [medical professionals] say because I feel I deserve better. (Rory)

Learning not to listen was a way for participants to manage what their GPs say about their bodies. It allowed participants the opportunity to block out the negative messages, both verbal and nonverbal, that they received from their GPs in order to try and deflect the messages they received about their body so that they didn't internalise them. Disturbingly, many participants also indicated that they had either learnt not to listen, or were learning not to listen to health advice that they received because it is always tied in with commentary about their weight.

Limiting Expectations

For participants, part of learning to protect themselves was the process of limiting expectations. This worked in two ways: limiting expectations worked to strip away the authority of what they heard from their doctors and it also worked to prevent and manage the fallout of what happened between them and their doctors. One woman described her approach to protecting herself:

If I expect nothing and I get nothing then I don't get hurt and I come away being able to brush it off much easier. (Jane)

The women believed that if they limited what they expected from their doctor, then they would not come away feeling so hurt, and part of doing this was working to discredit their doctors. And if they didn't get hurt, they then didn't have to deal with the emotions. One participant talked about how she had changed over years of interactions with GPs, and limiting expectations was a part of her strategy for protecting herself:

Doctors have said some appalling things to me over the years, and I have always just sat there and taken it. And I have then taken it home, had a cry and felt bad. But I refuse to do that anymore because I don't believe them - I have stopped trusting them. I don't believe what they say to me. I got so sick of them telling me that my weight was causing everything that I just stopped caring. And that seems to work. I don't leave the clinic, every time I see my doctor, wanting to slit my wrists. (Rory)

For participants, part of limiting their expectations was constructing medical professionals as individuals who were not good communicators:

I think that part of trying to distance myself from what is said to me is that I learn, well try to learn, not to expect anything from them... because everyone knows that they are good at bodies, but they aren't that great at interacting or being sensitive {doctors}. (Bec)

I asked one participant about how she managed her relationship with her doctor, in spite of everything she had shared which indicated quite a challenging and sometimes hurtful experience:

Look, I just go to get what I think I need. I don't really engage. If I think I have an infection or something that isn't going to pass, then I go. I rarely really get disappointed or hurt anymore because I expect nothing. (Nicky)

One woman talked about how she managed her experiences through the process of constructing her doctor as a technician, someone who just supplied what she needed:

I guess I get what I need, in terms of wellbeing, from friends and family – never from my doctor, because maybe that's not their job. It's not up to them to make me feel like the scum of the earth either. Maybe if they talked about other things as well as weight it would be more meaningful, but to just constantly crap on about weight... it's boring. And it takes away credibility as far as I am concerned. Do you talk like this to my father who is as thin as a stick and never does a scrap of exercise? I don't think so? But do you look at me and automatically assume that I don't do anything and sit eating all day? Most likely, yes. And that bores me, people working in medical centres and hospitals should know better. So, what I am saying is that I don't take them seriously. They are just part of a system that doesn't do this part of things very well, and so I expect little, receive little, and get hurt very little anymore. (Lena)

One woman described her process of coping as just limiting the consultation to the bare necessities:

If I have had a bad run, I just try and get in and get out without having too much, um, you know... too much to do with whoever is seeing me. (Maree)

Another woman talked about her way of coping with interactions about weight:

It's as simple as this.... I don't expect them to be my friend. If anything I expect the opposite. I have learnt not to expect them to counsel me or give me any real advice – like in relation to weight. They will happily say I need to do something, but that's as far as it goes. They offer nothing else. SO if the only thing they can do is say stuff about how my weight is bad, without ever really telling me why, then I just choose not to engage in that. (Nicky)

Participants described a process where over time they had learnt to lower their expectations:

The way the medical fraternity deals with weight doesn't fix the situation. Maybe it's my definition, I know that if I went to them I know that they might have the answer and whatever the issue is, my weight will come up anyway. It's like, inevitable. So I don't go and think they will help me. (Stella)

In contrast to what other participants talked about when they had to see new people, one participant said:

I don't have a GP that I see all the time at the moment, so it's easier that way too sometimes. They don't know you, and when that happens they generally don't care too much – they just hear what you want and then give you the script, or the x-ray form, or whatever. I have found that if I mix things up a bit, then I am less likely to get attacked and that way I don't have to try and process everything. (Joni)

Another woman described her approach:

I feel like it's better not to expect too much from him you know? After all this time in my body, I KNOW that some doctor is always going to say something. And I am prepared for that. Here's my thing though: if you can explain to me why you are making reference to my weight then fine. If you can't then I don't want to hear it. And I just shut off. If I think it's just some textbook response of what to say to a fat person, then I just shut off. (Bec)

For these women, however, the idea of limiting expectations as a way of trying to protect themselves wasn't a perfect science. So despite actively limiting expectations, women did still get hurt:

I try not to let it, but it still does. Sometimes it does hurt you. I mean, honestly, I don't think that many overweight women would actually enjoy talking about their weight? But sometimes they really do say things that you even though you KNOW is off the mark, it gets through your defences and it just hurts you. (Emily)

I asked participants about what happened when despite their processes for protecting themselves, they still got hurt:

I think of myself as pretty good now. I can go and have the inevitable conversation and walk away and feel ok. But every now and then, maybe I have my period or my defences aren't up like they should be... but every now and then she [GP] will say something and I take it to heart because it was 'from the doctor'. Sometimes I forget to remember that these people aren't really any different to all the other people who say stuff about weight – they are just as fixated, just as

biased, they just do it under the guise of health. So sometimes, yes, I do get hurt... and that's my fault because I forget to put them in their place in my head. I forget to remind myself to expect nothing. (Daisy)

Participant data suggested that women had learnt to curb their own expectations in order to try and shield themselves from as much hurt and comment as possible. They believed that the less one expected from their doctor, the less hurt one experienced.

Summary

Sally Gadow (1980, p172) said “the body that a patient experiences and a body that a practitioner treats are seldom the same” and the significance of this statement is revealed in the findings of this research. ‘Learning to manage’ their interactions with medical professionals was a necessary part of being a healthcare consumer for the women in this study. In order to try and counteract the attitudes and weight related bias they felt they were subjected to as patients; participants developed and performed a number of strategies which were intended to deflect and manage their interactions with medical professionals.

Women used strategies in order to increase visibility, and they also felt that by acting apologetically that somehow neutralised their largeness. Participant data suggested that playing the role of the apologetic or compliant patient worked to increase chances of getting the help they actually needed instead of the usually unwanted advice about weight. This also worked to decrease the chances of being openly judged about weight. Participants felt that if they acknowledged that their weight was a problem before the doctor did and apologised for it, then she or he would be more likely to treat the problem. If they didn’t do this, they believed that weight would become the sole focus of the interaction

Living in a large body was something which affected all the women in the research – all the participants had experienced some kind of stigma associated with being overweight or obese. And whilst the women engaged in different strategies for managing or coping with the effects of feeling defined by their bodies and everything this entailed, there were common threads within their experiences which have been discussed in these findings chapters. When women entered medical consultations, they took with them all the learned meanings that they had about their bodies, health and past experiences of healthcare.

Likewise, the medical professional had with her or him all of their understandings about obesity, personal experiences and opinions, and professional socialisation. Within this context, they then had to create a space where the interaction was based on shared meanings. However, this was rarely something that the women in this study described as having experienced. For participants there was little recognition from their doctors of how challenging it was to live in a body that was the site for so many social, cultural and medical discourses. And one thing that did come out of this study was that it's hard to be fat.

The basic social psychological process of 'Learning to Manage' which included the strategies explored as the sub-processes of 'Trying to be seen' and 'Protecting Myself', also including their respective categories, weren't independent of each other, and sometimes women used one strategy for several purposes. As far as participants were concerned, the process of 'Learning to Manage' embodied a number of strategies which they employed in their interactions with medical professionals, which they had developed over time, and through necessity. Through repeated interactions with medical professionals, women learnt that if they wanted to be identified by anything more than just their weight they needed to employ calculated strategies in order to try and minimise the impact of their weight and increase their visibility as an individual.

The following chapter will present a discussion relating to the substantive theory of 'Learning to Manage'. The discussion will draw on current literature accessed as part of data collection and analysis which will be used to situate the findings of this research within extant literature.

Chapter 8: Discussion

Introduction

The aim of this study was to develop insight into large bodied women's interactions with healthcare providers, with the intent of identifying both a basic social problem and a basic social process. The previous three chapters have presented participant data to introduce and demonstrate how the substantive theory of 'Learning to manage' was developed. The substantive theory 'Learning to Manage' provides one explanation for how the women in this study managed 'being defined' by their large bodies, and the patterns of behaviours they used to manage this. The substantive theory of 'Learning to Manage' explains the issues faced by large bodied female healthcare consumers and the strategies they used to resolve and manage them.

Whilst the large body is increasingly being constructed as a site of both social and medical concern and being targeted for interventions, for participants in this study it also acted as the barrier which stopped them receiving what they felt was constructive and beneficial help and attention from medical professionals. Further to this, they felt that their body size actually attracted negative attention. The findings of this research identify a collection of strategies used by participants to manage their shared problem of 'being defined' by their large body size. The basic social psychological process, which has been identified as 'learning to manage' details the strategies used by participants to try and neutralise, counteract or minimise the problems with 'being defined'.

Fatness, in women, has long been recognised as a negative social attribute within western culture. Women living in large bodies are continually faced with the consequence of their inability to meet social and medical norms around both normal and healthy bodies. Within healthcare settings, a normal body is one which fits within a weight range – anything outside of that is underweight, overweight or obese. Fat female bodies challenge what is considered normal and attractive, as well as defying what medicine says is normal – something which is powerful. The experience of living in a large body plays a critical

factor not just in how women engage with their medical professionals, but how they interact with broader society. Within western communities, the normal social body is one which is slim. Likewise, the normal body within healthcare settings sits within established parameters.

The issues facing women who live in large bodies have been explored in various disciplines, particularly within gender, feminisms and sociology. Kwan (2009) suggests that the study of the fat body has been conducted for some time by gender scholars, largely focusing on the oppression of the thin ideal. There are a number of ideologies around 'normal bodies' which dominate our culture and these significantly impact on the development of a healthy sense of self for overweight and obese individuals, especially women. Women are so used to seeing slim bodies, with overweight and obese bodies increasingly being used to illustrate only abnormality or sickness that they come to believe that their bodies are inherently wrong. Within the culture of healthcare, the women had also come to believe – based on their experiences – that their bodies were seen as 'wrong' and that they as individuals were somehow lacking or to blame for their bodies.

More contemporarily however there is an increasing public dialogue on the meanings attached to the fat body, some of which this study has endeavoured to examine. Engaging with the healthcare system was a complicated web of treatment and truth for large bodied patients, and like anything else, it was dependant on a number of things. Participants had learnt to feel ashamed and afraid as healthcare consumers, something which worked to make them feel bad and disempowered. This study highlighted that overweight and obese women feel that they endure both prejudicial and discriminatory treatment as healthcare consumers and that in order to manage this they use a range of behaviours aimed at manipulating the medical consultation.

The following discussion situates this research within the broader structure of biomedicine, as well as examining the medical interaction. The basic social psychological problem and the basic social psychological process, identified through participant data, will be discussed with reference to relevant literature. Stigma, and health and weight related discrimination, which underpins the findings of this study, will be explored. Literature relating to the strategies that participants used as part of *Learning to Manage* will also be

presented. Lastly, the ways in which stigma and discrimination can be addressed in clinical practice will be presented.

Biomedicine and the medical interaction

This research was situated within the context of healthcare, specifically the medical interaction. As such, I believed it necessary to provide a brief overview of biomedicine to begin this chapter. Biomedicine, according to Hahn and Kleinman (2005) has its own rules and laws which reflect its ancient origins. Schenck (1986) stated that “medicine is pre-eminently the practice of invading the most fundamental dimension of our lives – our bodies” (p45). Hahn and Kleinman (1983) describe biomedicine, also known as western medicine, as the “predominant medical theory and practice of Euro-African societies” adding that people practicing within this system refer to it simply as medicine. A biomedical model of illness views the body and mind as separate, and concentrates primarily on curing disease, and Conrad (2007) suggests that it is recognised that the clinical medical model concentrates not on social context, but on the individual.

Medical encounters have been theorised by many. Particularly relevant to this research is the view of James and Hockney (2007) who suggest that a Marxist perspective of the medical encounter assumes a problematic power structure whereby the patient is dependent on the expertise of the doctor, whom is viewed as an agent of social control. Thesen (2005) also asserts that doctors usually hold the position of power in medical consultations, suggesting that this is neither good nor bad depending on how the power is used. Cooper (1998, p119) states that “the cultural faith in medical science and its practitioners has led to fat people’s reliance on professional health experts”. Only a few participants openly identified ‘power’ as a problem for them when interacting with their doctors. However, time and time again when asked about how they responded to their doctor, particularly why they didn’t challenge disparaging remarks, they would say ‘*I didn’t want to make a fuss*’ (Emily) or ‘*I didn’t feel that I could say anything*’ (Molly). Participants felt that they couldn’t really ‘speak up’ when they were in a consultation with a healthcare provider, particularly with GPs and Specialists. Lupton (1997, p98) states that

From the Foucauldian perspective, power as it operates in the medical encounter is a disciplinary power that provides guidelines about how patients should understand, regulate and experience their bodies.

She further suggests that disciplinary power operates through comparison against established norms, bringing individuals into “a field of visibility” (p98). In relation to the obese female body, this is particularly relevant. Medicine, in particular, has been instrumental in shaping societal responses to illness and disease over the last century, and obesity is no different. As obesity is now part of the domain of medicine, women’s bodies are now being regulated in increasing ways and this was evident from the sentiments of the women in this study.

In this study the medical encounter was not a place where participants felt safe, partly because they did not feel that they could challenge the authority of their doctors. Women felt that their largeness somehow took some of their right to speak up and to speak out against discrimination. There is no doubting that medicine still holds immense power over individuals, and in shaping messages about our health and wellness. For participants to feel ‘unsafe’ in the system that they believed was meant to protect and heal was very confronting for them, and very damaging. To have such a powerful institution and social organisation so disapproving is difficult to manage both in reality and emotionally.

There is no doubting that medicine still holds immense power over individuals and in shaping messages about our health and wellness and what constitutes a ‘normal’ body. The power imbalance which has been extensively noted within the social sciences was present in the interactions with medical professionals that women talked about. For patients the combination of feel unsafe, lacking in power and being different (by virtue of their weight) in a system that they felt was meant to protect and heal them was very confronting, and damaging. To these women, their doctors had power and for someone living in a stigmatised body, it was hard to challenge that power. Additionally, to continuously have a powerful institution and social organisation such as medicine so disapproving was difficult to manage emotionally.

The present study identified that large bodied women, at least those in this study, did not feel they could challenge their doctors – even when what they felt was happening was inappropriate and detrimental to their personal health outcomes – such as getting the help they actually needed. The authority of medicine added gravitas to what the women’s doctors said about their bodies. Doctors have power afforded to them, and for someone

living in a stigmatised body such as the women in this study, it was hard to challenge that power. Paquette and Raine (2004) interviewed forty four women, aged between 21 and 61 years old, with the aim of understanding how sociocultural and personal contexts influence body image. Their findings suggested that for the women in their study body image was a fluid construct which changed as women “encounter new experiences and re-interpret old ones” (p1047). For these women their body image was influenced not by what others said, but their interpretation of its meaning. Women primarily talked about comments from their physicians, which similar to the current research was because that was the professional who they most commonly interacted with. Participant stories revealed that women’s feelings about their bodies were impacted by comments they received from their physician’s regarding their weight. The authors suggest that the women tended not to reinterpret meanings within a health context possibly due to power imbalances present in the consultation.

Repeated interactions in which large bodied women had felt afraid, invisible or judged because of their body had left women very cautious about their interactions with medical professionals. Without exception every woman had experienced some form of discrimination from their doctors concerning their body size, and more specifically, their weight. Most of the women in this study had in some degree lost faith in the system as anything beyond what they needed dispensed or diagnosed. Whilst the women believed that the weight commentary and discrimination they experienced from their doctors was usually inappropriate and frequently hurtful, they also felt that they had limited recourse - firstly because of the power held by medical professionals, and secondly because in some way they feared their weight might actually be responsible.

General Practice

The participants in this study were initially asked about their interactions with healthcare providers, however it was their experiences and relationships with General Practitioners (GPs) that they wanted to discuss, and which they viewed as the most significant and problematic. The General Practice environment in Australia is one under increasing demands and pressure. The General Practice management of obesity has been receiving increased attention since the beginning of the new millennia. During 2009 approximately 83% of Australians visited a General Practitioner at least once (Britt et al. 2010), with the

General Practice context being recognised as being the first point of contact for individuals seeking healthcare.

In 2004, The Royal Australian College of General Practitioners (RACGP) published SNAP (Smoking, Nutrition, Alcohol and Physical Activity), which was intended for use as a comprehensive guide to managing the behavioural risk factors for the health of Australians, particularly targeted for use by general practitioners and practice staff. This guide recommended a 5 step model helping patients including (RACGP, p7):

Table 2. SNAP Guidelines

Ask (1)	Identify patients with risk factors
Assess (2)	Level of risk factor and its relevance to the individual in terms of health
	Readiness to change/motivation
Advise (3)	Provide written information
	Provide a lifestyle prescription
	Brief advice and motivational interviewing
Assist (4)	Pharmacotherapies
	Support for self-monitoring
Arrange (5)	Referral to special services
	Social support groups
	Phone information/counselling services
	Follow up with the GP

Overweight and obesity is identified as a risk factor, with advice on how to apply the 5 A's. Step 3 of the SNAP model recommends advice and motivational interviewing. The aim of motivational interviewing is to assist patients in behavioural changes, and to do so in a supportive, non-judgemental way (Resnicow, 2006). The focus is on the patient being encouraged to address their ambivalence to change (specifically as it relates to the specific behaviour change) and then to make an informed decision about lifestyle changes.

Resnicow (2006, p2025) define motivational interviewing as:

An egalitarian, empathetic “way of being” that manifests through specific techniques and strategies, such as reflective listening, shared decision making, and agenda setting.

Motivational interviewing was rarely something that women in this study described as experiencing. Participants believed that weight was rarely raised in a way which was sensitive or supportive, and it certainly was never without judgment. Based on what these women said I would maintain that whilst they didn't wish to discuss weight at every consultation, having a medical professional initiate it in a supportive and judgment free manner would have made a difference.

In 2003, the Australian National Health and Medical Research Council released a guide for General Practitioners on how to deal with overweight and obesity in adult patients. The 10-step guide on the clinical management of weight in adult patients suggests the following in relation to discussing weight within clinical settings:

Consideration of body weight will often arise from a discussion of related co-morbidities. However, opportunistic diagnosis can also be important in cases where a patient presents for other purposes. Many patients will be happy to be given the option of weight loss as a baseline treatment for various metabolic disorders. When dealing with overweight and obese patients, however, it is important to communicate a non-judgemental attitude (NHMRC, 2003a, p3).

Given what was revealed by participants in this study, the idea of “opportunistic diagnosis” was not something that participants enjoyed or something that they found helpful. Women frequently felt that their fat bodies were the focus of attention, so much so they often felt like they lost their individuality and instead became seen as someone who was just overweight obese. They didn't enjoy weight always being raised. To participants, the concept of ‘opportunistic diagnosis’ was something they felt was inappropriate and often detrimental to other health needs. The mismatch in how medical practitioners are being advised to manage overweight and obesity compared to what the participants in this study wanted is diametrically opposed. Guidelines developed by national health and medical bodies have advised clinicians and medical professionals to opportunistically counsel patients about weight, however the findings of this research support that women do not want this. Bocquier et al (2005, p792) stated:

Physicians and patients have different perceptive and attitudinal models of weight problems, and one major obstacle may be the problem this creates in their relationship.

Pilnick et al (2000) suggest that primary health care medical consultations are typically organised around the twin goals of diagnosing the patient's medical problem and

recommending treatment. However the women in this study experienced medical consultations in a vastly different way than what is suggested by Pilnick *et al* (2000).

In this study, women's experiences with their GPs made their personal battles with excess weight seem more difficult because they ended up feeling extremely isolated from healthcare, especially the idea of seeking medical advice relating to weight loss. Most of them had battled significant feelings of disillusionment with their GPs, and only sought them out because they felt they had little other choice.

Being Defined

The basic social psychological problem shared by large bodied women was identified as 'Being defined'. For large bodied women 'being defined' by their excess weight worked to impede examination, changed the way the way their presenting health issue was managed, and also impacted on whether or not they received referrals onto other health professionals. For instance, women felt that often times if they went to the doctor with a complaint which could be exacerbated by weight, such as a back or knee injury, weight reduction would become the sole focus of the consult. In these instances when women also believed that weight was a factor in the management of the injury, simply due to the physics of additional weight creating extra pressure; however they also believed that simply discussing weight reduction did not help manage the actual issue they were presenting with.

Large bodied women considered weight the major determinant in how they experienced and negotiated health care. As soon as they entered into any consultation with a medical professional their weight became the defining part of their identities as patients, subsequently becoming the focus of the interaction. They believed that their large body size concealed who they were as individuals as well as influencing the healthcare they received, changing and colouring the nature of their interactions with medical professionals, particularly with their General Practitioners (GPs). In many instances like this, women were not referred on for further investigation or not prescribed medication for pain relief; instead they were advised just to lose weight. Potter *et al* (2001) surveyed 410 patients of two primary care practices in the US about their experiences of weight management in primary care and what they wanted from their physicians. This study

suggested that if patients wanted weight management, they wanted support which was inclusive of their lifestyle, factors such as diet and exercise recommendations and goal setting. This was in contrast to the most frequent weight loss approach that was reported, which was just telling patients to lose weight. Likewise, participants in this study found that 'just being told to lose weight' were perhaps the least helpful approach to their weight and general health. They believed that it defined them only in terms of weight, obscuring what their actual needs were.

The women in this study had, through their interactions with others, come to believe that they were negatively judged because of their weight. They believed that being defined by their body size was a negative thing because in this culture an overweight or obese person is viewed as someone who has maintained a certain body size because they are either lazy, sick, gluttonous or all three. When the participants in this study became patients the feeling of 'being defined' was central to their whole experience. Marilyn Wann (1999) stated that "the only thing anyone can diagnose, just by looking at a fat person, is the viewer's own level of prejudice toward fat people", and this was a sentiment echoed by participants. They firmly believed that as soon as they entered into a clinical consultation it was assumed that their large body would have something wrong with it or that whatever clinical issue they were presenting with would somehow be connected to or obscured by their weight.

Living in a large body is something that can be culturally problematic for women in western societies, and the women in this project were no exception. Fatness is seen as the consequence of indulgence (Gard, 2005), and has been this way for some time. Rothblum (1992, p61) said that 'obese women are both held accountable for their weight and rejected on account of their weight'. This was evident in this study. The contemporary western body standards, for women in this instance, which equate thinness with beauty and wellbeing is something that left few women untouched. However as a patient, being overweight or obese was additionally complex. Large bodied women recognised that when they chose to become a healthcare consumer they were entering a system where large bodies defy what is medically defined as normal, and consequently healthy. They were also aware that medical beliefs around large bodied were situated within the broader fabric of a society which abhors fatness.

Johnson (2004, p480) states that “the labels assigned to larger people go far beyond size” and this is reiterated by countless other authors in a range of disciplines. Johnson comments that it is remarkable that individuals seen as fat have any degree of functionality considering the constant negative messages and feedback they receive. Johnson (2004) offers recommendations, for clinicians working in the medical setting, for working with overweight and obese patients. Amongst her suggestions she argues that the patients presenting problem must be listened to independent of weight. She advised that in order for larger patients to be treated with respect and compassion it is important not to attribute every health issue to their weight. Johnson’s advice is extremely pertinent to this study. The experience of ‘being defined’ was linked with the fact that they never felt free of their weight. They never ever felt as though any issue could be addressed independent of weight, and this was extremely frustrating and something which happened all too frequently.

For patients in this study weight was *always* mentioned. However in a study conducted by Scott et al (2004) the findings pointed toward the fact that weight was not raised during clinical consultations. Scott et al conducted an analysis of descriptive field notes collected as part of a multi method comparative case study of 633 outpatient encounters in family practices in a U.S. state to investigate patterns of patient -physician communication around weight control. Contrary to the experiences of women in this research who felt weight was the primary conversation in every clinical encounter, the findings of Scott et al (2004) research revealed that in the majority of encounters weight was not mentioned even when a patient was visibly obese. They posit that this may be due to a reluctance to raise weight due to its sensitive nature. They recommended further study into this. They also suggest that a weight loss discussion, within a clinical consult, has to be a two-way interaction where both parties consider weight as a problem to be addressed.

Feeling invisible was a source of concern for women in this study, and one of the categories of ‘Being Defined’. For the women in this study, feeling invisible was borne from never feeling visible as anything more a fat, and subsequently diseased, body. It was a difficult feeling to manage because whilst they frequently felt invisible as a result of their bog bodies, they also frequently felt hyper visible because of their weight. For the women in this study, they wanted to ‘blend in’ and be treated like other patients but they also wanted to stand out – as individuals, rather than just a fat woman. Cooper (1998)

suggests that fat people are ‘super visible’ because they live in a body which differs from the norm. However the irony of this is that the same body that draws attention and criticism is also the body that made participants feel invisible.

In this culture being identified, or in the case of this research ‘being defined’ by something such as excess weight has extremely negative ramifications one of which was feelings of invisibility. Large bodied women described numerous times when weight had been blamed for whatever health issue they had thus obscuring the real reason they had sought medical advice. The women keenly felt the dichotomy of their size, believing that whilst their largeness rendered them hyper-visible, making them targets for unwanted intervention and advice about weight and as well as general advice relating to appearance, it also worked to make them feel ‘invisible’.

The ‘invisibility’ that women described largely related to being viewed as some of them described, as ‘just a fat body’ (*Emily & Stella*). According to participant descriptions, when you were viewed this way, you were never really ‘seen’ or ‘heard’ as a legitimate patient. Instead, the large bodied woman was viewed as someone who clearly was not complying with a lifestyle that was healthy, making them somehow at fault. For large bodied women ‘feeling invisible’ as a healthcare consumer meant that they were in a constant state of paradox which was at times difficult to manage: they knew that their body size increased their visibility to their doctors, but they also knew that this visibility somehow detracted from being or feeling free to express what they really needed to, because they believed their fatness detracted from their right to a voice. Charlotte Goodman (1995, p1) stated:

A big woman is neither seen nor heard in our thinness obsessed society, and is defined purely in terms of her weight and other people's prejudice.

Cooper (1998) writes about fat bodies, suggesting that whilst they are often highly visible in the physical sense, there are occasions when they are completely invisible. As a consequence, needs are not met or they are overlooked or disregarded as unimportant. Living in a large body is difficult to hide – you are immediately recognisable as belonging to a group of people which in our culture are thought of as second class, deviant, unattractive and unhealthy. In this way, large bodies are always very visible. Like race or

gender, body size can be and is a determinant of experience, and the stories of the participants echoed this. The women in this study were always aware of their body size, of the fact that they were living in a body which they believed was considered ‘bad’ in both society and in healthcare settings. The stigma attached to living in a large body was something that all of them had experienced. And it was something that was brought home to them every time they had to think about going to the doctor.

Samantha Murray, an Australian researcher who has published extensively in the area of fat embodiment, writes of her experience of consulting with doctors:

Having lived as a fat woman, on several occasions I have consulted with doctors about various maladies I was suffering from, which I was invariably told were a direct result of what they perceived as my ‘fatness’. Via the ‘clinical gaze’ of the doctor, my fat body was already pathological by virtue of its hypervisibility (2009, p84).

She explains that because her ‘diseased, obese’ body’ acted as a marker for pathology, her ‘bodily being was perceived by those concerned, as a negative, ‘problematic’ mode of embodiment’ (p84) and she was always urged to lose weight despite demonstrating no signs of ill health. Likewise, for the women in this study, weight always became the central component of the interaction often making them feel that there other concerns were trivial. Cooper (1998, p120) also writes that “as fat women, our expectation of health professionals contrast dramatically with our experience of them. Fatness is generally regarded as the root of whatever problem we may be suffering from”. For the women in this study, Cooper describes exactly the cause of their feelings of invisibility.

Invisibility has been explored by a number of researchers, primarily within literature that explores lesbian invisibility. Saari (2001) suggests that lesbian women experience ‘invisibility’ – which she describes as the “failure of others to recognise the significance of their sexuality and partnership relations” (p645). Saari (2001) also suggests that some lesbians may dress in a way which flaunts their lesbianism so that they don’t have to explicitly ‘out’ their sexuality, as a way of coping with invisibility. Cooper (1998) states that fat people “are culturally invisible”, and this is definitely echoed within the findings of this study. Adopting an overtly political fat identity may be seen as a way of counteracting the invisibility experienced by fat women; however women in this study rarely chose to do manage their feelings of invisibility in this way. Willis et al (2007) draw on Goffman’s

influential work on stigma, in which he used a symbolic interactionist approach, suggesting that individuals living with an obvious spoiled identity – such as obesity - may join with other similarly stigmatised individuals and ‘assert their difference’ in order to adapt (p440). Fat activism is as I see it a form of resistance. Hendon (1997) suggests that Foucault believed that there is always resistance where there is power, because power creates resistance. For the women in this study feeling invisible was a part of their everyday experiences. However, because of the power imbalance present with their doctors they rarely chose to claim their largeness in an open, positive way. While there was resistance, this was internal, and something they rarely displayed to their doctors. They did not feel confident to do so, even though at times they badly wanted to react against what was being said to them.

Fryberg et al (2010) also discuss invisibility in their work looking at how colour-blind ideologies impact American Indians. They argue that due to the fact that American Indians are significantly under-represented in areas such as media and school they experience an intense type of colour-blindness – that of being invisible. Invisibility, they suggest, prevents individuals from developing a sense of self, due to a lack of social representations of ‘how to be a person’ (p115). This in turn limits understanding of self for these persons, dwarfing what they believe is possible for themselves. However, perhaps most relevant to the findings of the current study is the work of Banister and Schreiber (2001) and their work with young women. Banister and Schreiber undertook a study of young women to identify the unmet health needs of women between the ages of 16 – 24. The two primary themes identified in their work were “struggling with independence” and “feeling invisible”. Participants in their study described “a paradoxical experience of feeling invisible while at the same time being seen as highly visible in problematic ways” (p637), which is identical to how women felt in the current research. For the young women in Banister and Schreiber’s study, part of the feeling of invisibility was ‘being stereotyped’ in which they felt they were seen as “highly visible representatives” of a stigmatised group (p640) ie just because they were young, they believed it was assumed that they were involved in illegal activities or were bad. Banister and Schreiber (p638) stated:

Women in this study also experienced invisibility in their relationships with physicians. In their dealings with physicians, participants expressed the belief that they were not valued as individual women with their own experiences and knowledge.

Likewise for the women in the current research, they believed that as soon as they entered a clinical consultation they were stereotyped, which contributed to their feelings of invisibility. The stereotyping was similar to that which they experienced in their social worlds, except that in the healthcare context, the stereotyping often worked to stop them getting the help they needed. Additionally, whilst the women in both studies were aware of the stigma processes at play, it didn't help to lessen their feelings of invisibility.

In 2000, Franklin and Franklin identified a conceptual model for understanding the effects of racism on African American males. Their model, identified as the 'invisibility syndrome' offers a way of understanding "intrapsychic processes and outcomes" in managing the stress rising from racial slights (p33). They describe 'psychological invisibility' as something which can occur after repeated experiences of perceived racial discrimination and prejudice, suggesting that this can result in the individual feeling that their individuality is not acknowledged or valued because of racial prejudice. Participants had repeated experiences of what they perceived as insults or discrimination originating from their body size. Franklin *et al* (2006) state:

Slights are fundamental to the invisibility syndrome. They provoke indignation and emotional upset because they are acts based upon biased attitudes and beliefs.

They further state:

Symptoms of the syndrome are an outcome of psychological conditions produced when a person perceives that his or her talents and identity are not seen because of the dominance of preconceived attitudes and stereotypes.

Franklin and Franklin's 'Invisibility syndrome' is an excellent framework through which to view the experiences of women in this study. Not only did participants frequently experience the 'slights' that the authors discuss, but they had learnt to expect it thus setting up a cycle of expectation. The 'invisibility syndrome' set forward by Franklin and Franklin is extremely pertinent to weight, and weight related discrimination and prejudice. Women in this study felt extremely devalued because of continued experiences of perceived weight related discrimination and prejudice from their medical professionals. They had learnt that all which was visible was their weight, which worked to create feelings of shame and upset, as well as feelings of invisibility.

Another aspect of clinical consultations which led to feelings of invisibility was when medical professionals concentrated only on weight instead of the issue at hand. Cossrow et al (2001) undertook research with 31 adult participants, investigating perceptions of weight based stereotypes and discrimination, and the impact that this had on participants. Data was collected via focus groups and questionnaires, and gender specific focus groups being used to inform the development of the questionnaire which aimed to garner in depth information about participant's personal accounts of whether they believed they had been treated differently or negatively because of their weight. Participants perceived that they had experienced weight based discrimination across a broad spectrum of domains, including healthcare, and women reported more frequent experiences of mistreatment, related to weight, than men. Interesting to note also was that only female participants reported experiences of weight related mistreatment from healthcare providers, believing that they often overlooked the issue that had prompted them seeking health advice and instead focusing on weight. In this way, the women felt a significant sense of invisibility.

Stigma

A discussion of stigma is central to the basic social psychological problem of 'being defined' described by participants in this study, as well as to the basic social psychological process of 'learning to manage'. The women in this study firmly believed that the way they were treated was based on how they looked, and subsequently, the meanings attached to how they looked. Being defined was about being judged on their appearance, namely their body size, which within contemporary healthcare is not regarded as desirous.

Goffman (1963) suggests that a stigma is a "special relationship between attribute and stereotype" (p14). Major and O'Brien (2005) also comment that definitions of stigma assume that stigmatised people share an attribute which marks their difference, thus leading them to be devalued in the eyes of others (p395). A characteristic must be shared by members of a group in order to be considered a stigma, because it is the group membership which 'spoils' interactions at both a group and individual level (Stangor and Crandall, 2000).

Stigma can be anything from a deviant behaviour, a moral failing or a physical characteristic (Crandall, 2000). A stigmatised person is considered to have departed from that which is considered normal (Dovidio et al. 2000). Goffman (1997, 2010) stated:

Society establishes the means of categorizing persons and the complement of attributes felt to be ordinary and natural for members of each of these categories.

Particularly relevant to a discussion concerning women and weight, Weiss et al (2006) suggest that stigma is a social process that is shaped by contextual factors such as power and domination, in combination with existing inequalities of race, class, gender and sexuality (Parker & Aggleton, 2003). Stigma is a multifaceted phenomenon experienced in a variety of ways, impacted by both the nature of the stigmatizing condition and the social situation of the individual (Fife & Wright, 2000). Scambler (2009) suggests that stigma is

Typically a social process, experienced or anticipated, characterised by exclusion, rejection, blame or devaluation that results from experience, perception or reasonable anticipation of an adverse social judgment about a person or group (p441).

Unlike other stigmas, which may create a sense of sympathy or empathy for the stigmatised, obesity does not usually engender such reactions in western society. For those who live in bodies so morbidly obese that they are often featured on television shows, would most often arouse feelings of revulsion and pity. Likewise, it is rare to see an image of an overweight or obese person which is depicted as healthy or as sexual. Weiss et al (2006, p285) suggest that “fears and fantasies provide fertile ground for stigma to flourish” and this notion is particularly pertinent to the dialogue surrounding obesity. Orbach (2009) suggests that fatness is demonised, and seen as a symbol of psychological weakness. Indeed, this sentiment is evidenced by numerous research studies, mainly external to medical researchers, which have examined attitudes toward obese individuals. The stigma of obesity is pervasive as it is viewed as a visible manifestation of something which social mores still says should be controllable.

Stigma, as initially coined by Goffman (1963) refers to an attribute of an individual which is discrediting. Stigma is either a physical or symbolic mark which elicits shame in the marked individual (Crandall, 1991). Since then various disciplines, particularly the social sciences and psychology have all contributed to extending Goffman’s theory resulting in a number of ways in which stigma is conceptualised (Butt, 2008). Erving Goffman (1922 –

1982) was a sociologist, and was the first to write about what he described as a spoiled identity (Goffman, 1963). According to Goffman (1963, 1997) there are three types of stigma – abominations of the body, blemishes of character, and tribal or racial stigmas. Obesity falls into the first category, and although DeJong (1980) points out that Goffman did not include obesity on a list of physical stigmas, it is evident that society holds negative attitudes towards obese individuals.

Bayer (2008) suggests that clinical encounters were the source of much of the classic work on stigma, with a plethora of literature from the 1960's onwards investigating how stigma impacted the lives of people with mental illness, the obese, drug users and sexually transmitted diseases. Goffman's theory situating stigma within a context of deviance depicts stigma as a negative personal attribute or trait that discredits the individual in the eyes of society (Butt, 2008). The overweight body unavoidably becomes a deviant object within a health environment, due to the fact that the overweight body falls outside the 'normal' standards of body weight commonly used in medicine and health settings. Lemert (1972, in Lauder, 2002) differentiates between two distinct categories of deviance. The first category he believes is 'primary' deviance, which refers to those persons who do not conform to social norms. 'Secondary' deviance occurs when primary deviance is labelled, resulting in further stigma. Lemert's categories of deviance fit neatly into an exploration of the experiences of large bodied women.

Concerns about body weight are not a recent phenomenon. Body modification, particularly in regard to weight, is evidenced over the last two centuries. However, despite this, overweight and obese individuals living in the western world are still largely viewed as deviant (Sobal, 1995). Women in this study felt that their largeness, their spoiled identity, somehow robbed them of their right to speak up and to speak out against discrimination they experienced within healthcare consultations. The participants talked about the difficulties in challenging their doctor – how frightening it was to try and stand up to them even though they believed they were being discriminated against.

Major and O'Brien (2005) suggest that stigmatising marks may be linked to behaviour, group membership or appearance. They also add that these 'marks' can be invisible or visible, and controllable or uncontrollable. Important to note, they add, is the fact that

stigma is not housed within an individual; it is specific to relationships and contexts. They describe four ways through which stigmatization affects the stigmatised individuals:

- negative treatment and direct discrimination
- expectancy confirmation processes
- automatic stereotype activation, and
- Identity threat processes (p396).

Participants in this study had experienced all four mechanisms described by Major and O'Brien, through which stigma affects the stigmatised individuals.

Kohlenberg *et al* (2008) suggests that stigma is an everyday part of medical interactions which influences the care that individual's received. They delineate between two different types of stigma: 'felt' stigma which are the feelings such as shame which can influence whether an individual asks for help, and 'enacted' stigma which is when the healthcare provider interacts differently with the patient due to judgements they have made about their behaviour or background. Kohlenberg et al (2008) depict obesity as a group which has been targeted by enacted stigma. They suggest that there is something about these groups that make physicians frustrated or uncomfortable in some way, which then in turn allows them to avoid or disengage from these patients in some way, which in turn influences the care that these patients receive. Kohlenberg et al (2008) describe the process of 'self-stigma' which is when the enacted stigma that an individual feels becomes internalised, potentially resulting low esteem. For these individuals, avoiding healthcare or not complying with medical advice may occur because they believe they are not worthy of help Murray (2007) suggests that we internalise all the societal statements made about certain body type and live them out (p 363). She suggests that it is these discourses which shape the way we understand each other, and which govern our experience and interactions with each other.

Fabricatore, Wadden, and Foster (2005) commented on two research surveys which were conducted in the 1980s, suggesting that in both studies physicians' associated obese patients with poor hygiene, noncompliance, and dishonesty. Based on these findings, the authors offer a hypothetical diagram which illustrates how negative attitudes from healthcare providers can become self-perpetuating (p31).

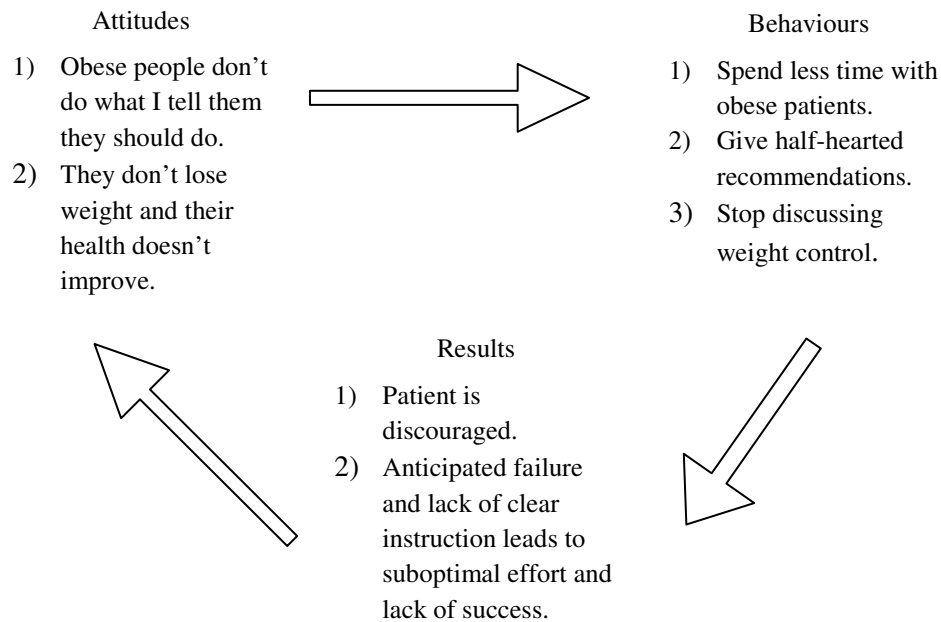


Figure 8. A self-perpetuating cycle of negative attitudes

This cycle illustrates the impact that negative physician attitudes can have on a patient. While it is from the perspective that a negative attitude will prevent weight loss, instead of preventing these attitudes because they are morally wrong, it is still important to note.

Stigma, which is a central concern of the women in this study, generates prejudice and discrimination (Drury & Louis, 2002). It is important in reading this discussion that certain terms are distinguishable. The terms prejudice and discrimination are often used interchangeably; however Giddens (2001) differentiates between the two. Prejudice, he states, can be positive or negative and is 'the holding of preconceived ideas about an individual or group, ideas that are resistant to change even in the face of new information'. Discrimination refers to "activities that deny to members of particular group, resources or rewards which can be obtained by others" (p696).

Smith (2002) suggests that stigma changes according to context and culture, and this is illustrated in the findings of the current research. Dovidio et al (2000) also linked stigma to culture, suggesting that it is a social construction shaped by history and culture. These authors suggest that stigma has at least two essential components:

- the recognition of difference based on some distinguishing characteristic or ‘mark’; and,
- a consequent devaluation of that person (p3).

Smith (2002) states “for stigmatisation to occur, such differences must be linked to undesirable traits”. He draws on the stigma of mental illness, suggesting that part of the stigma is due to association with stereotypes of potential violence and unpredictability (p 317). Likewise for fat people, association is drawn to stereotypes of individuals which are dirty, unintelligent, lazy and greedy. He suggests that those who are stigmatised are characterised as ‘them’, not us, and they generally lack power and experience a decrease in social status (p317).

Yang et al (2007) suggest that sociologists advocate the notion of stigma as a social process which has multiple dimensions. They state that “stigma is seen to be embedded in the interpretative engagements of social actors, involving cultural meaning, affective state, roles, and ideal types” (p1627/28). Phelan, Link and Dovidio (2008) suggest that stigma and prejudice occur as a consequence of an individual’s failure to comply with social norms. Stuber, Galea, and Link (2008b) suggest that there are some views of stigma which suggest that it is an everyday part of life used to encourage conformity with social norms. They suggest that for behaviours or identities which are believed to be voluntary, such as smoking or obesity, the use of stigma to try and increase conformity with social norms is particularly pertinent.

Pescosolido, Martin, Lang and Olafsdottir (2008, p432) also believe that stigma is “socially constructed, in and through social relationships”, namely social interaction. They point out that whilst social interactions occur on an individual level, individuals are part of sociocultural and political contexts which influence them. In 2006 Weiss et al (2006b) offered a definition of health related stigma, describing it as:

Stigma is typically a social process, experienced or anticipated, characterised by exclusion, rejection, blame or devaluation that results from experience, perception or reasonable anticipation of an adverse social judgment about a person or group This judgment is based on an enduring feature of identity conferred by a health problem or health-related condition, and the judgment is in some essential way medically unwarranted (p 280).

The definition of health stigma offered by Weiss et al (2006) is particularly relevant to the women in this research. For women living in large bodies, the stigma attached to this is extremely significant. It has been recognised for some time that large bodied individuals, especially women, defy norms about what constitutes a 'normal' body which results in the daily management of cultural attitudes which suggest that there size evidences moral failings such as gluttony, lack of self-control, and will power. Additionally, large bodies now also defy what is considered medically normal, which has led to the development of an entire new level of stigma. Part of the problem for the women in this study was definitely the intermingling of these two stigmas, and their belief that their GPs attitudes and advice were more to do with social norms, which are laden with negative connotations, than genuine medical advice.

Stigma has been well explored in research literature, particularly within disciplines such as psychology and sociology. It is noted that health related stigma can contribute to delay in health seeking (Weiss et al. 2006). Within medical literature there is mention made to the stigma experienced by obese individuals, however this is largely addressed in reference to the potential for depression and anxiety in obese individuals due to the stigma and discrimination they experience. However there has been little research conducted which investigates how stigmatised individuals, in this case obese women, interact with healthcare professionals, and engages with the system as a whole.

Weight related stigma in healthcare

The women in this study recounted multiple stories of what they believed was weight related stigma. Weight stigma and discrimination have been increasingly documented over the last decade, primarily through quantitative investigation. Holland *et al* (2010, p363) state that disease-related stigma 'tends to be greatest for conditions that provoke the most fear and threat'. They argue that stigma may be greatest when beliefs about personal responsibility and stigmatising behaviour are held. The Rudd Center for Food Policy and Obesity, at Yale University, defines weight related bias as:

Negative judgments of an overweight or obese individual based on stereotypes, such as being incompetent, lazy or lacking in self-discipline; may result in unfair treatment, prejudice, and discrimination (2008).

Obesity stigma, as conceptualised by Finkelstein et al (2007) and Cooper (1998) is different to other types of social stigma because it is still socially acceptable. Cooper lends another voice to this mode of thinking suggesting that anti-fat attitudes and discrimination is still culturally sanctioned (1998). This is a critical point when looking at the experiences of the women in this study who believed that they often experienced comments from their doctors which reflected the negative cultural attitudes toward large bodies. Brown (2006) suggests that the social discrimination associated with obesity has been recognised for at least the last thirty years. Given this, it is interesting to note the lack of research which has investigated weight stigma within clinical settings.

Murray (2007) contests that medicine and its practitioners can operate outside the 'cultural context that it/they operate within' (p361). She goes on to suggest 'that clinicians are unable to leave their embodied being, their own culturally constructed (tacit) understandings of ('fat') bodies and selves, normalcy and pathology, *behind* when treating their patients' (p368). Kohlenberg *et al* (2008) also comment on this, suggesting that physicians will always bring their own biases about certain patient groups into medical consultations, based on their own experiences. In the case of this research, this is particularly pertinent.

Puhl (2008) posits that weight stigma is everywhere, including healthcare, which is supported by the findings of the current research. In 2009, Puhl and Heuer undertook a systematic literature review of studies published between 2000 and 2008, updating their initial review which was the first of its kind to review documented weight stigma and bias. One of the areas specified was the healthcare setting, in which they found that healthcare workers sanction stereotypical assumptions about obese patient and that patients who experience stigma may delay or forgo essential preventative care. Based on their review, they posit that it is evident that the healthcare experiences of overweight and obese individuals need to be improved.

Puhl and Brownell (2003b) also suggest that the distinction between overweight and obesity are important clinically when identifying health risks, however with regard to stigma the distinction between the two is less important. Brownell (2005, p2) discussed the effect of weight related stigma, arguing that it can cause profound suffering. She states:

Obese people suffer, plain and clear. They exist in a socially constructed world that determines what is right and wrong, what is pleasing and disgusting, how blames is assessed, and who deserves some version of a scarlet letter.

Latner *et al* (2008) undertook research with undergraduate psychology students from three different universities in two different countries which compared the strength of weight bias against members of other minority groups, which in this study were based on sexual orientation and religious faith. Each cohort completed a modified version of the Universal Measure of Bias, specifically directed at either “fat”, “gay” or “Muslim” individuals. Findings of this study indicate that weight bias was significantly stronger than bias against the other two groups, as well as suggesting that it may also be more socially acceptable. They suggest that this may be because weight bias is not widely accepted as a form of prejudice.

Schwartz *et al* (2006) undertook a study to examine the influence of an individual’s body weight on the strength of implicit and anti-fat bias (p440). They surveyed 4283 people through an online sample of people ranging from underweight to extremely obese. This study found that all groups displayed considerable anti-fat bias. Thinner individuals were more to automatically attribute negative attributes such as “bad” and “lazy” to fat people, as well as to explicitly rate them as less motivated and lazier than thin people. Almost fifty percent of the sample indicated that they would rather give up one year of life than be obese. Most respondents who indicated that they would be willing to trade off something were thinner individuals, which were noted by the authors as something which requires further research.

Various studies support the fact that patients experience bias and discrimination at the hands of health professionals. Drury and Louis (2002) posit that evidence reveals that obesity incites negative responses from health care professionals, with health and physical issues frequently being attributed to weight before any actual examination has occurred. They describe obese persons as vulnerable, due to the stigma they suffer, suggesting that obese women could avoid or delay treatment if she felt humiliated or blamed by her health care provider (p559). Given the widespread stigma attached to overweight and obesity, it is of little surprise that health professionals also hold discriminatory beliefs and attitudes toward obese persons. Teachman and Brownell (2001) concur that weight stigma exists

within health professionals, however states that this may come as a surprise. Others have suggested that weight stigma has been documented within healthcare settings for several decades (Huizinga, Cooper, Bleich, Clark and Beach, 2009). Huizinga *et al* (2009) report on findings from their study which suggested that patients with a high BMI are associated with lower physician respect. Blumberg and Mellis (1985) administered a survey to 100 undergraduate medical students to obtain their attitudes toward obesity and morbid obesity. Results indicated that students rated underweight persons as neutral or positive, obese persons as neutral or negative, and morbidly obese persons as consistently negative. The authors suggest that the attributes rated by students, such as perceiving morbidly obese people as 'unpleasant', 'worthless' and 'bad', echoed prejudice based on stereotypes.

Friedman *et al* (2005) evaluated the relation among weight-based stigmatization, ideological beliefs about weight, and psychological functioning in obese individuals seeking treatment at a residential weight loss facility. Ninety-three participants, predominately women, completed a series of self-report questionnaires aimed at measuring their attitudes about weight and its controllability, psychological adjustment, and frequency of stigmatization related to weight. The most common experiences of stigma reported by participants were physical barriers, social exclusions and having negative assumptions. This study showed that individuals who were more extremely obese experienced a greater degree of stigma. Results also indicated that experiences of weight stigmatization appeared to influence overall self-esteem. The authors were interested in ascertaining whether personal belief systems were related to experiences of stigma and body image. Participants who reported greater experiences of stigma were more disapproving of obesity, whilst individuals who were more accepting of obese did not reveal that their experiences of stigma had effected how they felt about their own bodies. Thus, they postulate that those who internalise negative societal ideals about obesity experience higher levels of body dissatisfaction and body shame when exposed to situations in which they are stigmatised. These findings reiterate those found in other studies which suggest that people seeking treatment for weight loss appear to experience significant levels of weight based discrimination. Added to this, they appeared to internalise messages sociocultural anti-fat attitudes and biases, which may lead to psychological distress. In light of this, they recommended that obese individuals endeavour to develop ways of coping with stigmatization which could improve overall mental health.

They argue that by treating the experiences of stigma, and all that comes with this, individuals are then free to move onto dealing with issues and beliefs about weight. Whilst this study recognises that this sample was of people actively seeking treatment for weight loss, thus potentially altering the reports of stigmatization, others studies report similar findings for individuals not seeking treatment. So whilst these findings cannot be generaliseable to a primary care population, they do illustrate the importance of taking stigma into account within clinical encounters. It also serves as a reminder that for obese patients, stigma can and is a significant part of their experience of body weight.

Weiss et al (2006) note that health related stigma can contribute to delay in health seeking. The Rudd Center for Food Policy and Obesity (2008) suggest that the experience of weight stigma may affect patients in several ways including healthcare avoidance, experiencing negative psychological effects and feeling discouraged from making positive lifestyle changes. Drury and Louis (2002) conducted research which investigated obesity stigma and its effect on healthcare utilisation, as well as satisfaction with medical care, and healthcare avoidance/delay behaviours. Their convenience sample of 216 women revealed that a higher BMI was associated with delayed health seeking or avoidance, and that social and medical stigma toward obesity act as a barrier to seeking healthcare (p559). One of the reasons that participants avoided or delayed going was because they knew that they would be told to “lose weight” (p554). The women in this study had strong beliefs about what they *knew* was going to be said to them. However, for the most part, healthcare avoidance was not something that they engaged in. This could be due to the particular participants which were attracted to this study. However they certainly experienced other side effects of health stigma as described above.

Women were used to being judged by their bodies. In most cases, women had been the target of open bullying and weight related discrimination. Whilst the experiences they had within the healthcare context reflected experiences of weight related discrimination that they had suffered socially, what they endured within the context of healthcare held vastly different meanings for participants. Within their social worlds women described the process of learning to transcend negative comments that people made about their bodies because they could attribute these comments as belonging to people who ‘*didn’t know any better*’ (Stella). When these same attitudes and comments came from medical

professionals, it tended to cause more emotional damage because women didn't feel that they could just shrug off the comments as easily.

Johnson (2004) suggests that research supports the notion that physicians may regard large patients with contempt, finding failed attempts at weight loss frustrating. Conversely, she adds that large patients also experience frustration in their interactions with physicians, who they fear will reprimand them about their weight, potentially leading to avoidance and further decreases in self-esteem. Johnson (2004) suggests that researchers have explained these findings by drawing attention to the fact that healthcare professionals are exposed in the same anti-fat attitudes as broader society, thus have developed many of the same prejudices. Johnson's analysis about physician bias is a critical part of what participants in this research felt about their interactions with doctors. They firmly believed that what they often received was reprimanding based in personal values which reflected those prevalent in broader society.

The women in this research shared stories of incidences where medical professionals had said things to them which they found extremely upsetting. Chapple, Ziebland and McPherson (2003) advise that healthcare professionals need to demonstrate care and sensitivity when interacting with patients who have illnesses which are considered self-inflicted. These authors undertook a qualitative research study with 45 patients with lung cancer in the United Kingdom to examine their perceptions and experiences of stigma. Respondents in this study reported negative attitudes from their doctors who assumed that their lung cancer was through smoking. Puhl *et al* (2008) conducted a qualitative study with 318 participants, which asked about participant experiences of weight stigmatization. Health professionals were identified as a source of frequent stigma, and when asked to identify things that they believed would improve attitudes toward obese people one third of participants suggested "interventions to increase sensitivity and weight tolerance" towards obese individuals (p354).

As most of us do, participants had certain expectations of healthcare. They felt that they had a right to be seen the same as everyone else, and they had a right to not have their weight commented on at every turn. They also believed that the disappointment and consequence of weight related discrimination was somehow worse when suffered at the hands of a doctor than if it had occurred in a community. The women in this study

believed that medical professionals displayed extremely negative attitudes toward their body size. As illustrated in the findings of this study, participants had developed the expectation that they would be treated in a certain way by health professionals, especially their GPs. Hebl and Mason (2003) suggest that if physicians treat overweight patients in a negative way, this may create a cycle where patients learn to expect substandard levels of care which in turn they then blame themselves for. This is echoed in this study, to some degree, by participants who couldn't rid themselves of the nagging feeling that they were in some way to blame for what they were experiencing even though in some cases that knew that this wasn't true.

Like other people with diseases or chronic illness, the participants in this research did not want to be totally defined by their illness – especially by something such as weight that over half of participants didn't actually believe actually constituted sickness. There are similarities between the stigma attached to chronic pain and people who live in large bodies. Ballweg (1995) suggests that one reason people with chronic pain experience stigma is from the flawed reasoning that pain stems from a psychiatric illness or character flaw. Avery (1995) suggests that health professionals can present significant obstacles to people suffering chronic pain, blaming patients when they fail to show results from treatment. Likewise, overweight and obese people report feeling blamed for their inability to lose weight through their refusal to adhere to weight loss plans which people, medical professionals in this instance, assume that they should be on.

Attitudes toward overweight and obese patients

Participants didn't identify their primary healthcare providers as people who they could rely on to support them in achieving healthy outcomes, either physical or emotional. The majority of participants felt that what they got from their GPs was not professional and supportive health advice, but social commentary based in negative cultural opinions of overweight and obesity.

Teachman and Brownell (2001) investigated implicit anti-fat bias in amongst a sample of health professionals who work in obesity treatment using an attitude and beliefs based IAT. Eighty four participants, predominantly male, completed a series of measures which tested implicit and explicit attitudes and beliefs, and which were then compares to a

sample of the general population. These findings suggested that whilst lower than the anti-fat beliefs and attitudes demonstrated in the general population, there was still evidence of implicit anti-fat bias within the sample comprised of health professionals. These findings suggest that there exists in society and within this study the expectation that healthcare professionals, particularly doctors, will provide healthcare which is completely independent of their own biases and judgements ignoring the broader cultural and social fabric which they are part of and deliver care free. However the findings of this study, and others, suggest that this isn't the case. Teachman and Brownell (2001) suggest that weight stigma exists within health professionals, stating that this may come as a surprise. However others have suggested that weight stigma has been documented within healthcare settings for several decades (Huizinga et al. 2009). Huizinga et al (2009) report on findings from their study which suggested that patients with a high BMI are associated with lower physician respect.

Women's experiences of feeling judged were significant, and it affected the outcome of their consultations with medical professionals. It also affected the help they got, and how they saw themselves – and their GPs. Puhl and Brownell (2006) investigated weight discrimination in a sample of overweight and obese adults, which they separated into two subsamples – one of 2449 women, and the other a mixed sample of 222 men and 222 women. Both samples completed online questionnaires in which they were asked about weight discrimination and the most common sources of bias, attitudes about weight and obesity, self-esteem, symptoms of depression, and binge eating behaviours (2006, p1803). Their findings suggested that discrimination was common in both samples, with no gender difference reported. The authors listed the coping responses to stigma in the female only sample, which included 'heading off negative remarks', ignoring situation, making no response', 'refusing to hide, being visible', 'avoiding', and 'refusing to diet'. They also listed family members and physicians as the top two most frequent sources of interpersonal stigma. This study highlights that overweight and obese people experience a wide range of weight stigma, with the female sample depicting doctors as the most common source of stigma.

Several studies have identified that GPs and other health professionals find weight management professionally unrewarding, and whilst this research did not investigate GP attitudes toward working with overweight and obese patients the studies which have done

so are important to recognise. Serdula et al (2003) suggest that the treatment of obesity is often perceived as an unsuccessful and labour intensive by physicians and other healthcare workers (p1747). Similarly, Johnson (2004) comments that research supports the notion that physicians may regard overweight or obese patients with contempt, finding failed attempts at weight loss frustrating. Conversely, she adds that large patients also experience frustration in their interactions with physicians, who they fear will reprimand them about their weight, potentially leading to avoidance and further decreases in self-esteem. Johnson suggests that researchers have explained these findings by drawing attention to the fact that healthcare professionals are exposed in the same anti-fat attitudes as broader society, thus have developed many of the same prejudices. Johnson's analysis about physician bias is a critical part of what participants in this research felt about their interactions with doctors. They firmly believed that what they often received was reprimanding based in personal values which reflected those prevalent in broader society.

There is also a small body of research that has investigated nurses' attitudes toward overweight and obese patients. A 2009 study by Poon and Tarrant investigated attitudes toward obese individuals and the management of these individuals in a sample of undergraduate and registered nurses. A survey consisting of the Fat Phobia Scale and the Attitudes Toward Obese Patients Scale was distributed to 352 undergraduate nursing students and 198 registered nurses. The data indicated that registered nurses demonstrated significantly higher rates of fat phobia than did undergraduate students. Over half of the participants in this study believed that obese patients should be commenced on a diet whilst in hospital, whilst between sixty to eighty percent of participants believed that obese patients were slow, unattractive, and more likely to overeat and like food. The authors comment that given that nurses play a key role in counselling obese patients to lose weight and caring for obese patients, these attitudes are particularly disturbing. The findings of the current research highlight the significance of the relationships between overweight and obese women and their healthcare providers, and given the primacy of contact that GPs have with the population these findings are very significant.

In 2006, Brown undertook a literature review of the attitudes toward obese patients held by nurses. The findings of his review suggest that there is a percentage that holds discriminatory and negative beliefs and attitudes toward obese patients. He suggests that there are very few studies that investigate nurse's attitudes toward the problems face by

obese patients. This being said, there are also relatively few studies, although increasing in number in the last decade, which document GP attitudes toward obese patients (Brown, 2006). Brown and Thompson (2007) looked at the attitudes of 15 primary care nurses in the north of England. The authors conducted a qualitative study aimed at investigating nurses' attitudes, beliefs and own body size in relation to obesity management. The nurses in this study were cognisant of the obesity stigma, and because of the sensitivity surrounding obesity used strategies to establish good rapport and try and minimise stereotypes. Participants were mindful of the fact that their own body size changed the way they interacted with patients – nurses who had a slim build were concerned that they lacked authenticity of experience, whilst large bodied nurses drew on their shared experienced yet worried that they presented as a poor role model. One of the primary themes in Brown and Thompson's research was that nurses felt a 'sensitivity about weight'. They believed obesity was potentially a sensitive and awkward issue to address, primarily because obesity was a stigmatised condition, and one in which they needed to navigate with care. They believed the easiest context through which to raised weight was one in which a patient had presented specifically in order to obtain weight support. This sentiment is also echoed in other research, however is in direct contrast to the experience of participants in the current research.

The women in this study believed that their GPS viewed them as people who did not act in their best interests of their bodies. They believed that once their GP, or medical professional, viewed them they were seen as individuals who ate poorly, did little exercise and generally made poor lifestyle choices. Studies have indicated that GPs and other health professionals view overweight and obese patients as non-compliant. Other research have also indicated that health professionals, including GPs, hold negative attitudes towards overweight and obese patients that subsequently impact the practitioners' involvement and interaction (Campbell, Engel, Timperio, Cooper & Crawford, 2000). In 2000, an Australian study investigated GP attitudes and practices toward the prevention and management of overweight and obesity (Campbell et al. 2000, p459). The cross-sectional random survey of 1500 GPs revealed that whilst GPS considered themselves well placed to provide relevant weight advice, they considered weight management professionally unfulfilling. Similarly an American study of more than 600 GPs reported that more than 50% of GPs viewed obese patients as awkward, ugly, unattractive and non-compliant, and primarily views obesity as a behavioural problem. The findings of this

study also revealed that GPs share negative societal views about the personal attributes of obese individuals (Foster et al. 2003). For the participants in this study, their stories revealed that medical professionals had often said things to them – within the context of the medical interaction – which were extremely inappropriate and seemingly based in personal and negative views about overweight and obese bodies.

In 2003 Foster et al surveyed a random sample of 5000 primary care physicians, and found that out of 620 respondents more than 50% viewed obese patients ‘awkward, unattractive, ugly and noncompliant’, believing that obesity is chiefly a behavioural problem primarily caused by lack of physical activity. Nearly half of respondents also rated ‘psychological problems’ as an important cause of obesity. Epstein and Ogden (2005) undertook a qualitative investigation of 21 GPs in London to examine their attitudes toward obesity, and managing recent obese patients. The authors asked GPs open ended questions about their consultations with obese patients, including how they felt about the patient; whether they considered the consultation a success; what they believed patient expectations were, and their thoughts on the various types of obesity interventions. Their findings illustrated that GPs conceptualised obesity as an issue of patient responsibility, believing patient obesity to be a cause of lifestyle and denial. However they also believed that patients viewed their obesity as a medical responsibility, something which should be managed by the GP. The findings of this research illustrate the experiences of the women in this study. Participants certainly described feeling that GPs projected their views about weight responsibility within clinical consultations. Participants felt blamed, and shame, when this occurred. However, in contrast to the findings of Epstein and Ogden who investigated GPs, these female patients did not want their weight to be managed by a GP. They were accepting of it arising when appropriate, but very few participants believed that their weight was something that should be ‘managed’ by their GP. Rather, for those that wanted to discuss weight, they indicated that they wanted to talk about it as an individual issue that they would like GP support or advice about.

Harvey and Hill (2001) report on their research which investigated the attitudes of general practitioners and clinical psychologists toward overweight people and smokers. Their analysis of 255 surveys revealed that attitudes toward overweight people were both negative and neutral, and suggested that obese people, rather than moderately overweight, were more likely to be the target of ‘apparent negative attitudes’. However, as Harvey and

Hill (2001) point out, the fact that the role of health professionals may be compromised by these attitudes is a concern. Also of interest is a study Anderson et al (2001) who surveyed 209 physicians about their attitudes toward overweight and obese individuals and whether patient sex influence treatment recommendations. Their findings showed that physicians were more likely to recommend weight loss and increased treatment options for women who fell into the overweight category, but less likely to comment on women in the obese category than men of the same size. These findings demonstrated that gender plays a role in how physicians treat patients.

Bocquier et al (2005) administered a four-part telephone survey to a sample of 600 GPs in France. The survey assessed personal and professional characteristics, attitudes and opinions about obesity, knowledge and training, and weight practices such as diagnostic methods and clinical assessments, counselling and weight loss objectives (p787). The results of this study showed that almost a third of GPs held negative attitudes toward obese patients and set up unrealistic weight loss goals. Whilst more than three quarters of GPs considered weight management to be a part of their role, over fifty percent did not believe that they did it effectively, and a third found it professionally unrewarding as well as holding negative and stereotypical views of overweight and obese patients. Cade and O'Connell (1991) undertook a postal survey to evaluate GPs knowledge, attitudes and current practices of obesity treatment and weight problems in two cities in the United Kingdom. Of the 299 doctors who responded over 75% used leaflets and counselling on healthy eating as their method of educating overweight and obese patients. GPs believed that family and the media had more influence on patient weight loss than they did. They also indicated that whilst they would provide counsel on weight reduction if required, they had little faith in their ability to make long term weight loss changes.

Out of all the participants in this research, there were very few positive experiences reported. Some participants, as presented in chapter 5, did discuss what they believed was the 'right way' to discuss weight, however these still participants had also still experienced discrimination and stigma relating to their body weight. There are only several studies which contradict the findings of most other studies that report on overweight and obese patient satisfaction and experience. Hebl and Mason (2003) surveyed 125 patients, both overweight and non-overweight in Houston, USA. They asked patients about the care they had received, including the positivity and length of the consult with the physician, and how

much of the consult centred on weight related topics. The overweight patients in this study reported the same levels of care as non-obese patients, and overweight women actually reported superior care than those women of average weight. Hebl and Mason (2003) subsequently suggest that whilst physician care may be less impacted by weight than previously considered, patient weight definitely impacted physician care. Interestingly though they reported that whilst overweight men reported lower levels of care, they speculated that overweight women may have reported enhanced care because they were 'engaging in denial strategies compensatory behaviours or that assure them of quality care' (p269). Despite the findings of the study, they reported that female participants expressed their discomfort at having to see their physicians given the perceptions that their stigmatised body would be the central issue of the consult. In 2000, Wadden et al surveyed 259 patients who participated in a clinical obesity trial and the findings of this study contrast with most other studies investigating this issue. Wadden et al (2000) findings suggested that 90% of the women in the study had not experienced any treatment from their primary care physicians which they regarded as insensitive or disrespectful. This study, however, contrasts with the majority of other studies which suggest the opposite.

In 2002, Kaminsky and Gadaleta conducted a study with patients of four bariatric practices in the United States before, during and after they had undergone weight loss surgery. The research questioned respondents about the attitudes of staff across the healthcare spectrum, and the appropriateness of hospital equipment. Of interest is also the representation of women in the sample – thirty four out of forty respondents were women. The authors found that the medical personnel were regarded favourably, and questioned whether the negative cases were actually based on participants own prejudices and fears rather than directly relating to their body size. Kaminsky and Gadaleta (2002) also suggest that whilst morbidly obese patients have expressed that they experience misunderstanding and mistreatment from physicians and non-medical personnel who view their obesity as an oddity or a character flaw, 'bariatric physicians and surgeons do not share these discriminatory views' (2002, p14).

Given the widespread stigma attached to obesity, interactions with medical professionals can present particular challenges for overweight or obese individuals. Whilst there is recognition that overweight and obesity are not only medical as well as social conditions

which have consequences, little has been done within medicine to correct anti-fat attitudes and bias. Health professionals are exposed to the same social messages regarding overweight and obese bodies that the general population are, however there is an expectation that they will not also display the same weight bias within their roles as health professionals. For the women in this study, the fact that they did this had devastating effects.

A lot of work which investigates physician's attitudes is conducted from the viewpoint that negative attitudes can lead to failed loss attempts. Rebecca Puhl and Charlotte Cooper, both of whom are prominent writers in their respective areas of weight research, argue that there has to be an end to weight stigma, however they come from very different positions. Like Fabricatore et al (2005), Puhl argues for action against weight stigma with the view that this may actually facilitate weight loss and a more effective way in which to tackle the problem of obesity. Alternatively, Cooper argues that weight stigma has become part of a culturally approved form of fat hatred, and that it has to end because it is morally wrong and harmful to those who fall outside socio-medical constructions of 'normal' bodies.

In a recent Australian study, Thomas, Hyde and Karunaratne (2008) conducted a qualitative project investigating both the lived experience of obesity and the impact of socio-cultural factors on people who were obese. Community and purposive sampling was employed to recruit 76 participants who were then interviewed. The participants in this study revealed that there wasn't a single 'lived experience' of obesity, however common experiences relating to discrimination, social isolation and being misunderstood by health professionals were recurrent. The findings from this study provided an assortment of experiences with health professionals. At least three quarters of the participants had consulted their GPs for assistance with weight advice, however instead of focusing on their weight they tended to talk about problems they were having emotionally – leading to GPs prescribing them antidepressants. Fifty percent of the participants described being humiliated by healthcare professionals; however they also reported very positive encounters. They believed that medical professionals, particularly GPs, were a critical force in assisting patients with obesity however believed that this had to be part of a multi-disciplinary team of people to provide long-term weight support. Likewise, the findings of this research emphasize the importance of GPs in addressing and/or managing weight in ways which are positive and helpful.

In contrast to this research, and that of most other studies, the majority of participants in the study by Thomas *et al* (2008) reported that most doctors did not broach the subject weight with their patients. Instead patients felt that weight was something that they struggled with alone, and when they did raise the topic with their GP their weight had reached a point where there was little the GP could do except recommend further dieting, medication or weight loss surgery. However despite this, participants also described feeling satisfied when their GP spent time talking with them about their general health and wellbeing, which is interesting to note in light of the findings of the current research, as it relates to the feeling of being seen as more than just an overweight or obese patient. Similar also to the women in the current research, participants in Thomas's study (2008) felt that what they needed was practical support, not just verbal advice about what to do. They also expressed their need to be treated as individuals, rather than being offered a 'blanket remedy' for obesity (p327). Participants reported low levels of satisfaction with their GPs in relation to weight management and intervention. The participants described an 'emerging culture of blame' which they felt was highlighted by medical professionals, the media and policy makers (p325). Puhl and Shortus *et al* (2005) undertook a qualitative study with 16 patients to examine their experiences of living with chronic illness, and their attitudes toward healthcare. One of the themes that the authors identified was what they labelled "strategic noncompliance". The patients in this study suggested that when they were newly diagnosed they took all their doctors advice, however as time progressed and they gained more information and experience, they would choose which advice they would comply with and adapt it to suit their circumstance. The same applies for women in this study, albeit in a different way.

Learning to Manage

For the participants in this study the experience of living with and managing the stigma of their body size was a critical part of their daily lives, and of being a patient. Learning to manage was a dual process comprised both of the participants trying to protect themselves, and see beyond their visible stigma – being overweight or obese. Through their engagement with the healthcare system participants had come to believe that their doctors also judged them for their body size and that they then treated them in ways which reflected this judgement. By learning ways of 'managing' the interaction, women felt they

were able to retain or try and regain some of the control of the situation, which meant that they could minimise the hurt they experienced. Herndon (2002) suggests that whilst medical literature focuses on the individual responsibility for weight, medicine conversely pays scant attention to fat people as individuals. The backdrop to this research is the increasing research and medical 'evidence' which identify obesity as the cause of numerous health issues. These constant messages which depict obesity as the cause of multiple health problems, combined with the unequal power relation between doctor and patient underpinned the way that women interacted with and responded to their doctors. . Although participants frequently felt that they were inappropriately treated or targeted because of their weight, they rarely said anything. Instead they found ways of managing it which didn't involve confrontation.

Goffman (1963) points out that the management of stigma is an everyday part of society, and that individuals whose identity deviates from that of an "identified norm" will generally become adept at managing. Dovidio et al (2000) posit that context is a determinant in the psychological consequences of stigmatisation, and that something may be stigmatised at one era in history, but not in another. In this study, context was extremely important and something which had worked to shape the experiences of the women in this study. As referred to throughout this thesis, the current socio-medical constructions of obesity are deeply entrenched in the fabric of our day to day lives, and extremely important in understanding the experiences of the women in this research. At this time in modernity, being an overweight or obese female has significant connotations. Likewise, within the context of medicine and healthcare interactions, being overweight or obese has negative connotations attached to it.

In 1991, Sobal proposed a four part model through which can obese individuals help cope with stigmatization. This model included: recognition and awareness of stigma; preparing themselves for stigmatizing situations; reacting to these situations in ways which minimise its associated problems; and repairing the problems caused by stigmatization (p310). This model, perhaps the most relevant to this study, reflects the processes which women used in order to cope with their engagement with medical professionals. In the current study, the women identified early on that they were well aware of how individuals, namely their medical professionals, viewed their bodies. They were also able to contextualise this in the broader framework of social values around women's bodies, and the obesity panic which

is gaining global attention. When they entered medical consultations they believed they were going to be viewed in a negative fashion because of their weight, and thus they were prepared for this (depicted in this study as 'expecting the worst'). Subsequently, they developed a range of strategies and behaviours aimed at both minimising the problems and repairing the damage which were conceptualised as '(re) constructing acceptable selves', 'limiting expectations', 'learning not to listen' and 'always apologising'.

Schroeder (1981) examined obesity within a symbolic interactionist conceptual framework. Schroeder (1981, p80) suggests that fat people stimulate different interactions than thin people which means that fat people must respond differently. For the women in this study, the outcomes and experiences within healthcare were something that they had to actively manage. What emerged from the study is that most of the participants felt that they had to apologise, or in some way compensate for the fact that they were presenting to their doctor in an overweight or obese body. They felt that if they didn't, they would not be taken seriously, that they would be judged, and that they would be ignored.

Lupton (1997) draws on the work of Foucault to examine the ways in which individuals respond to medical interactions. She states:

The doctor-patient relationship is a central site at which subjugated knowledge's and the practices of the self-play a major role in the interrelation of institutional and localised power (p105).

Lupton suggests that in a medical interaction the individual makes a conscious decision in how to respond to 'disciplinary techniques' they view as restricting their autonomy. Patients may choose not to comply with doctors' orders or they may present themselves as a 'good patient', actively working on presenting themselves to the doctor in this way. In either case the patient is actively presenting themselves in a certain way or manner, dependent on the social or embodied position of the individual at that time (Lupton, 1997). For participants in this study, the basic social psychological process of 'Learning to Manage' involved both the conscious and unconscious adoption of certain roles that they performed in order to both manage their interaction with their doctor and to cope with the consequences of that interaction. Drawing on Lupton's thought, the participants responded to the disciplinary measures they received from medical professionals by responding in ways which they believed negated these measures.

Falvo (2005, p4) describes coping as:

A constellation of many acts rather than a single act, is constantly changing, and is highly individualised. Coping mechanisms are learned and developed over time. Individuals use them to manage, tolerate, or reduce the stress associated with significant life events and to attempt to restore psychological equilibrium after a stressful or traumatic event.

For participants in this study, the experience of interacting with medical professionals as a large body woman were often traumatic, and something which over time they had learnt that needed managing. Whilst this theory discusses the commonality of the generic processes that women used in order to cope with their experiences as patients, the way they used the coping mechanisms were all different and implemented in reaction to their own personal triggers.

Falvo (2005, p5) also states that:

Coping does not occur in a vacuum. The social milieu in which individuals find themselves can facilitate or discourage effective coping. In general, an optimum environment is one that helps individuals gain a sense of control by actively participating in decision making and taking responsibility for their destiny as much as possible.

As patients, women felt that they had little power in participating in changing the nature of the interaction. The environment in which they found themselves was *not* one in which they felt powerful. Thus, their coping was more about limiting the damage enacted through the interaction, rather than trying to as Falvo suggests “take responsibility for their destiny” (p5).

As stated previously, women were aware that weight related stigma was as one participant described ‘*bigger than me*’ (Emily). Women knew that they lived in bodies which provoked misguided and damaging cultural and medical attitudes toward them, and at times this was extremely difficult. As adult women, very few of the women experienced the weight related social taunting or commentary they had experienced as young adults. Most of the women had learnt to cope with the social attitudes toward their bodies to some degree, and they tried hard not to let the cultural values about slimness get them down.

However, even as adults their experiences with doctors created feelings of shame and guilt. Rebecca Puhl (2010) suggests that weight stigma can negatively impact obese patients, becoming a negative and shaming experience. She stresses the importance of the healthcare professionals in managing stigma, suggesting that clinicians should encourage patients to share experiences of stigma. However, according to the women in this research, the physicians were usually agents of oppression rather than those who addressed it with a view to positively changing the experience of stigma.

Dovido et al (2000) discuss the notion of controllability, which involves the stigmatised person's responsibility for possessing the stigmatising mark, and their subsequent maintenance or elimination of the mark. These authors argue that controllability is important because those perceived to have controllable stigmas, such as overweight people, face more rejection and more judgement. The notion of controllability was important for the women in this study, because they believed that they were blamed by their GPs for failing to keep their weight at a healthy standard. The fear that their weight was responsible in creating their individual health issues was something that women had thought a lot about. And it was something that frightened them when they had to visit a doctor. Participants believed that the fear of being blamed was partly a by-product of the sociocultural messages around weight that society is increasingly bombarded with, and partly due to the fact that weight is now regarded as such a significant health issue. They also considered that these fears were compounded by weight constantly being focused on in all their clinical interactions. Whilst they discussed the sometimes irrationality of this, especially when a doctor tried to link health issues like ear infections to weight (*Emily*), it was definitely something which women thought about and discussed. Spitzack (1990, p109) states that:

Personal responsibility for disease is pervasive in the history of medicine, and is not restricted to illnesses in which a patient's lifestyle contains blatant body abuse. Cultural and medical responses to diseases such as alcoholism, obesity, and drug addiction, are merely cases within a web of connections between illness and individual character.

Clearly evident within participant data, was that large bodied women had learnt to feel shame and apology about their bodies – which then worked toward making them feel at times powerless, frustrated and hurt. Lazarus (1999) suggests that both guilt and shame arise from personal failure, generally in the presence of another individual who is

disapproving (p238). Shame, Lazarus suggests, is difficult to manage because it usually occurs in response to something which is perceived as a failure of character – which in this research, is being overweight or obese. One of the by-products associated with learning to manage their interactions with doctors, was that most people in order to do this became defensive.

Heuer (2010) also argue that despite a significant body of scientific work that documents both the psychological and physiological consequences of obesity stigma, the public health implications have been ignored and obese people are blamed for their weight. In the current study women often felt that they were blamed or their weight held accountable for whatever had brought them to the doctor, even if it was not related to weight. Additionally, they also felt that they were blamed for letting their bodies transgress what is considered normal, that somehow they had willingly let themselves become unhealthy. Within western society there still exists the mindset that it is acceptable to judge individuals based on weight, something which all of the women in this study had experienced. Cowan (1997) wrote that that society must be convinced that weight harassment is ‘politically incorrect’ resulting in the same consequences as other forms of prejudice (p77). He states:

Members of society learn, from an early age, that such large individuals are guilty of a self-caused malady which they should be able to handle themselves, if only they had the ‘will’ to do so.

Women who carry excess weight are seen as having ‘made themselves’ that way and participants in this research described feeling that way when they interacted with medical professionals. Conrad (2007) suggests that it is recognised that the clinical medical model concentrates not on social context, but on the individual. Spitzack (199p, p109) concurs with Conrad, stating:

Personal responsibility for disease is pervasive in the history of medicine, and is not restricted to illnesses in which a patient’s lifestyle contains blatant body abuse Cultural and medical responses to diseases such as alcoholism, obesity, and drug addiction, are merely cases within a web of connections between illness and individual character’.

Research supports the fact that by accepting cultural values about how fat is greedy or fat is unacceptable, fat women learn to feel responsible for the oppression they suffer. Women

in this study reiterated these sentiments, and demonstrated the strong messages regarding fear of fat related ill health. Goffman (1963) suggested that one of the most significant outcomes of stigma is that the stigmatised individuals take on the negative evaluations, and thus begin to believe that they are responsible for their oppression (Rothblum, 1992). Brownell and Puhl (2003) suggest that obese individuals internalise societal anti-fat messages, believing the pro-thin biases. Women in this study echoed this sentiment, expressing time and time again their guilt and feelings of responsibility for their bodies which they felt had betrayed them. A number of studies have investigated feelings of shame and guilt in people whose bodies are not considered 'normal'. Thomas et al (2010) interviewed a community sample of 142 obese Australian adults in order to find out how individuals felt about their bodies, what influenced their feelings, and how they coped. Almost seventy five percent of participants in this study were females, and reported feelings of shame and guilt due to their weight. Relevant to this is a widely cited article by Major and Crocker (1989) who have published considerable work in the area of stigma, who proposed several ways in which members of stigmatised groups protect themselves against prejudice from others, namely through what they describe as the "self-protective properties of stigma". Particularly relevant to this research is the mechanism they labelled 'attributing negative feedback to one's group membership'. They suggest that members of stigmatised groups may attribute negative attitude or poor outcomes to the prejudiced attitudes of others toward their group in order to protect their self-esteem (Crocker & Major, 1989). The women in this research definitely did engage in the process described by Major and Crocker; however, it was not generally enough to cancel out the feelings and messages they had and continued to receive from their medical professionals.

One of the most challenging things for participants was that despite how annoyed and sick they were of physicians focus on the size of their bodies, they were also slightly scared that there was an element of truth in what they are saying— simply as it related to carrying excess weight. And whilst the participants did become adept in 'learning to manage' and coping with the shame and guilt associated with 'feeling judged', and the broader medicalisation of obesity as a disease, they could never shake the doubt, or the fear, that they were in some way responsible for what was happening to them. Cooper (1998, p72) states:

Since disease is loaded with negative connotations, and health with positive one, to regard fat people as diseased entails thinking of us as

abnormal and bad, and thinner people (although not very thin) as healthy and virtuous. This impacts on fat peoples self-image through guilt and embarrassment, and promotes a belief that we must lose weight to become acceptable.

A lot of what the women in this study felt was, according to Weiner (2006) moral emotions. Shame, according to Weiner (2006, p90) refers to “a belief that the self is uncontrollably ‘flawed’ and that this deficiency in character has been displayed to others”. Rich and Evans (2005) suggest that in a culture where weight loss is endorsed, feelings of guilt and shame and detachment which accompany this are marginalised within public dialogue.

For participants, ‘being defined’ was about having a fat identity thrust onto them, and all that this encompassed. In response, ‘learning to manage’ involved the development of strategies aimed at trying to manage this identity and be seen as an identity beyond this. Degher and Hughes (1999) discuss coping strategies which obese individuals can use to ‘neutralise’ their obese identity, once a fat identity is internalised. Two strategies, which particularly relate to this suggest that compliance is a category of a coping strategy and compensation and compliance. According to Degher and Hughes, obese individuals use these coping strategies to “socially manage their stigmatised identities” (p4). Similarly, Shih (2004) suggests that stigmatised persons develop skills in order to compensate for stigma (p177). They suggest that stigmatised individuals are engage in compensatory strategies such as “trying harder to be more likeable” stating that stigmatised persons “strategically manipulate their interpretations of their social environments to protect their self-worth” (p178). This for example could mean that when obese people are faced with failure, they attribute this to weight discrimination, whilst non-obese people in the same circumstance would more likely attribute the blame to themselves. The women in this research used a number of compensatory strategies aimed at increasing their visibility, ‘trying to be seen, and trying to protect themselves from the negative consequences of feeling judged. ‘Always apologising’ was a compensatory strategy women frequently used, because they believed that it made doctors view them more favourably.

Miller et al (1995) conducted research with 77 obese and 78 non-obese women to test the hypothesis that obese women compensate for the prejudice of others. They did this by having both groups of women have telephone conversations with an individual that they

believed, rightly or wrongly, could or could not see them on television monitors (p 1093). The social skills of obese women were more negatively rated than non-obese women when they were visible, but believed they were not. However, obese women gave themselves increased ratings for likeability and social skills when they were believed they were visible to other women. Their findings ultimately supported the fact that when needed, obese women can compensate for others' reactions to their appearance. They suggest that compensating behaviours may have both positive and negative effects of the social interactions of obese women. They suggest that whilst obese women cannot entirely escape the impact of prejudice, the skills and strategies they adopt in order to alleviate the stigma may result in more long-term resilience. In the current study, the notion that coping and compensatory strategies may lead to resilience is a misnomer of sorts. Whilst the strategies that participants employed definitely helped them navigate their way through medical consultations with the least amount of hurt possible, it had also led to deeply held feelings that they weren't regarded as worthy of treatment as people of normal weight.

Participants in this research were always wary of what was coming in any in any interaction they had with medical professionals, particularly as it related to negative experiences or outcomes. Crocker and Garcia (2006, p295) state that "vigilance for early cues of prejudice and devaluation might help the stigmatised person avoid conflict by taking defensive measures to avoid experiences with prejudice". Shih (2004) suggest that research findings show that people living with stigma monitor their social interactions with more vigilance. They suggest that individuals living with stigma can protect themselves by drawing on 'alternate identities' (p179). Stigma is a social constriction and as such an identity which identity which may be acceptable in one setting is not in another. The participants in this research had worked out ways through which to project different identities in order to protect themselves and make themselves more appealing to their doctors. They did this because being more likeable or more acceptable made getting the care they needed easier, and because it made the experience less stressful to manage. Hebl and Kleck (2002) discuss the use of "acknowledgement" as a strategy through which stigmatised people try and avoid or change consequences of their stigma in social interactions. They mention using acknowledgement for obese individuals, but suggest that whilst it may work to bolster the self-esteem of some groups, it doesn't necessarily apply in all settings. . This relates to the participants use of apologising for their obesity in order to deflect conversations about weight, or to minimise the effects of weight discrimination.

Wang *et al* (2004) tested anti-fat bias amongst overweight individuals across a range of attitudes and stereotypes using both implicit and explicit measures. The Implicit Association Test (IAT) is a frequent measure of bias in research investigating anti-fat bias. Wang *et al* describe the IAT:

It is a timed instrument that examines associations between target groups and beliefs, and has been used to assess valenced associations of race, gender, and more recently, of weight. Participants are presented with words that fit into two target groups (egg, 'fat people' and 'thin people') and two groups of attributes (egg, 'bad' or 'good'). Pairings that may be attitude-consistent (egg, 'fat people' paired with 'bad') or attitude-inconsistent (egg, 'fat people' paired with 'good') are presented. Participants respond more quickly when classifying words that are typically associated. (p1334)

Implicit measures assess beliefs without the individuals' awareness of the purpose of the assessment, which in turn reduces reactivity to the measure. Implicit testing, such as used in the IAT, used Explicit measures, they suggest are less reliable as individuals are often less inclined and potentially less able to articulate discriminatory attitudes (Wang *et al*, 2004). The authors conducted two studies, with study one containing 68 overweight patients participating in a university weight loss research program, and study 2 comprising 48 overweight individuals. Both samples included significantly more women. The authors suggested that the findings of this study add to evidence that overweight people internalise the social stigma attached to being overweight. They postulate about the effects of this, suggesting that in-group bias may work to maintain the stigma they experience from external sources. Participants in their study held strong explicit beliefs that fat people are lazy, which is underpinned by the belief that obesity is controllable and thus caused by the irresponsibility of the individuals. They also suggest that constant failed attempts at weight loss may aide the perceptions about lack of willpower and laziness. They recommend that changing societal stigma toward obesity is a critical part of improving the lives of overweight individuals.

For women in this study, ways through which to try and overcome or avoid the consequences of being an overweight patient was to pretend that had started or were in the process of losing weight. This, they believed, would make present a more acceptable front to their doctors, thus making it more likely that they would be viewed as someone who

was deserving of medical care. Puhl and Brownell (2003a) suggest that in order to try and avoid the negative attention of others, obese individuals may pretend to comply with pressures to lose weight. Degher and Hughes (1999) describe this as ‘face compliance’, a process in which the obese person agrees to lose weight but has no intention of following through with this. Other strategies mentioned such as confrontation, communal coping and activism, which are noted in other obese individuals were not strategies used by the participants in this research. Few participants in this study were happy with the being defined by a body which held such negative and powerful cultural and medical stereotypes. . However whilst there are increasing numbers of fat activists who have reclaimed the positives of a fat identity, there were few women in this study who aspired to, or appeared to aspire to this.

All patients are part of an interactive process of identity construction with their health provider, in this case, their doctors. However this research suggests that there are specific challenges related to being large bodied. Nina Grytten and Per Måseide (2005) state that ‘the body plays a crucial role in how people relate to other people in everyday face-to-face interactions’ and this is particularly important for anyone who embodies a stigmatised identity. Degher and Hughes (1999) suggest that avoidance is a coping strategy most commonly employed by fat people, in order to reduce the stress caused by problematic situations. Through avoiding participants could minimise some of the negative consequences of being fat (p19). There was definitely evidence of participants avoiding visits to doctors and other healthcare providers however this was limited amongst this group of women.

Through the process of experience and time, participants learnt that limiting expectations was a way of what one participant described as ‘surviving the system’ (*Sam*). In this research, underpinning the concept of ‘limiting expectations’ was the devaluing of the medical professionals attitudes. If participants passed off the commentary as purely consequential of weight stigma, then they didn’t have to take it on board. Likewise, part of limiting their expectations was telling oneself that they were likely to receive advice which was clouded by weight bias, thus lessening the disappointment and the impact the commentary had on them. Puhl and Brownell (2003a) reviewed literature on how obese individuals cope with stigma, and identified ten potential coping strategies. Amongst these, and relevant to the processes used by participants in this research are strategies such as

self-protection, compensation, personal attribution, negotiation of identity, losing weight and avoidance and psychological disengagement. In a study by Thomas et al (2008) in which overweight and obese individuals were interviewed about their experiences of being fat, participants described one of their coping strategies as 'switching off'. This is similar to the findings of the current research where participants described 'learning not to listen' as a strategy through which to try and protect themselves.

The process of 'learning not to listen' was consistently used by participants as a way of 'learning to manage'. Puhl and Brownell (2003a) suggest that one way of avoiding stigmatising areas of life is through what they identify as psychological disengagement. Schrader et al (2001, p93) defines 'psychological disengagement as' the defensive detachment of self-esteem from a particular domain'. One way to do is through 'devaluing' whereby a stigmatised individual places more value on an area which she or he is can succeed, and devalues the area in which the group that she or he has membership is stigmatised. The notion of 'devaluing' is witnessed frequently throughout this study, particularly as one of the strategies in which participants learnt to protect themselves. Psychological disengagement is likely to be employed in evaluative situations where one's self view is threatened, such as in healthcare situations when you have a body that is stigmatised. By doing this, the individual can maintain their self-esteem in an environment in which they are threatened by information which indicates their inferiority in that area (Schrader et al. 2001). Major et al (1998) also discuss psychological disengagement, defining it as "defensive detachment of self-esteem from outcomes in a particular domain, such that feelings of self-worth are not dependant on successes or failures in that domain" (p35). The processes of disengaging often occur in situations which poor performance is experienced or expected. Domains which are known to generate poor outcomes for stigmatised individuals can lead to a pre-emptive disengagement of self-esteem. This process was seen time and time again during this study. Women learned not to listen as a way of protecting themselves so that their experiences with their GPs, and other medical professionals, did not affect their self worth.

Oysterman and Swim (2001) suggest that not all responses to stigma centre on prevention. Rather they suggest that for some individuals, the focus is on trying to achieve a positive outcome, in spite of the discrimination, by trying harder, seeking out opportunity or trying another vantage point. The participants in this study put considerable effort into strategies

aimed at changing their interactions with medical professionals, and whilst it was not a positive strategy, 'learning not to listen' was definitely a mechanism they used in order to improve the situation. They didn't believe they could change or challenge the weight related discrimination they felt so they concentrated on changing themselves. Through the process of disengaging, learning not to listen, they were able to achieve a more positive outcome for themselves. Overall though, this was not a positive outcome because whilst it did serve participants in the short term, it also acted as a barrier to the relationship with their doctors.

The women in this study participated in processes which assisted them in the management of the issues associated with interacting with healthcare providers in a body which they perceived was the source of discrimination. At the heart of 'Learning to Manage' were participants' attempts to try and manage their stigmatised identities. People who are stigmatised are cognisant of the negative stereotypes of other individuals, which may influence the outcome of any given interaction (Crocker & Major, 1993). Prior *et al* (2003) suggests that the contemporarily the term stigma is used as more than a description of signs, rather it is used as an explanation of a diverse range of social processes. Byrne (2000) suggests that stigma has become a 'marker for adverse experiences' such as shame and blame, discrimination and isolation (p66).

Stigma management is a general part of society, a process occurring wherever there are identity norms (Goffman, 1963). For the women in this study, managing their stigma – and thus their stigmatised identities – were an everyday part of their experiences as healthcare consumers. Murray (2007) suggests that discourses around body types inform the way we make sense of each other, which in turn manages the way we interact with each other. She states "we manage our identities through perception – we believe we can come to know the essence of a person through the way they appear to us" (p363). For these participants, weight usually became the defining part of their identities as patients, subsequently becoming the focus of the interaction. Naue and Kroll (2008, p26) state that 'identity is formed by social processes' which in this research was the interactions between medical professional and large bodied women.

One of the significant challenges for these women, however, was that they felt that their identity was primarily constructed by their doctor based on the size of their body, and once they entered into a clinical consultation they had no part in the construction of how they were seen. If as Degher and Hughes (1999a) suggest, identity is constructed through the internalisation of social cues which convey negative messages about fat bodies, participants in this study are at a high risk of developing very poor health outcomes. The authors suggest that an interactionist perspective plays a significant role in identity theory. Contemporary identity theory focuses on the process of interactions between individuals and how this impacts of identity formation (p11). They define identity as “the internalisation of societal conceptions regarding specific statuses” (p19).

Major and O’Brien (2005, p359) depict stigma as an identity threat stating that “stigma is relationship- and context-specific; it does not reside in the person but in a social context”. Major and O’Brien (2005) propose an identity-threat model of stigma, which incorporates both the identity threat models of stigma and a transactional model of stress and coping. Major and O’Brien (2005) state that the identity threat model “assumes that possessing a consensually devalued social identity (a stigma) increases one’s exposure to potentially stressful (identity-threatening) situations” (p398). Below is the proposed identity threat model:

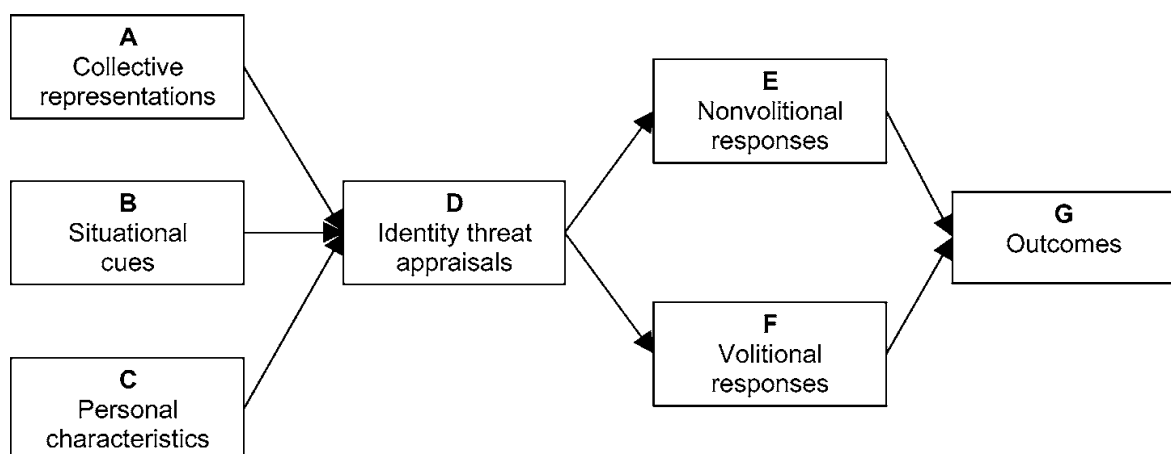


Figure 9. An identity-threat model of stigma

Collective representations, which the authors describe as the “shared understanding that members of stigmatised groups have based on the awareness that they are both socially

devalued” (p398), are unique to what each individual brings to a situation, meaning that situations are appraised differently by different people. These collective representations also impact how stigmatised individuals perceive and appraise ‘stigma-relevant’ situations (situational cues). The personal characteristics box refers to individual characteristics which can influence how situations are appraised and perceived. These include ‘stigma sensitivity’ (an individual’s sensitivity to stigma), ‘group identification’ (stigmatised individuals who view their stigmatised social identity as an integral component of their self-identity) , ‘domain identification’ (an individual’s identification with domains where their group is negatively stereotyped which increases their potential for identity threat due to their increased likelihood for regarding performance feedback in those areas as self-relevant) and ‘goals and motives’ (goals and motives of the individuals which influence how they perceive and appraise situations). Identity threat (*box D*) occurs when a person judges the demands of a stigma-relevant stressor (such as the doctor in a medical consultation) as holding the power to harm to her/his social identity, and as greater than her/his ability to cope with those demands. Responses to identity threat can be involuntary (*box E*) or voluntary (*box F*). Involuntary responses, such as fear or anticipation, are emotional, behavioural and physiological responses which do not serve to regulate. Voluntary responses are conscious coping efforts employed by individuals to regulate emotions, behaviour, and the environment. Lastly, the ‘Outcomes’ box refers to things such as self-esteem, academic achievement, and health.

Like the model proposed by Sobal (1991) to assist obese individuals cope with stigma, the model suggested by Major and O’Brien illustrates the chain of events which work to threaten the identity of people who are stigmatised. This model charts the processes involved in interacting with medical professionals for the women in this study. As illustrated in the results of this research, women experienced both involuntary and voluntary responses to identity threat when they were patients. They discussed at length the fear and anticipation associated with visiting their doctor, as well as the conscious efforts they used to try and regulate the way they responded to their interactions with their doctors. For the women in this study part of ‘learning to manage’ was learning to cope with the fat identity through which they felt they had been forcibly labelled. Participants felt that whenever they entered an encounter with a medical professional, that weight became the most dominant part of their health identity; something which they felt had no part and little power in constructing.

Walker et al (2007) discuss Goffman's views on self-concept. Goffman compared the experience of living to "a drama that takes place in the theatre of everyday life" (p27). According to this view, individuals' social roles can be viewed as roles in a play in which society is the stage. In order to maintain our role, we use various props to present the image we want to portray, a concept Goffman identified as "impression management". When an individual becomes a patient their everyday 'props' are usually stripped away, hence their normal social roles not be as apparent. Subsequently individuals use other strategies to communicate their roles and identities. In this study, women used strategies such as telling their doctors they had started losing weight, or had joined a gym, as a way of presenting a self which was responsible. Managing their identity in this way enabling them the treatment they felt they did not receive otherwise.

In order to cope with their stigma, the women in this study would try and downplay or avoid conversation about weight by talking about starting a diet or the fact that they had started losing weight. Crandall (2000) suggests that most people have experienced the devaluation, embarrassment and isolation of stigma and whilst this is a process actively avoided by most people, nearly everyone has also rejected or withdrawn from individuals who are stigmatised. Miller et al (1995, p1094) discuss research on self-affirmation, and they suggest that in order to overcome 'undesirable traits or behaviours' individuals use strategies to compensate. They state:

Research on self-affirmation suggests that stigmatised people, like anybody who face a threat to self-regard, will try to buttress the integrity of the self by focusing on or bolstering socially desirable aspects of the self. This suggests that obese people will emphasise aspects of themselves other than appearance when they interact in situations in which they believe their weight will be a handicap.

Whilst weight is something that cannot be concealed, such as with other disease stigmas, Goffman (1963) writes about the process of 'covering' as a way in which stigmatised individuals attempt to manage stigma. He states:

It is a fact that persons who are ready to admit possession of a stigma (in many cases because it is known about or immediately apparent) may none the less make a great effort to keep the stigma from looming large. The individuals' object is to reduce tension, that is, to make it easier for himself and the others to withdraw covert

attention from the stigma, and to sustain spontaneous involvement in the official content of interaction (p125).

Goffman (p127) suggests that for individuals living with a stigma, especially those with a physical handicap, may have to learn about the structure of interaction in order to learn about the lines within which they must reconstitute their conduct if they are to minimise the obtrusiveness of their stigma. From their efforts, then, one can learn about features of interaction that might otherwise be too much taken for granted to be noted. This is extremely pertinent to the participants in this study. Women had become adept at reading the interaction, and knew when to implement certain strategies in order to try and downplay their weight.

Crocker and Major (1989) have suggested that an explanation for why stigmatised persons do not suffer from a decrease in self-esteem is because the people whom are discriminating do not represent as a 'significant other' for the stigmatised group member. They refer to the seminal work of symbolic interactionists Cooley and Mead who believed that it is the appraisals of significant others which become incorporated into one's self view. Some sociologists argue that self-concept develops through interaction with others based on how we evaluate ourselves and our subsequent incorporation of these others' views into our self-concept (Crocker & Major, 1989, p610). This perspective holds that individuals interacting with specific individuals who devalue or discriminate against them may develop negative self-concepts. They also suggest that the development of a negative self-concept may occur if an individual is part of a culture which devalues them. The above work by Crocker and Major (1989) raises the issue which is overlooked in most contemporary obesity research conducted within medical research, pointing out that patients who inhabit large bodies have developed particular ways of coping with the world in which they live, which ultimately illuminates the defensive behaviour of overweight and obese patients. This is important to note when attempting to develop new ways to address the crisis of obesity. Most current interventions do not include a consideration for the role that living with stigma has had in the lives of obese patients. And addressing the stigma attached to obesity is important because as this research shows, the management of that stigma significantly changes the way patients interact with their doctors.

Addressing Health and Weight-related Stigma

Stigma has been well explored in research literature, particularly within disciplines such as psychology and sociology. Medical research does note the stigma associated with obesity, but without the critical intent that questions the cultural attitudes, social structures and organisations responsible for perpetrating anti-fat and discriminatory views. Within medical literature stigma the stigma experienced by obese individuals is largely addressed in reference to the potential for depression and anxiety in obese individuals due to the discrimination they experience. There has been little research conducted which investigates how stigmatised individuals, in this case obese women, interact with healthcare professionals, and engages with the system as a whole.

Komesaroff and Thomas (2007) suggest that there is a need for obesity research which has a focus on culture. They suggest that as we progress toward a more multidimensional approach to the problem of obesity, it is critical that the cultural dimension of obesity and the needs of overweight individuals are not excluded. Like others, Komesaroff and Thomas (2007) stress the importance of recognizing that there are many experiences of obesity which needs to translate through to a fine-tuning of clinical strategies to focus on the needs of individuals, suggesting that “doctors and policy-makers will need not only to speak effectively to each other, but also to find the language in which to speak with the community itself” (p289). They recommend that research needs to look at the cultural components underpinning the problem, as well as understanding the main health concerns of obese individuals and whether these needs are being met by health professionals.

Puhl and Heuer (2010) suggest that despite the work of some theorists which argue that stigma can work to encourage individuals to change that which is creating their stigmatisation, evidence in several areas fails to identify this line of thinking with obesity. For example, they argue that if this was the case, obesity rates would be shrinking, rather than increasing at a rapid rate. Secondly, they report that numerous studies have demonstrated that weight stigma actually leads to a decrease in physical activity and an increase in unhealthy eating, both things which are linked with weight gain. Puhl and Brownell (2003b, p213) recommend that:

A thorough understanding of weight stigma and its impact may be important to document the social and psychological consequences of

obesity, and may be central to revealing the totality of effects of excess weight on health and well-being.

Puhl and Brownell (2003b) undertook a review of existing theoretical and empirical literature in order to investigate reasons for the stigmatisation of obese individuals, as well as looking at ways through which to reduce weight bias. They stress the importance of developing weight stigma theories, suggesting that without stigma-reduction interventions obese individuals are isolated in their attempts to cope with prejudice. They also suggest that given the increasing numbers of obese individuals the impact of bias and discrimination on public health could be significant, becoming so widespread and acceptable that negative attitudes become an accepted at an institutional level. Puhl and Brownell (2003b) suggest that both social attribution theory and the social consensus model can provide a way of understanding more about weight related stigma. Other models which have been tested in relation to weight stigma also include Realistic Conflict Theory, Social Identity Theory, Integrated Threat Theory and evolutionary theories (Puhl and Brownell, 2003). Puhl and Brownell (2003b) suggest that within the field of weight bias the attribution approach has received the most empirical attention. Attribution theory is a dominant theory in social psychology which refers to the processes by which people understand relationships between cause and effect, and how they make judgements about responsibility and blame. According to Weiner et al (1988) attribution theory provides a framework in which to investigate stigma because it integrates perceptions of both actors and observers, as well as a variety of other behavioural responses such as personal motivation. Puhl and Brownell (2003) suggest that the attribution model of stigma is useful for its ability to provide explanation for why specific traits are attributed to obese individuals. Attribution theory predicts that individual's characteristics outside of one's control, such as height of eye colour, would not be stigmatised whereas as negative traits related to internal control could lead to weight stigma. These authors suggests that attribution theory could be helpful in helping to change attributions of controllability, thus reducing weight stigma and negative attitudes toward obese individuals.

Also relevant to a discussion on how to address weight related stigma, Weiss and Ramakrishna (2006) offer recommendations in regard to the importance of further research into health related stigma.

They suggested a list of research objectives which included:

- ◆ documenting the burden of stigma;
- ◆ investigating stigma in different contexts, and for different health conditions;
- ◆ Identifying determinants of stigma, and its impact on health policy and the experience on illness and behaviour;
- ◆ Evaluate change in stigma over time, and responses to social change and interventions
- ◆ Improve the knowledge about the nature and risk of target health problems so that policy and health laws can minimise stigma, and
- ◆ Develop unambiguous messages about complicated health problems and stigma.

Summary

This chapter has discussed the findings of the substantive theory ‘Learning to Manage’ in relation to existing extant literature. Existing literature has been used to support and discuss finding by focusing on the basic social psychological problem of ‘being defined’ and the basic social psychological process Learning to Manage’.

The findings of this research have significant ramifications on their health. Whilst it is easy to understand why women would want to tune out or not listen to advice which they felt was underpinned by moral beliefs, it is more frightening to think of what they might be missing, in terms of medical support and advice. With the growing population of individuals who are overweight and obese it now seems more critical than ever to find ways through which to ensure that what medical professionals, and indeed all health professionals, are communicating in the best way possible.

Cohen *et al* (2005) propose 5 unintended consequences of the focus on obesity. Firstly, they suggest that the focus on obesity and weight leads to an increase in the uptake of fad diets, rather than nutrition. They suggest that this is in part due to the global weight loss industries who promote the mindset where individuals aim to look better, instead of trying to feel better. Secondly, they posit that the focus on weight can seriously impact mental health due to the stigma which obese people face. Thirdly, they believe there is a mismatch between the medical and public ideas of what constitutes healthy weight, which can result in eating disorders. Fourthly, and pertinent to this research, they believe that the stigma associated with obesity can affect preventative health care. They argue, for

example, that feeling judged when having to be weighed by ones doctor is not an incentive or indeed conducive to progressing health. Lastly, they suggest that focusing on ‘obesity’ actually prevents the focus from focussing on developing healthy lifestyles. They believe that striving to achieve unrealistic ideals of thinness coupled with the societal obsession with weight loss is damaging to everyone, not just obese individuals due to the fact that not everyone can realistically achieve weight loss in the same way, due to genetics or social influences. They propose a social ecological approach to weight which takes into account the real lives of individuals, including focusing on healthy behaviours and healthy eating. They suggest that this approach decreases isolation and discrimination and addresses the broader context of people’s lives.

The following chapter presents a concluding summary of this research, including a statement addressing the research aims, an evaluation of this grounded theory, and a final summation of the research. The substantive theory will be evaluated against the criterion proposed by Charmaz (2006). Finally, recommendations for further research and implications for clinical practice will be discussed.

Chapter 9: Conclusion

‘Sometimes I look at my doctor and just think ‘I don’t know why I keep coming back to see you because I don’t listen to what you have to say anymore because I don’t trust you. (Emily)

Introduction

The purpose of this study was to develop a substantive theory of large bodied women’s interactions with healthcare providers. This research provides one explanation for the challenges faced by large bodied women when they interact with medical professionals and the strategies they developed in order to manage them. The substantive theory of ‘Learning to Manage’ illuminates both the basic social psychological problem shared by participants, and the basic social psychological processes participants used to manage the problems and issues they faced as large bodied healthcare consumers. The theory of ‘Learning to Manage’ situates the experience of these women within the current socio-medical constructions of obesity.

The previous chapters have presented both the findings of the research, as well as a discussion of the findings in relation to existing extant literature. This chapter will provide a statement addressing the achievement of the study aims, an evaluation of the grounded theory method used in this research, recommendations for research, healthy policy, practice and education, and a final summation of the research.

Achievement of Study Aims

This research was undertaken with the objective of expanding on understandings of overweight and obese female health care consumers through explicating and interpreting women’s understandings of their individual health experiences.

As stated in the first chapter of this thesis, the study aims were to:

- ◆ Gain insight into large bodied women as healthcare consumers.
- ◆ Develop an understanding of the shared social problem experienced by large bodied female healthcare consumers.
- ◆ Detail the basic social psychological processes used by large bodied female healthcare consumers which details the strategies they use to resolve the shared basic social problem.

Through the process of data collection and analysis, the basic social psychological problem of 'being defined' and the basic social psychological process of 'learning to manage' were identified and explained. The findings of this research were detailed firstly by describing the shared concerns of the participants (the basic social psychological problem), and secondly by elucidating the strategies that they used to manage the problems they faced (the basic social psychological process). Together, this has been developed to generate the substantive theory 'Learning to Manage'. As demonstrated within the body of this thesis, these aims have been achieved.

The Value of a Constructivist Approach to Grounded Theory

Starks and Trinidad suggest that grounded theorists develop 'explanatory theories of basic social processes studied in context' (2007, p 1372), and this has been the intention of this research. Reed and Runquist (2007) also suggest that grounded theory which is philosophically informed by symbolic interactionism will have a focus on identifying the social processes occurring in specific contexts, particularly focusing on the effect of roles, self-image and identity on how participants view their social realities. As stated previously, I have used grounded theory methods in a similar way to that which has been described by Charmaz. My grounded theory uses constructivist methods, and is informed by a symbolic interactionist theoretical perspective. Constructivism and symbolic interactionism are concerned with the study of how meaning and actions are constructed (Charmaz, 2003). One of the objectives of grounded theory methods, according to Charmaz, is to develop an abstract theoretical framework that explains the studied process (Charmaz, 2006).

Schreiber and Stern (2001) comment on the value of using grounded theory in order to understand how people manage their lives in the context of existing or potential health challenges. Crooks (2001, p 25) propose that “grounded theory gives us a picture of what people do, what their prime concerns are, and how they deal with these concerns”. She suggests that whilst evidence based nursing journals will publish the findings of qualitative research as scientific evidence, medical journals rarely do. At the time of writing she suggested that medicine was more concerned with frequency and outcomes, where individuals are ‘assumed in the mean’, rather than what individuals actually do (Crooks, 2001). Although almost a decade ago, medical journals still predominantly rely on quantitative research findings.

Maurer and Sobal (1999) advocate the use of a social constructionist perspective through which to research weight problems because it creates a focus on “how these problems are created, maintained, and promoted within various social environments” (p x). The benefits of constructionist research are that it focuses on processes, viewing social problems as the result of collective understandings and public definitions. This is particularly relevant to obesity, which is underpinned by both social and medical understandings. Maurer and Sobal (1999) argue that most weight related research has been conducted from an objectivist perspective, which tends to concentrate on patterns, prevalence and the severity of the problem. The objectivist stance, which still continues to hold privilege in terms of its power, they suggest views obesity as a social problem only in as much that body weight falls above medically defined norms.

Hallberg (2006) suggests that in constructivist grounded theory, the researcher presents the research as more of a story or narrative than as a theory. I have strived to present a combination of both, including both a theoretical understanding of the experiences of participants as well as the voices of women in narrative form.

Evaluating Grounded Theory

As cited previously in this study, I have used criterion proposed by Charmaz (2006) to address whether this study has met its aims. These criteria included credibility, originality, resonance and usefulness and will be addressed below.

Credibility

In a 2006 interview Charmaz stated that the ‘most important criterion for a good grounded researcher is credibility’ (Puddephatt, 2006). As I have stated previously in this work, people have questioned my ability to remain impartial given that I am researching a group of which I am a member. I have made no secret of the fact that I am a large bodied woman, however I am also a health professional and it is interesting to note that no one has questioned my ability for impartiality regarding my status as a member of the profession of which I belong. I consider that membership in both groups have shaped and continue to shape the way that I view myself, the participants in this research, the subject matter, and the way that I have written up this research. I am what Goffman (1963) describes as the “sympathetic other”. This sympathetic other is someone who shares the stigma, which makes me sympathetic and understanding to the stigmatised individual. I maintain now, as I did at the beginning of this research, that this has created a richer research product.

As introduced in the Methods chapter, Chiovitti and Piran (2003) address the notion of credibility as a method for enhancing rigour, suggesting that two ways of doing this are to use participant words in the theory and to document the personal ideas of the researcher through the use of memos or journaling. I have attempted to be as transparent as possible with the development of the theoretical ideas which eventually led to the construction of the substantive theory ‘Learning to Manage’, and have used these two methods as a way of lending credibility to this research. Excerpts of participant data have been used throughout this thesis to support the findings and discussion of analytical ideas. Additionally, I chose to include a Prologue chapter which introduced myself as the researcher and revealed my personal and professional background. I did this to provide the reader with a lens through which to understand the thesis.

Ultimately the credibility of this study can be judged by the depth of the constructed theory. Twenty two participants, identifiable as overweight and obese women, participated in in-depth interviews which led to the development of a rich substantive theory. This theory identified both the shared problems of the women in this study, as well as a range of specific behaviours employed by participants in order to try and overcome and neutralise the ramifications of ‘being defined’ by their large body size.

Originality

This work reveals that when overweight and obese women become health care consumers they engage in processes which help them *learn to manage* what they view as the negative consequences of their body size, such as feelings of invisibility and being judged.

Subsequently, the interaction then becomes an exercise in management of these issues, not in seeking advice and help from their doctor. There is very little health science research which documents the effect that having to manage weight stigma has on the clinical interaction, and the impact of this on the consumer. While other research has investigated the presence of weight stigma, very few studies have conducted in depth investigation into how women living in large bodies manage this as part of their interactions with medical professionals. The importance of acknowledging and addressing the presence of weight stigma within clinical interactions cannot be underestimated, and this research contributes new information to this topic. This study adds to the small amount of qualitative research which looks at weight stigma from the perspective of healthcare consumers whilst also illuminating the challenges that face medical professionals who interact and treat this population.

Charmaz (2006) also proposes the question as to whether there is a social and theoretical significance to the research. Given the increasing cultural and medical ramifications of overweight and obesity, the findings of this research are extremely important both to healthcare professionals and consumers. This research is also significant in that it contributes to a very small area of research.

Resonance

Resonance, as part of a criterion for evaluating grounded theory, questions whether the end product 'makes sense' to participants. This was particularly important to me as the researcher. So I ensured that from the outset of the research that I set mechanisms in place through which I kept in contact with several of the participants in order to gain their feedback about the ideas I was developing. Charmaz (2006) believes that resonance is increased through a combination of credibility and originality, which as described above has been achieved.

I was engaged in a continuous process of feeding back information to participants and bouncing ideas of them with several goals in mind. Firstly, I wanted to make every effort to ensure that the participants felt that the narrative and theory I was constructing was still connected to the information they had shared with me. Secondly, I wanted to try and develop a theory which gave something back to participants in the form of challenging ideas and creating new possibilities for the way they understood their interactions with medical professionals.

The concept of resonance also refers to whether the research has uncovered taken for granted meanings, something which I think this study has done. There is widespread acknowledgment of the fact that weight stigma and discrimination exists, and the construction of the substantive theory 'Learning to Manage' explicates some of which this manifests for consumers. It revealed the strategies that participants used in order to deflect the discrimination they experienced, which ultimately impeded the clinical interaction.

Usefulness

I have endeavoured to generate a theory which both reveals insights into this group of healthcare consumers and acts as a foundation for future research. This theory identified that large bodied women felt that being overweight or obese created a significant barrier to positive clinical interactions with their medical professionals. Given the global increase in anti-obesity interventions, and the continuing failure of these interventions, the findings of this research add new knowledge at a time when it is desperately needed. This study demonstrates the importance in recognising obesity as a multifaceted phenomenon.

The findings revealed the critical mismatch between what patients wanted versus what actually happened for them when they entered into medical consultations. Whilst there is a significant body of work which has investigated the management of stigmatised identities, the management of overweight and obesity as identities which hamper meaningful healthcare interactions remains under investigated. This research makes a new contribution to existing health science literature.

These findings have the potential to be extremely important for medical and other healthcare professionals. The small amount of literature which documents medical

professionals (and other healthcare professionals) attitudes toward overweight and obese patients, as well as patients experiences of interactions with medical professionals, reveal that this is not a relationship which is working. Research indicates that medical professionals do not hold favourable attitudes toward overweight and obese patients, whilst these same patients feel unsupported and judged by their doctors. The current research reveals the critical need to address the presence of weight related stigma.

Limitations

I believe that due to the nature of this research, which called for women to self-select, a certain type of woman was attracted. By this, I consider that women were attracted to this study that had something to say. Every kind of research, which calls for individuals to participate on a voluntary basis, attracts people who are either interested in the topic or who have experienced it firsthand. In this instance, the women involved in this research had experiences that they wanted to describe and discuss, both positive and negative. Participants were well aware of the discourse surrounding large bodies – whether it was medical, social or cultural. In fact, many people that I have encountered have suggested that this fact would have influenced the findings. My response to this is was of course it did. Medical professionals in particular have suggested that large bodied women, because of their experiences would not present a ‘balanced’ view of the issue. Another suggested that perhaps results would be skewed because this research project would draw ‘disgruntled’ women.

One criticism of the research came from a review board of a paper I submitted for presentation at a medical conference. The paper, whilst accepted, received comments directed at the sample which questioned whether the call for participants had ‘attracted a disgruntled type of woman’. Even though I didn’t have a particular opinion either way, from that point onwards I began to ask women why they wanted to be involved in the research. Some replied they wanted to help, others because they felt they had something to say, and some because they did have negative experiences. Cannon et al (1991) posit that qualitative inquiry is at risk of racial and social class biases because it’s commonly white, middle-class people who voluntarily participate in self-reflective, in depth studies. This was demonstrated in the current research, and is acknowledged as a potential limitation of this study.

On another occasion it was also suggested that I should try and make my sample more culturally diverse, as well as encouraging women representing lower socioeconomic groups to participate. I chose not to do this in the present study. Some were for reasons of time, or lack of time, and also because I didn't feel comfortable in specifically targeting women from a low socioeconomic population. As the researcher, I felt an innate sense of discomfort about the possibility of directly targeting particular groups of women in order to diversify my sample – this felt both unnatural and exploitative. Thus, the sample was not culturally diverse, which some might view as a limitation of the research. However it can be justified by not generalising the findings beyond the participants.

Recommendations

This research highlights a number of significant issues relevant to health and medical professionals, undergraduate education within the health sciences, and clinical practice. The recommendations below relate to areas of research, education and clinical practice.

Further study into weight related stigma in healthcare consumers

The findings of this study illustrate how damaging perceived or actual physician bias can be for consumers. The most critical recommendation that has emerged from this research is the need for further study to be conducted into obesity stigma in clinical settings, and the effect of both stigma and discrimination on overweight and obese patients. While there is recognition that overweight and obesity are social conditions which are subject to considerable levels of bias and discrimination, there has been limited attention to this paid in health and medical research. Further research is needed into the experience and prevalence of weight related stigma in healthcare consumers.

Further study into weight related stigma in medical and health professionals

While this study has focused on large bodied women's interactions with medical professionals, primarily their GPs, the implications for practice apply to all healthcare professionals who interact with patients. Although this study did not include interviews with medical professionals, there is a critical need for further research into how medical professional attitudes toward overweight and obese patients influence both the experience

and health outcomes for patients. This will promote a more complete picture which involves the perspective of both parties involved in the interaction. Given the increasing number of overweight and obese individuals it is critical that medical professionals take into account the powerful stigma attached to obesity and the effect that this can have in clinical interactions. Research which can provide detailed description of physician attitudes toward overweight and obese patients could play a significant role in illuminating the presence of biased attitudes within this population.

Further research into the General Practice management of obesity

It is critical, particularly given the increasing prevalence of obesity, to generate evidence which reveals more about the health experiences of large bodied consumers within the General Practice Setting. Given that this research has highlighted the importance of the primary care interaction, there is a need for a deeper understanding into how this relationship can be improved. GPs in particular are well positioned to play a critical role in the management of obesity, however little is known about their experiences of treating overweight and obese patients. It is

Qualitative Investigation into healthcare and weight stigma

Qualitative research, which has traditionally been under represented in this field of research, would be of particular value in elucidating detailed information about physician attitudes toward overweight and obese patients. Further qualitative research which investigates the management of stigma from a consumer perspective is needed.

Introduction of weight related stigma to Health Science curriculum

Fundamental to any successful change is the need to address the cultural context of the given issue or situation. Weight related stigma and discrimination needs to be introduced into undergraduate curriculum as a real and significant issue for both consumers and medical professionals. Similarly it is not just undergraduate students who require education around the impact and presence of weight stigma. Educators and clinicians who are involved in teaching also need to be aware of their own biases regarding weight because whilst there is recognition that obesity is a social conditions which is subject to considerable levels of bias and discrimination, there has been little recognition within the literature that healthcare educators and practitioners also hold discriminatory attitudes. In

order to create change then the implementation of units into undergraduate curricula which discuss and challenge weight stigma and bias, and which educate both undergraduate and practising clinicians, has to be a priority.

Adopting an embodied perspective to study weight stigma

The findings of this research highlight notions of embodiment, which is critical to developing a more holistic approach to the treatment of overweight and obese patients. Embodiment emphasises the role that the body has in shaping the mind, which is particularly relevant to discussion of bodies which have visible stigma. There is a whole field of work about embodiment, a sociological concept which refers to the experiences of living in one's own body. Wilde (1999) suggests that embodiment offers a way of thinking about the body and mind as a whole, as opposed to the Cartesian dualism perspective of the mind and body as separate entities. Rather, Wilde (1999) supposes that an embodied perspective suggests that no part of the human being can be separate from the rest, and that all parts of the body are essential to the human being, and that we "do not 'have' bodies, but we 'are' our bodies as body/subjects" (2003).

Participant's descriptions of their experiences of healthcare, namely General Practice, illustrate the separation between body and mind. Most GPs, according to participants treated a body as opposed to a whole person, a notion which has been well covered in health sociological research. In that way, this research reflects previous writings which have tended to issues of patients being treated just like bodies. Whilst this research was concerned primarily with healthcare environment, specifically the interactions women had with medical professionals, the embodied experience of living in a fat body makes up part of the context of this research. Using embodiment as a perspective to study the experiences of overweight and obese patients could be very helpful to health sciences. One of the assumptions underpinning the notion of embodiment is that there is not a split between mind and body; that all parts of the body make up a human being. Adopting an embodied perspective within research investigating stigmatised identities, such as for individuals who are overweight or obese, means situating the large body within world and acknowledging the cultural, social and medical forces that affect us all (Wilde, 1999); a perspective which remains marginalised within the health sciences.

Improving Authentic Clinical Communication

This research has highlighted the effect that weight stigma or discrimination can have in clinical consultations. The barriers to authentic clinical communication that have been highlighted in this research, such as the presence of stigma and the subsequent management of that stigma, illustrate the critical need for further investigation into this area. This research reveals that being an overweight or obese healthcare consumer was a barrier to beneficial interactions with medical professionals, and was emotionally destructive for participants. In many instances the consequences of perceived or actual weight related bias or discrimination prevented genuine interaction from occurring with medical professionals and instead the focus, for the participants, became about trying to manage and cope with the consequences of the interaction. Given the rising incidence of obesity, and the accompanying weight related stigma which shows no signs of abating, it is critical that stigma interventions are developed specifically for use within medical consultations.

This research identified a critical mismatch in how medical professionals are being advised to manage weight compared to how the participants wanted to be treated. Medical professionals are being advised that they should use opportunistic diagnosis of overweight or obesity when patients present for other issues. Meanwhile the women in this study revealed that their weight being raised as a topic of conversation when they were there for something completely unrelated was something which made them angry and upset. It is critical that future research address this in order to generate new information which can assist both physicians and patients.

Conduct further research into the coping strategies used by overweight and obese patients

Participants in this study used a number of strategies in order to try and manage their interactions with medical professionals. The strategies used by participants are echoed in the work of other studies which have investigated stigma management for overweight and obese patients. However, there is limited research on the coping mechanisms which overweight and obese patients use to manage stigma within clinical settings. Two of the key processes used by women in this study were conceptualised as ‘learning not to listen’ and ‘limiting expectations’. These were strategies which were intended to try and block

out the negative messages they received about their bodies. Unfortunately, a by-product of this strategy was a confessed lack of faith in medical professionals, which in turn minimised the uptake of advice provided to them about both weight and non-weight related issues. For a population already at risk, this can have significant ramifications. Research which investigates similar coping strategies to those used by the women in this research is urgently needed.

Development of weight related guidelines, which include stigma, for medical and healthcare professionals

Despite the development of national clinical guidelines for working with overweight and obese patients, very little attention has been given to weight related stigma within these guidelines. A key strategy to improving national guidelines and policies for working with overweight and obese patients would be the inclusion of a section which acknowledges the effect that weight related stigma and discrimination has on both the lives of those living in large bodies, and within the clinical encounter. Additionally, practical examples of ways in which medical professionals can talk to women about weight is critical to the success of national strategies.

Development of public health, primary health and tertiary obesity interventions which recognise weight stigma

There is a need to take into account issues of stigma and body image when designing and implementing campaigns aimed at addressing the obesity epidemic. To date, most interventions aimed at reducing obesity have failed. There is a need for a coordinated strategy through all levels of healthcare (whole of health approach – prenatal, aged care, community, and acute care). There needs to be a coordinated strategy within healthcare organisations which take weight related stigma into account when designing and implementing these initiatives. There is widespread recognition that prevention needs to be a driving force in the ‘fight’ against obesity. While there have been significant efforts made to combat the rising incidence of obesity, intervention strategies have largely failed to address the role that the socio-medical stigma and weight related discrimination play in the effectiveness and uptake of these interventions. Part of any intervention strategy then has to recognise and include the effect which obesity discrimination and weight stigma has on the clinical intervention or clinical communication.

Health service utilisation by overweight and obese consumers

While some literature suggests that obese patients use health services more than others, the findings of the current research suggest that this could be because they consumers that they often have to make several visits in order to get the help that they need. Further research is needed in order to investigate health service utilisation in overweight and obese patients.

Summary

The bodies in this study were considered bodies. These were bodies of women which had been and continued to be subject to critical gazes from a number of sources. Participants were torn by the dichotomies embedded in their large bodies, and this was evident in my interactions with them. Women wanted their doctors to acknowledge that their struggle with weight was a difficult and lifelong journey, but they didn't want weight to be the focus of every consultation. They wanted to be commended for losing weight, but not chastised for being overweight or obese. They appreciated and wanted support and advice, but they didn't want to be lectured. They wanted to be thinner, because in this culture they believed thinner was more socially accepted, but they also wanted to be accepted for who they were and how they looked. They wanted to be listened to, and they wanted to be seen. And they wanted to feel like they had a right to the same level of care that everyone else has – and by everyone, they meant women of 'normal weight'.

The women in this study experienced a strong conflict of desire regarding what they wanted and needed from their doctors. Women expressed time and time again that they wanted and needed to be viewed as more than just a fat body. However, they also wanted General Practitioners to be aware that fat is an issue which is imbued with negative meanings and that they deserved to be treated in a respectful and sensitive manner. In order for a real change to occur, there needs to be both an awareness and active engagement in the change process by both parties. For the large bodied women, there needs to be a willingness to lower their barriers and defences and talk honestly about weight. Achieving this was difficult and frightening if continually faced with medical professionals who approach their body it was diseased purely by virtue of its size. Likewise, medical professionals need to become cognisant of the fact that large bodies are stigmatised, and that they themselves might be agents of discrimination and bias.

The participants felt like the way they looked changed the way they were viewed and interacted with. Living with an identity which is intrinsically linked to something socially and medically undesirable was something which dramatically altered women's experiences as patients. It changed the way they planned for healthcare visits, their experience within the consultation, and how they processed their experiences after they had left. Unlike other 'diseases' in which patients can decide whether to reveal their disease or not, people living in large bodies do not have this choice. Because of their inability to hide their fatness, women felt they had little choice but to develop ways in which to manage the consequences of their embodiment.

The substantive theory of 'Learning to Manage' provides one explanation of how women cope with the problems associated with 'being defined' by their large body size as a healthcare consumer. The basic social psychological processes elucidated as 'learning to manage' revealed that for the women in this study managing their interactions with medical professionals was something that they all did in order to cope with the stigma and consequences of being in a body which they believed was viewed as medically unacceptable.

This research highlights the difficulties associated with managing weight in clinical settings, especially in the current health landscape where obesity is depicted as a major public health crisis. The value of this research is therefore threefold. Firstly, it makes a contribution to dialogue in which overweight and obese women remain a marginalised group. Secondly, this research makes a contribution to research in an area in which qualitative research remains secondary to quantitative investigation of weight stigma and bias. Thirdly, it highlights the critical role that weight related stigma plays in the interactions and outcomes between medical professionals and healthcare consumers. It is imperative that further research into obesity stigma within healthcare settings is conducted. Additionally, it is equally important to further explore the effect that experiencing weight – related discrimination in clinical settings has on the affected individuals. To continue viewing obesity within a purely medical framework will see the issues raised by participants in this study continue to occur. The current research demonstrates the importance of addressing obesity in a context that remains person centred and not disease focused.

Researcher Musings

I have always endeavoured to shake the oppression that is directed at women who live in large bodies. But it's hard – it's hard not to let the negativity overwhelm you. It's hard to remember that you don't believe in any of the words that you are hearing. It's hard to remember that just because you are fat, that somehow you are not a second-class citizen. (Stella)

The presence of discrimination and bias within the healthcare professions present an ugly and inconvenient truth. I doubt any profession wishes to confront the bigotry embedded within their own practice – particularly if one of their key messages (that excess weight is bad) is intrinsically linked to such damaging anti-fat attitudes.

In 1992 Esther Rothblum conducted an extensive literature review on women and weight. Based on her findings, she argued that it was time for large bodied women to be considered an oppressed minority group. When reading that I reacted against it, because it felt somehow disabling to that have that label applied to what I consider 'normal' women. However through the course of this study I have realised that what she was saying was really part of the context of this research. Large bodied women, despite being in the majority, are still a marginalised group and undertaking this research has reiterated to me the need to construct women living in large bodies as a group who do need consideration. Whilst I am aware that some within the fat acceptance movement would strongly react against this sentiment, in the context of the health sciences I believe that having large bodied women recognised as a group which experience significant prejudice would work to improve their experiences.

I have learnt a lot about myself during the course of this PhD, which I would consider is par for the academic course. I have emerged from this research changed in many ways. However what I wasn't expecting the depth of the change in me. I never expected it to be so difficult. For me, I think it would have been impossible to examine deeply the stories and feelings of women who share some of my experiences and not be unchanged. At times, I felt overwhelmed by the findings and emerging categories because of the emotions

it brought up for me, and at times I wondered whether I had made the right choice in choosing to undertake research in an area which is so personal to me. Despite having considered my own connection to a 'fat identity' in some depth, I was surprised time and time again at how multifaceted the web of managing a fat body was. Star (2007) described grounded theory as an emotional challenge and as a call for 'methodological maturity', and I think this project definitely called for both a methodological and emotional maturity.

Since I commenced this study the public hospital where I worked has gone from possessing one bariatric bed, to having a program which specifically addresses the needs of bariatric patients and the staff who look after them. Given that I was working as a registered nurse in an acute cardiothoracic environment when I started this research I believed that participants would talk about their hospital experiences. Ironically, women's experiences of hospitalisation remain largely unexplored in this study. Instead participants talked about their experiences of General Practice, particularly their relationships with their General Practitioners (GPs). GPs were identified by participants as the most significant person in their healthcare journey, largely I think because these were the group most frequently interacted with. For those women who had increased interaction with healthcare providers, such as women with chronic conditions, they also talked about their experiences of seeing specialists as well as of being hospitalised. Whilst most of the participants have depicted their relationships with GPs as their most significant concern, I believe that relationships with other healthcare providers are just as problematic, just less frequently mentioned in this research. Thus this research evolved into a thesis situated within the broader context of the health sciences, and not within nursing as I originally expected.

Wann (1999) suggests that there is nothing wrong with being fat and that like height or skin colour they are part of one's identity and birth right. I don't think that I could honestly say that any women in the study viewed their bodies as a part of their birth right that they were particularly proud of. Most of the women that took part in this study felt like their bodies were part of them that they had to constantly manage and try and control. Most of the women in this study had been involved in a constant cycle of weight reduction, with most not achieving long term success. And whilst I consider myself as an activist around weight related issues, not all the women in this research were. Embracing a fat identity is a deliberately political act, some may even say provocative. The personal is still political in

relation to body size. Choosing to lay claim to a fat identity is a political act, especially within a context such as healthcare where obesity is not regarded as desirable. There is evidence of scholarly discussion around the adoption of a 'fat' identity, which is a conscious choice made by some individuals in order to construct or reclaim a positive body image. However for the women in this study, they were not happy with being labelled, or having a fat identity forced upon them.

Many of the women in this research were not comfortable in being identified as 'bigger women' or whatever label they used to describe themselves. They didn't want to be always be labelled as a big woman before they were seen as anything else, and they didn't want to have to constantly think about how they were going to manage situations where there was a high risk of something being said to them. But this was their reality.

Widespread anti-fat attitudes and fat oppression have seen the birth of the fat acceptance movements. Groups such as the National Association to Advance Fat Acceptance (NAAFA), is a non-profit American organisation dedicated to improving the quality of life for fat people and to fight size related discrimination. NAAFA supports individuals classed as obese by the medical profession to accept their bodies, and works to disseminate what they deem 'responsible' information about being fat (NAAFA, 2007). The medical discourse regarding weight is largely negative, and according to participants in this study, one that is very predictable – if you are fat, you are unhealthy. However Henig (2008) and others have commented on the growing fat acceptance movement that questions this mindset, suggesting that that fatness may not be the root of all evil, and that health should be based on measures more meaningful than simply weight.

In 1995, self-identified fat activist Nomy Lamm wrote about her experience of life as a fat woman. She wrote 'sometimes I feel like my whole identity is wrapped up in my fat. When I am fully conscious of my fat, it can't be used against me'. This statement in some way reflects the strategies used by participants to manage their interactions with their GPs, although perhaps in a different way to which the author originally meant. Through their awareness of how past experiences had worked against them, the women had become conscious of how much their size impacted their interactions with medical professionals. In this context, if they were 'fully conscious' of their size, and consequently used the strategies they had developed, they felt then that they were more likely to been seen as a

whole person, and less likely to be totalised and passed off as '*just another fat woman*' (Emily).

I am not alone in arguing that obesity is a complicated health problem which presents a multitude of challenges for individuals and communities. It is important to note that the medical professionals discussed in this study aren't necessarily the villains. They are simply representative of a culture that has demonised fat. This research illustrates the problems with a purely medicalised approach to the body. Like other conditions, obesity has been medicalised to the point where the individual is now barely recognisable. Fat has become a barrier to being seen as individual.

Toward the end of my research I found a very prominent local surgeon looking at a poster detailing my research, including some preliminary findings. He asked me if it was my research, and I confirmed that it was, and he then looked at me and asked me if I was the girl in the photo on the poster (see below).



I said it wasn't and he then said 'it is my experience that most fat people tell lies'. Upon questioning, he elaborated that in his years of practice he rarely came across an overweight or obese person that told the truth about what they eat, what they weigh or the amount of physical activity that they do. I have reflected on this statement for several months now and whilst in some ways I found this very offensive there are parts of his comments which

now resonate with me. Given what I now know I do think that some large bodied patients probably DO tell lies to their doctors. Because they feel they have to. Similarly, I have always found it somewhat offensive when large bodied women are depicted as overly sensitive or defensive when it comes to their weight. There have been times during this research when I have been struck by the realisation that women *are* defensive about their weight – especially when one has what society sees as an excess of it. Again the feminist adage, the personal is political, rings true. Fat female bodies are political, and they are personal.

References

- Allman-Farinelli, M, King, L, Bonfiglioli, C & Bauman, A. (2006) *The Weight of Time: Time influences on overweight and obesity in women*, NSW Centre for Overweight and Obesity, Sydney. Accessed March 20, 2010.
- Annells, M. (2006) Triangulation of qualitative approaches: hermeneutical phenomenology and grounded theory. *Journal of Advanced Nursing*, **56**(1) 55 – 61.
- Appleton, J & King, L. (1997) Constructivism: A Naturalistic Methodology for Nursing Inquiry. *Advances in Nursing Science*, 20(2) 13 – 22.
- Appleton, J, & King, L. (2002) Journeying from the philosophical contemplation of constructivism to the methodological pragmatics of health services research. *Journal of Advanced Nursing*, **40**(6) 641 – 648.
- Aronne, L. (2004) Treatment of Obesity in the Primary care Setting, in, Wadden, T & Stunkard, A (eds), *Handbook of Obesity Treatment*, The Guildford Press, USA.
- National Preventive Health Taskforce 2010, *Australia: The Healthiest Country by 2020 – National Preventative Health Strategy – Overview*, viewed March 22, 2010
[http://www.health.nsw.gov.au/pubs/2006/spans/wot_womeninternet/preventativehealth/publishing.nsf/Content/AEC223A781D64FF0CA2575FD00075DD0/\\$File/nphs-overview.pdf](http://www.health.nsw.gov.au/pubs/2006/spans/wot_womeninternet/preventativehealth/publishing.nsf/Content/AEC223A781D64FF0CA2575FD00075DD0/$File/nphs-overview.pdf)
- Australian Institute of Health and Welfare (2006) *Australia's Health 2006*, AIHW cat. AUS 73. Canberra: AIHW.
- Avery, C. (1995) The Stigma of Chronic Pain, in Ballweg, M (ed) 1995, *The endometriosis sourcebook: the definitive guide to current treatment options, the latest research, common myths about the disease, and coping strategies- both physical and emotional*, Contemporary Books, USA.
- Ballweg, M. (ed) (1995) *The endometriosis sourcebook: the definitive guide to current treatment options, the latest research, common myths about the disease, and coping strategies - both physical and emotional*, Contemporary Books, USA.
- Banister, E & Schreiber, R. (2001) Young women's health concerns: revealing paradox. *Health Care for Women International*, **22**(7) 633 – 647.
- Barker, DJ & Barker, M. (2002) The body as art. *Journal of Cosmetic Dermatology*, 1(2) 88-93.
- Barkway, P. (2001) Michael Crotty and nursing phenomenology: criticism or critique. *Nursing Inquiry*, **8**(3) 191 – 195.
- Bayer, R. (2008) Stigma and the ethics of public health: Not can we but should we. *Social Science & Medicine*, **67**(3) 463–472.

- Benoliel, J. (1996) Grounded Theory and Nursing Knowledge. *Qualitative Health Research*, **6**(3) 406 – 428.
- Benzies, K. & Allen, M. (2001) Symbolic Interactionism as a theoretical perspective for multiple method research. *Journal of Advanced Nursing*, **33**(4) 541 – 547.
- Bertakis, K. & Azari, R. (2005) The Impact of Obesity on Primary Care Visits. *Obesity Research*, **13**, 1615–1623.
- Birks, M. & Mills, J. (2011) *Grounded Theory: A Practical Guide*, Sage Publications Ltd. London.
- Blumberg, P. & Mellis, L. (1985) Medical Students' Attitudes toward the Obese and the Morbidly Obese. *International journal of Eating Disorders*, **4**(2) 169-175.
- Blumer, H. (1969) *Symbolic Interactionism: Perspective and Method*, Prentice-Hall Inc, New Jersey.
- Bocquier, A., Verger P., Basdevant, A., Andreotti, G., Baretge, J., Villani P., & Paraponaris, A. (2005) Overweight and obesity: knowledge, attitudes, and practices of general practitioners in France. *Obesity Research*, **13**, 787–795.
- Bordo, S. (1993) *Unbearable weight: feminism, Western culture, and the body*, University of California Press, USA.
- Bovey, S. (1994) *Being Fat is not a Sin*. Pandora, London.
- Bray, G. (2002) The Underlying Basis for Obesity: Relationship to Cancer. *Journal of Nutritional Sciences*, **132**, 3451s - 3455s.
- Britt, H. & Miller, G (eds) (2009) *General Practice in Australia, health priorities and policy 1998 to 2008*. General Practice Series 24. Cat. GEP 24. Canberra: AIHW
- Britt H, Miller GC, Charles J, Henderson J, Bayram C, Pan Y, Valenti L, Harrison C, O'Halloran J, Fahridin S. (2010). General practice activity in Australia 2009-10. General practice series no. 27. Cat. no. GEP 27. Canberra: AIHW.
- Brown, J. (1990) *The science of human nutrition*, Harcourt Brace Jovanovich, USA.
- Brown, I. (2006) Nurses' attitudes towards adult patients who are obese: literature review. *Journal of Advanced Nursing*, **53**(2) 221 – 232.
- Brown, I. & Thompson, J. (2007) Primary care nurses' attitudes, beliefs and own body size in relation to obesity management. *Journal of Advanced Nursing*, **60**(5) 535–543.
- Brownell, K. (2005) Introduction – The Social, Scientific, and Human Context of Prejudice and Discrimination Based on Weight, in, Brownell, K, Puhl, R,

- Schwartz, M, & Rudd, L (eds), *Weight bias: nature, consequences, and remedies*, The Guilford Press, USA, 1 – 13.
- Puhl, R. & Brownell, K. (2003) Psychosocial origins of obesity stigma: toward changing a powerful and pervasive bias. *Obesity Reviews*, **4**(4), 213 – 227.
- Brownell, K. (1991) Dieting and the search for the perfect body: Where physiology and culture collide. *Behavior Therapy*, **22**(1) 1-12.
- Bryant, A & Charmaz, K. (eds.) (2007) *Handbook of Grounded Theory*. London: Sage.
- Buffart L, Allman-Farinelli, M. King, L. van der Ploeg, H. Smith, B. Kurko, J & Bauman, A. (2008) Are general practitioners ready and willing to tackle obesity management? *Obesity Research & Clinical Practice*, **2**(3) 189-194.
- Byrne, P. (2000) Stigma of mental illness and ways of diminishing it. *Advances in Psychiatric Treatment*, **6**, 65–72.
- Cade, J. & O'Connell, S 1991, Management of weight problems and obesity: knowledge, attitudes and current practice of general practitioners. *British Journal of General Practice*. **41**(345) 147–150.
- Campbell, K., Engel, H. Timperio, A., Cooper, C. & Crawford, D. (2000) Obesity Management: Australian General Practitioners' Attitudes and Practices. *Obesity Research*, **8**(6) 459 – 466.
- Cannon, L., Higginbotham, E & Leung, M. (1991) *Race and class bias in qualitative research on women*, Beyond methodology: Feminist scholarship as lived research, Indiana Press, Bloomington.
- Carpenter, D. (2003) Grounded Theory as Method. *Qualitative Research in Nursing: advancing the humanistic imperative*. H. J. Speziale and D. R. Carpenter, Lippincott Williams & Wilkins. USA.
- Catford, J & Caterson, I. (2003) Snowballing Obesity: Australians will get run over if they just sit there. *Medical Journal of Australia*, **179**, 577-579.
- Ceci, C, & McIntyre, M. (2002) A 'quiet' crisis in health care: developing our capacity to hear. *Nursing Philosophy*, **2**(2) 122-130.
- Chang, V & Christakis, N. (2001) Extent and Determinants of Discrepancy Between Self-evaluations of Weight Status and Clinical Standards. *Journal of General Internal Medicine*, **16**, 538 - 543.
- Chapple A, Ziebland, S. & McPherson, A. (2004) Stigma, shame, and blame experienced by patients with lung cancer: qualitative study. *British Medical Journal*, **328**, 1470 - 1473.
- Charmaz, K. (1990) 'Discovering' Chronic Illness: Using grounded theory. *Social Science Medicine*, **30**(11), 1161 – 1172.

- Charmaz, K. (2003) Qualitative Interviewing and Grounded Theory Analysis, in, Holstein, J, and Gubrium, J (eds) 2003, *Inside Interviewing: New Lenses, New Concerns*, Sage Publications Inc., USA, 311 – 330.
- Charmaz, K. (2003) Grounded Theory: Objectivist and Constructivist Methods, in, Denzin, N, & Lincoln, Y (eds – 2nd edition) *Strategies of Qualitative Inquiry*, Sage Publications, Inc., USA, 249-291.
- Charmaz, K. (1999) Keynote Address: Fourth Qualitative Health Research Conference Stories of Suffering - Subjective Tales and Research Narratives. *Qualitative Health Research*, **9**(3) 362 – 382.
- Charmaz, K. (2004) Keynote Address: Fifth International Advances in Qualitative Methods Conference – Premises, Principles, and Practices in Qualitative Research: Revisiting the Foundations. *Qualitative Health Research*, **14**(7) 976 – 993.
- Charmaz, K. (2005) Grounded Theory in the 21st Century: Applications for Advancing Social Justice Studies, in, Denzin, N, & Lincoln, Y (eds), 2005, *Sage Handbook of Qualitative Research*, Sage Thousand Oaks, UK.
- Charmaz, K. (2006) Constructing grounded theory: a practical guide through qualitative analysis, Sage Publications, USA.
- Charon, J. (1979) Symbolic Interactionism: An introduction, an interpretation, an Integration, Prentice-Hall Inc., Englewood Cliffs, NJ.
- Chenitz, W, & Swanson, J. (1986) *From Practice to Grounded Theory: qualitative research in nursing*, Addison-Wesley Publishing Company, USA.
- Chiovitti, R. & Piran, N. (2003) Rigour and grounded theory research. *Journal of Advanced Nursing*, **44**(4) 427–435.
- Clugston, G. & Smith, E. (2002) Global nutrition problems and novel foods. *Asia Pacific Journal of Clinical Nutrition*, **11**(56), S100 - S111.
- Cohen, L., Perales, D. & Steadman, C. (2005) The O Word: Why the Focus on Obesity is Harmful to Community Health. *Californian Journal of Health Promotion*, **3**(3) 154-161.
- Conrad, P. (1992) Medicalization and social control, *Annual Review of Sociology*, **18**, 209 - 232.
- Conrad, P. (2007) The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders, The John Hopkins University Press, USA.
- Cooper, C. (1997) Can a Fat Woman Call Herself Disabled? *Disability & Society*, **12**(1) 31 – 42.
- Cooper, C. (1998) *Fat and Proud: The Politics of Size*, The Women's Press Ltd. London.

- Cordell, G. & Ronai, C. (1999) Identity management among Overweight women – narrative resistance to Stigma, in, Sobal, J & Maura, D (eds), *Interpreting weight: the social management of fatness and thinness*, Transaction Publishers, 29-47.
- Cossrow, N. Jeffery, R., & McGuire, M. (2001) Understanding weight discrimination: a focus group study. *Journal of Nutrition Education*, **33**, 208–214.
- Coyne, I. (1997) Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries? *Journal of Advanced Nursing*, **26**, 623 – 630.
- Cowan, G. (1997) What Do Patients, Families and Society Expect From the Bariatric Surgeon? (A Keynote Address: Second Congress of the International Federation for the Surgery of Obesity). *Obesity Surgery*, **8**, 77-85.
- Crandall, C. (1991) DO heavy-weight students have more difficulty paying for college? *Personality and Social Psychology Bulletin*, **17**, 606 – 611.
- Crandall, C.(2000) Ideology and lay theories of stigma: the justification of stigmatization, in Heatherton, T F, Neck, RE, Hebl, MR, & Hull JG (eds.), *The social psychology of stigma*, Guilford Press, USA 126–150.
- Crawford, D. & Ball, K. (2002) Behavioural determinants of the obesity epidemic. *Asia Pacific Journal of Clinical Nutrition*, **11**, Issue Supplement s8, s718 – s721.
- Crocker, J. & Garcia, J. (2006) Stigma and the Social Basis of the Self: A Synthesis, in, Levin, S. & van Laar, C (eds) 2006, *Stigma and Group Inequality – Social Psychological Perspectives*, Lawrence Erlbaum Associates, Inc, Publishers, USA.
- Crocker, J. & Major, B. (1989) Social stigma and self-esteem: The self protective properties of stigma. *Psychological Review*, **96**, 608 – 603.
- Crocker, J. & Major, B. (1993) Reactions to Stigma: The Moderating Role of Justifications, in *The Psychology of Prejudice*, Zanna, M, & Olsen, J (eds), Psychology Press, United Kingdom, 289 – 314.
- Crooks, D. (2001) The importance of Symbolic Interactionism in Grounded Theory Research on Women’s Health. *HealthCare for Women International*, **22**, 11 – 27.
- Crossley, N. (2004) Fat is a Sociological Issue: Obesity Rates in Late Modern, ‘Body-Conscious’ Societies. *Social Theory & Health*, **2**(3) 222-253.
- Crotty, M. (1999) *The foundations of social research: meaning and perspective in the research process*, Allen & Unwin, Australia.
- Davis, L. (1995) *Enforcing normalcy: disability, deafness, and the body*, Biddles Ltd, Guildford and King’s Lynn, Great Britain.

- Degher, D. & Hughes, G. (1999) The adoption and management of a fat identity, in Maurer, D. & Jeffery Sobal (eds), *Interpreting Weight: The Social Management of Fatness and Thinness*, Aldine de Gruyter, New York.
- DeJong, W. (1980) The Stigma of Obesity: The Consequences of Naive Assumptions Concerning the Causes of Physical Deviance. *Journal of Health and Social Behaviour*, **21**, 75 – 87.
- Dilinie H. & Komesaroff, P. (2008) Being fat in today's world: a qualitative study of the lived experiences of people with obesity in Australia. *Health Expectations*, **11**, 321–330.
- Dixon, S. Currie, Peters, J. (2000) The cost of diabetes: time for a different approach? *Diabetic Medicine*, **17**, 820 - 822.
- Dixon, T. & Waters, A. (2003) *A growing problem: trends and patterns in overweight and obesity among adults in Australia, 1980 to 2001*, Australian Institute of Health and Welfare (AIHW): Bulletin 8. AIHW Cat. AUS 36. Canberra: AIHW.
- Dovidio, J., Major, B. & Crocker, J. (2000) Stigma: introduction and overview, in Heatherton, TF, Neck, RE, Hebl, MR & Hull, JG (eds.), *The social psychology of stigma*, Guilford Press, New York, 1–28.
- Draucker, C., Martsolf, D., Ross, R. & Rusk, T. (2007) Theoretical Sampling and Category Development in Grounded Theory. *Qualitative Health Research*, **17**, 1137 – 1148.
- Drury and Lewis (2002) Exploring the Association Between Body Weight, Stigma of Obesity, and Health Care Avoidance. *Journal of the American Academy of Nurse Practitioners*, **14**(12) 554–561.
- Duffy, K., Ferguson, C. & Watson H. (2004) Data collecting in grounded theory – some practical issues. *Nurse Researcher*, **11**(4) 67 – 78.
- Duscher, J. & Morgan, D. (2004) Grounded theory: reflections on the emergence vs. forcing debate. *Journal of Advanced Nursing*, **48**(6) 605 – 612.
- Eaves, Y. (2001) A synthesis technique for grounded theory data analysis. *Journal of Advanced Nursing*, **35**(5) 654 – 663.
- Fabricatore, A. Wadden, T. & Foster, G. (2005) Bias in Health Care Settings, in, Brownell, K, Puhl, R, Schwartz, M & Rudd, L (eds), *Weight bias: nature, consequences, and remedies*, The Guilford Press, USA, 29 – 41.
- Flavo, D. (2005) Medical and Psychosocial aspects of Chronic Illness and Disability, Jones and Bartlett Publishers, Inc, USA.
- Fagerhaugh, S. (1986) Analyzing data for basic social processes, in Chenitz, W, & Swanson, J (eds), 1986, *From Practice to Grounded Theory; qualitative research in nursing*, Addison-Wesley Publishing Company, California, 133-145.

- Fife B, & Wright, E. (2000) The Dimensionality of Stigma: A Comparison of Its Impact on the Self of Persons with HIV/AIDS and Cancer. *Journal of Health and Social Behavior*, **41**(1) 50-67.
- Filozof, C. Gonzalez, C, Sereday M, Mazza C, Braguinsky J. (2001) Obesity prevalence and trends in Latin-American countries. *Obesity Reviews*, **2**(2) 99 - 106.
- Finkelstein, E. Linnan, L. Tate, D. & Birken, B. (2007) A Pilot Study Testing the Effect of Different Levels of Financial Incentives on Weight Loss Among Overweight Employees. *Journal of Occupational and Environmental Medicine*, **49**(9) 981-989
- Fontaine, K & Barofsky, I. (2001) Obesity and health-related quality of life. *The International Association for the Study of Obesity: Obesity Reviews*, **2**, 173 - 182.
- Foster, G. Wadden, T. Makris, A. Davidson, D. Sanderson, R. Allison, D. & Kessler, A. (2003) Primary Care Physicians' Attitudes about Obesity and its Treatment. *Obesity Research*, **11**(10)1168 – 1177.
- Fryberg, S & Stephens, N. (2010) When the World Is Colorblind, American Indians Are Invisible: A Diversity Science Approach. *Psychological Inquiry*, **21**(2) 115 - 119
- Gadow, S. (1980) Body and Self: A Dialectic, *The Journal of Medicine and Philosophy*, **5**(3) 172 – 185.
- Gailey, J. & Prohaska, A. (2006) Knocking Off a Fat Girl: An Exploration of Hogging, Male Sexuality, and Neutralizations. *Deviant Behavior*, **27**(1) 31–49.
- Gallagher, S. (1996) Meeting the needs of obese patients. *American Journal of Nursing*, **96**(8) Su1S - 12S.
- Gard & Wright, (2005) *The Obesity Epidemic: Science, Morality and Ideology*, Routledge, London.
- Germov, J. & Williams. L. (1999) Dieting Women: Self-surveillance and the Body Panopticon, in, Sobal, J & Maurer, D (eds), *Weighty issues: constructing fatness and thinness as social problems*, Aldine De Gruyter, USA, 117 - 132.
- Gill, T, Antipatis, V & James, W. (1999) The global epidemic of obesity. *Asia Pacific Journal of Clinical Nutrition*, **8**(1) 75 - 81.
- Gill, T. (2002) Importance of preventing weight gain in adulthood. *Asia Pacific Journal of Clinical Nutrition*, **11**, SuS632 - S636.
- Glaser, B. & Strauss, A. (1967) *The Discovery of Grounded Theory*, Sage Publications, Chicago.
- Glaser, B. (1978) *Theoretical Sensitivity*, The Sociology Press, USA.

- Glaser, B. (1999) Keynote address from the fourth annual qualitative health research conference. *Qualitative Health Research*, **9**(6) 836–845.
- Glaser, Barney G. (2002). Constructivist Grounded Theory? [47 paragraphs]. Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, 3(3), Art. 12, <http://nbn-resolving.de/urn:nbn:de:0114-fqs0203125>.
- Germov, J. (2009) *Second Opinion* (4th edition), Oxford University press, South Melbourne.
- Goffman, E. (1963) *Stigma: Notes on the management of a spoiled identity*, Prentice-Hall Inc., New Jersey.
- Goffman, E. (1997) Selections from *Stigma*, in, Lennard, D (ed) 1997, *A Disability studies reader*, Routledge, Great Britain. 203 – 216.
- Goodman, C. (1995) *The Invisible Woman: Confronting Weight Prejudice in America*, Gurze Books, USA.
- Greer, G. (1999) *The Whole Woman*, Random House Australia, Milsons Point.
- Gremillion, H. (2005) The Cultural Politics of Body Size. *Annual Review of Anthropology*, **34**, 13–32.
- Grytten, N, & Måseide P. (2005) What is expressed is not always what is felt: coping with stigma and the embodiment of perceived illegitimacy of multiple sclerosis. *Chronic Illness*, **1**, 231–243
- Guba, E, & Lincoln, Y. (2005) Paradigmatic controversies, contradictions, and emerging confluences, in Denzin, N, & Lincoln, Y (eds), *The Sage Handbook of Qualitative Research Third Edition*, Sage Publications Inc., USA, 191-216.
- Hahn, R, & Kleinman, A.(1983) Biomedical Practice and Anthropological theory: frameworks and directions. *Annual Review of Anthropology*, **12**, 305 – 33.
- Harvey, E. & Hill, A. (2001) Health professionals' views of overweight people and Smokers. *International Journal of Obesity*, **25**, 1253 – 1261.
- Harvey, E. Glenny, A. Kirk, S. & Summerbell, C. (2002) An updated systematic review of interventions to improve health professional management of obesity. *The International Association for the Study of Obesity: Obesity reviews*, **3**, 45 - 55.
- Hauck, K. & Hollingsworth, B. (2010) The Impact of Severe Obesity on Hospital Length of Stay. *Medical Care*, **48**, 335–340.
- Heath, H. (2006) Exploring the influences and use of literature during a grounded theory study. *Journal of Nursing Research*, **11**(6) 519 – 528.

- Hebl, M. & Kleck R 2002, Acknowledging One's Stigma in the Interview Setting: Effective Strategy or Liability? *Journal of Applied Social Psychology*, **32**(2), 223-249.
- Herndon, A. (2002) Disparate But Disabled: Fat Embodiment and Disability Studies. *NWSA Journal*, **14**(3) 120-137.
- Herndon, A. (2005) Collateral Damage from Friendly Fire?: Race, Nation, Class and the War Against Obesity. *Social Semiotics*, **15**(2), 127-141.
- Hood, J. (2007) Orthodoxy vs Power: The Defining Traits of Grounded Theory, in, Bryant, A. & Charmaz, K (eds) 2007, *The Sage Handbook of Grounded Theory*, Sage Publications, London.
- Holm, K., Li., S. Spector., N. Hicks., F. Carlson., E. & Lanuza, D. (2001) Obesity in adults and children: a call for action. *Journal of Advanced Nursing*, **36**(2) 266 – 269.
- Holland, J., Kelly, B. & Weinberger, M. (2010) Why Psychosocial Care is Difficult to Integrate into Routine Cancer Care: Stigma is the Elephant in the Room. *Journal of the National Comprehensive Cancer Network*, **8**(4) 362 – 366.
- Hughes, J. & Martin, S. (1999) The Department of Health's project to evaluate weight management services. *Journal of Human Nutrition and Dietetics*, **12**, 1-8.
- Huizinga, M., Cooper, L. Bleich, S., Clark, J., & Beach, M 2009, Physician Respect for Patients with Obesity. *Journal of General Internal Medicine*, **24**(11)1236-9.
- James, A. & Hockney, J. (2007) *Embodying Health Identities*, Palgrave Macmillan, United Kingdom.
- James, W. (2008) The epidemiology of obesity: the size of the problem (Review). *Journal of Internal Medicine*, **263**, 336-352.
- Jeon, Y. (2004) The application of grounded theory and symbolic interactionism. *Scandinavian Journal of Caring Sciences*, **18**, 249 – 256.
- Joachim, G. & Acorn, S. (2000) Stigma of visible and invisible chronic conditions. *Journal of Advanced Nursing*, **32**(1) 243- 248.
- Johnson, C. (2004) Obesity, Weight Management, and Self- Esteem, in, Waddem, T.& Stunkard, A (eds), *Handbook of Obesity Treatment*, The Guildford Press, USA.
- Jonassen, D. (1991) Objectivism versus constructivism: Do we need a new philosophical paradigm? *Educational Technology Research and Development*, **39**(3) 5-14.
- Jones, M. Kriflik, G. & Zanko, M. (2005) Grounded Theory: A theoretical and practical application in the Australian Film Industry 2005, accessed 7th March 2009, <http://ro.uow.edu.au/commpapers/46>

- Jutel, A. (2001) Does Size Really Matter? Weight and Values in Public Health. *Perspectives in Biology and Medicine*, **44**(2) 283 - 296.
- Jutel, A. (2005) Weighing Health: The Moral Burden of Obesity. *Social Semiotics*, **15**(2) 113 – 125.
- Kai-Cheong Chan & Gillick, A. (2009) Fatness as a disability: questions of personal and group identity. *Disability & Society*, **24**(2) 231-243.
- Kaminsky, J. Gadaleta, D. (2002) A Study of Discrimination within the Medical Community as Viewed by Obese Patients, *Obesity Surgery*, **12**, 14-18.
- Kern, S. (1975) *Anatomy and Destiny: A cultural history of the human body*, Bobbs-Merrill Company, New York.
- Kipnis, L. (1998) Fat and Culture, in, Dirks, N (ed) 1998, *In near ruins: cultural theory at the end of the century*, University of Minnesota Press, USA.
- Kirby, S. (2007) The contextual researcher: celebrating ‘experiential alertness’ in grounded theory in prison research. *Nurse Researcher*, **14**(2) 51- 65.
- Klugman, D. (1997) Existentialism and Constructivism: a Bi-polar model of subjectivity. *Clinical Social Work Journal*, **25**(3) 297 – 313.
- Kohlenberg, B. Watkins, M. & Fletcher, L. (2008) Stigma and Medicine, in, Guerrero, A. & Piasecki, M. (eds). *Problem-Based Behavioral Science and Psychiatry*, Springer Science + Business Media LLC, USA.
- Kolotkin, R. Meter, K. Williams, G. (2001) Quality of life and obesity. *Obesity Reviews*, **2**, 219 - 229.
- Komesaroff, P & Thomas, S. (2007) Combating the obesity epidemic: cultural problems demand cultural solutions. *Internal Medicine Journal*, **37**, 287–289.
- Kosofsky Sedgwick, E. (1993) *Tendencies*, Duke University Press, USA.
- Kulick , D & Meneley, A. (2005) *Fat: The Anthropology of an Obsession*, New York.
- Kwan, S. (2009) Framing the Fat Body: Contested Meanings between Government, Activists and Industry. *Sociological Inquiry*, **79**(1) 25–50.
- Lamm, N. (1995), It’s a Big Fat Revolution, <http://www.tehomet.net/nomy.html>
- Latner J, O’Brien, K. Durso, L. Brinkman L.& MacDonald,T. (2008) Weighing Obesity stigma: the relative strength of different forms of bias. *International Journal of Obesity*, **32**, 1145–1152
- Lawler, J. (1991) *Behind the Screens: Nursing, Somology and the Problem of the Body*, Churchill Livingstone Melbourne.

- Lazarus, R. (1999) *Stress and Emotion*, Springer Publishing Company, Inc., USA.
- Lebesco, K. (2004) *Revolting bodies?: the struggle to redefine fat identity*, University of Massachusetts Press, United States of America.
- Lempert, L. (2007) Asking Questions of the Data: Memo Writing in the Grounded Theory Tradition, in, Bryant, A, & Charmaz, K (eds) 2007, *The Sage Handbook of Grounded Theory*, SAGE Publications, London.
- Lupton, D. (1997) Foucault and the medicalisation critique, in, Peterson, A & Bunton R (eds), *Foucault: Health and Medicine*, Routledge, USA.
- MacDonald, M. (2001) Finding a Critical Perspective in Grounded Theory, in, Schreiber, R, & Stern, P (eds) 2001, *Using Grounded Theory in Nursing*, Springer Publishing Company, USA.
- Mallory, C.(2001) Examining the Differences Between Researcher and Participant: An Intrinsic Element of Grounded Theory, in, Schreiber, R & Stern, P (eds) 2001, *Using Grounded Theory in Nursing*, Springer Publishing Company, USA.
- Major, B & O'Brien, T. (2005) The Social Psychology of Stigma. *Annual Review of Psychology*, **56**, 393–421.
- Major, B., Spencer, S., Schmader, T., Wolfe, C. & Crocker, J. (1998) Coping with Negative Stereotypes about Intellectual Performance: The Role of Psychological Disengagement., *Personality and Social Psychology Bulletin*, **24**, 34 – 50.
- Malterud, K, Candib, L, & Code, L. (2004) Responsible and responsive knowing in medical diagnosis: the medical gaze revisited. *Nordic Journal of Feminist and Gender Research*, **12**, 1 8-19.
- Marsh, P., & Bradley S. (2004) Sponsoring the obesity crisis. Social issues research centre. Available from URL: http://www.sirc.org/articles/sponsoring_obesity.shtml Accessed May 29, 2010.
- Maurer , J. & Sobal, J. (1999) The Social Management of fatness and Thinness, in Sobal, J & Maurer, D (eds) 1999, *The Social Management of fatness and Thinness*, Walter Gruyter, Inc., New York, 3 – 10.
- McCallin, A. (2003) Designing a grounded theory study: some practicalities. *Nursing in Critical Care*, **8**(5) 203 – 208.
- McDonald, C., & McIntyre, M. (2002) Women's health, women's health care: complicating experience, language and ideologies. *Nursing Philosophy*, **3**(3) 260 – 267.
- McGhee, G., Marland., G., & Atkinson, J. (2007) Grounded Theory Research: literature reviewing and reflexivity. *Journal of Advanced Nursing*, **60**(3) 334 – 342.

- McKinley, N. (1999) Ideal Weight/Ideal Woman: Society Constructs the Female, in, Sobal, J & Maurer, D (eds), *Weighty issues: constructing fatness and thinness as social problems*, Aldine De Gruyter, USA. 97 – 116.
- Milliken, J., & Schreiber, R. (2001) Can You ‘Do’ Grounded Theory Without Interactionism? in, Schreiber, RS & Stern, PN (eds), *Using grounded theory in nursing*, Springer, New York, 177-190.
- Miller, B., & Lundgren, J. (2010) An Experimental Study of the Role of Weight Bias in Candidate Evaluation. *Obesity*, **18**(4) 712–718.
- Miller, CT., Rothblum, ED, Felicio, D, & Brand, P. (1995) Compensating for stigma: Obese and nonobese women’s reactions to being visible. *Personality and Social Psychology Bulletin*, **21**, 1093–1106.
- Mills, J., Bonner A, & Francis, K. (2006a) Adopting a constructivist approach to grounded theory: Implications for research design. *International Journal of Nursing Practice*, **12**, 8 – 13.
- Mills, J., Bonner, A, & Francis, K. (2006b) The Development of Constructivist Grounded Theory. *International Journal of Qualitative Methods*, **5**(1), 1 – 10.
Retrieved [date] from http://www.ualberta.ca/~iiqm/backissues/5_1/pdf/mills.pdf
- Morse, J. (2001) Situating grounded theory within qualitative inquiry, in, Schreiber, RS & Stern, PN (eds), *Using grounded theory in nursing*, Springer, New York, 1-15.
- Morse, J. (2010) Sampling in Grounded Theory, in Bryant, A & Charmaz, K (eds), *The Sage Handbook of Grounded Theory*, Sage Publications, London, 229 – 245.
- Muller, M., Mast M., Asbeck, I., Langnäse, K. & Grund, A. (2001) Prevention of obesity - is it possible? *Obesity Reviews*, **2**, 15 - 28.
- Murray, S. (2005) (Un/Be) Coming Out? Rethinking Fat Politics. *Social Semiotics*, **15**(2) 153 –163.
- Murray, S. (2007) Corporeal Knowledge and Deviant Bodies: Perceiving the Fat Body. *Social Semiotics*, **17**(3)361 – 373.
<http://www.informaworld.com/smpp./title~db=all~content=t713446841~tab=issueslist~branches=17-v17>.
- Murray, S. (2009) The Pathologisation of Obesity: Positioning ‘Fatness’ in our Cultural Imaginary, in Wright, J & Harwood, V (eds), *Biopolitics and the Obesity Epidemic: Governing Bodies*, Routledge, London, 78 – 90.
- Nankervis, A., Conn, J., & Knight, L. (2006) Obesity and reproductive health: Further complications of the ‘obesity epidemic’. *Medical Journal of Australia*, **184**(2) 51.
- National Association for the Advancement of Fat Acceptance, 2007, NAAFA Information Index, <http://www.naafa.org/documents/brochures/naafa-info.html#whatis> October 2007.

- National Health and Medical Research Council, Overweight and Obesity in Adults and Australia: A Guide for General Practitioners, Canberra, 2003a.
- National Health and Medical Research Council, Clinical Practice Guidelines for the Management of Overweight and Obesity in Adults. Canberra: NHMRC, 2003b.
- Naue, U & Kroll, T. (2008) The demented other: identity and difference in dementia. *Nursing Philosophy*, **10**(1) 26 – 33.
- Norton, L. (1999) The philosophical bases of grounded theory and their implications for research practice. *Nurse Researcher*, **7**(1) 31-43.
- O'Brien, P, Dixon, JB, & Brown, W. (2004) Obesity is a surgical disease: overview of obesity and bariatric surgery. *ANZ Journal of Surgery*, **74**, 200-204.
- O'Brien, P., Brown, W., & Dixon, J. (2005) Obesity, weight loss and bariatric surgery. *Medical Journal of Australia*, **183**(6) 310 – 314.
- Oliver, J. (2006) *Fat politics: the real story behind America's obesity epidemic*, Oxford University Press, USA.
- Olsen, C., Schumaker, H., & Yawn, B. (1994) Overweight Women Delay Medical Care. *Archives of Family Medicine*, **3**, 888–892.
- Orbach, S. (1990) *Fat is a feminist issue*, Berkley, USA.
- Orbach, S. (2009) *Bodies*, Picador, USA.
- Oyserman, D., & Swim, J. (2001) Stigma: An Insider's View. *Journal of Social Issues*, **57**(1), 1–14.
- Parker, R. & Aggleton, P. (2003) HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action. *Social Science and Medicine*, **57**(1), 13 – 24.
- Pasquali, R., Patton, L., & Gambineri, A. (2007) Current Opinion in Endocrinology, Diabetes and Obesity. *Reproductive endocrinology*, **14**(6) 482-487.
- Peters, J. (2002) The challenge of managing body weight in the modern world. *Asia Pacific Journal of Clinical Nutrition*, **11**, Supp S714 - S717.
- Pescosolido, B., Martin, J., Land, A. & Olafsdottir, S. (2008) Rethinking theoretical approaches to stigma: A Framework Integrating Normative Influences on Stigma (FINIS). *Social Science & Medicine*, **67**, 431–44.
- Phelan, J., Link, B., & Dovidio, J. (2008) Stigma and prejudice: One animal or two? *Social Science and Medicine*, **67** (3) 358 – 367.

- Phillips, P. (2002) The rising cost of healthcare: can demand be reduced through more effective health promotion? *Journal of Evaluation in Clinical Practice*, 8(4) 415 - 419.
- Philipson, T. (2001) The World-Wide Growth in Obesity: An Economic Research Agenda. *Health Economics*, 10(1) 1 - 7.
- Pilnick, A., Hindmarsh, J., & Gill, V. (2009) Beyond 'doctor and patient': developments in the study of healthcare interactions. *Sociology of Health & Illness*, 31(6) 787–802.
- Poon, M., & Tarrant, M. (2009) Obesity: attitudes of undergraduate student nurses and registered nurses. *Journal of Clinical Nursing*, 18, 2355–2365.
- Prior, L., Wood, F., Lewis, G., & Pill, R. (2003) Stigma revisited, disclosure of emotional problems in primary care consultations in Wales. *Social Science & Medicine*, 56, 2191–2200.
- Puddephatt, A. (2006) An Interview with Kathy Charmaz: On Constructing Grounded Theory. *Qualitative Sociology Review*, 2(3) 5 – 20.
- Puhl, R. (2008) Weight stigmatization and bias reduction: perspectives of overweight and obese adults. *Health Education Research*, 23(2) 347–358.
- Puhl, R., & Brownwell, K. (2001) Bias, discrimination, and obesity. *Obesity Research*, 9, 788–805.
- Puhl, R. & Brownell, K. (2003) Psychosocial origins of obesity stigma: toward changing a powerful and pervasive bias. *Obesity Reviews*, 4, 213–227.
- Puhl, R., & Brownell, K. (2006a) Confronting and Coping with Weight Stigma: An Investigation of Overweight and Obese Adults, *Obesity*, 14(10) 1803 – 1815.
- Puhl, R., Henderson, K & Brownell, K. (2006b) Social consequences of obesity, in, R Kopleman, P., Caterson, I. & Dietz, W (eds) 2006, *Clinical Obesity in Adults and Children* (second edition), Blackwell Publishing Ltd, USA.
- Puhl, R., & Heuer, C. (2009) The Stigma of Obesity: A Review and Update. *Obesity*, 17, 941 – 964.
- Puhl, R., & Heuer, C. (2010) Obesity Stigma: Important Considerations for Public Health. *American Journal of Public Health*, 100, 1019–1028.
- Pursely-Crotteau, S., Bunting, S., & Draucker, J. (2001) Grounded Theory and Hermeneutics: Contradictory or Complementary Methods of Nursing Research, in, Schreiber, R, & Stern, P (eds) 2001, *Using Grounded Theory in Nursing*, Springer Publishing Company, USA.
- Pyles, S., & Stern, P. (1983) Discovery of a nursing gestalt in critical care nursing: The importance of the gray Gorilla Syndrome. *Image: Journal of Nursing Scholarship*, 15(2) 51 – 58.

- Reed, P., & Runquist, P.(2007) Reformulation of a Methodological Concept in Grounded Theory. *Nursing Science Quarterly*, **20**(2) 118-122.
- Resnicow, K., Davis, R. & Rollnick, S. (2006) Motivational Interviewing for Paediatric Obesity: Conceptual Issues and Evidence Review. *Journal of the American Dietetic Association*, **106**, 2024-2033.
- Rich, E., & Evans, J. (2005) ‘Fat Ethics’ – The Obesity Discourse and Body Politics. *Social Theory & Health*, **3**, 341–358.
- Ritenbaugh, C. (1982) Obesity as a culture-bound syndrome. *Culture, Medicine and Psychiatry*, **6**, 347–361.
- Robinson, B., Bacon, J. & O'Reilly, J. (1993) *Fat* phobia: Measuring, understanding, and changing *anti-fat* attitudes. *The International Journal of Eating Disorders*, **14**, 467-480.
- Rothblum, E. (1992) The Stigma of Women’s Weight: Social and Economic Realities. *Feminism and Psychology*, **2**(1) 61 – 73.
- Royal College Smoking, Nutrition, Alcohol and Physical activity (SNAP): A population health guide to behavioural risk factors in general practice. 2004. The Royal Australian College of General Practitioners, South Melbourne.
- Rudd Center for Food Policy & Obesity, 2008, accessed 6th December 2009, http://learn.med.yale.edu/rudd/weightbias/overview_intro.asp enter for Food Policy
- Sands, E., & Wardle, J. (2003) Internalization of ideal body shapes in 9–12 year old girls. *International Journal of Eating Disorders*, **33**(2), 193–204.
- Santry, H. (2005) Trends in Bariatric Surgical Procedures. *Journal of the American Medical Association*, **294**(15) 1909 – 1917.
- Schamder, T., Major, B. & Gramzow, R. (2001) Coping with ethnic stereotypes in the academic domain: Perceived injustice and psychological disengagement. *Journal of Social Issues*, **57**(1) 93 – 11.
- Schroeder, M. (1981) Symbolic Interactionism: A Conceptual Framework Useful For Nurses Working with Obese Persons – how personal values, interactions, and relationships after weight loss. *Journal of Nursing Scholarship*, **13**(3)78 – 81.
- Schreiber, R. (2001), The ‘How To’ of Grounded Theory: Avoiding the Pitfalls, in, Schreiber, R & Stern, P (eds) 2001, *Using Grounded Theory in Nursing*, Springer Publishing Company, USA, 55 – 84.
- Schreiber, R., & Stern, P. (2001) Preface, in, Schreiber, R & Stern, P (eds) 2001, *Using Grounded Theory in Nursing*, Springer Publishing Company, USA, xiii – xiv.

- Schwartz, M., Vartanian, L., Nosek, B., and Brownell, K. (2006) The influence of one's own body weight on implicit and explicit anti-fat bias. *Obesity*, **14**, 440–447.
- Schwartz, M., Chambliss, H., Brownell, K., Blair, S., & Billington, C. (2003) Weight bias among health professionals specializing in obesity. *Obesity Research*, **11**, 1033–9.
- Schwandt, T. (1998) Constructivist, Interpretivist Approaches to Human Inquiry, in, Denzin, N & Lincoln, Y (eds), *The Landscape of Qualitative Research: Theories and Issues*, Sage Publications, Inc., USA: 221 – 260.
- Scott, J., Cohen, D., DiCicco-Bloom, B., Orzano, A., Gregory, P., Flocke, S., Maxwell, L, & Crabtree, B. (2004) Speaking of weight: how patients and primary care clinicians initiate weight loss counselling. *Preventative Medicine*, **38**(6) 819 – 827.
- Semple, C., Chehata, A., Wilkinson, S., & Wertheimer, M. (2003) Laparoscopic adjustable gastric banding: initial Tasmanian experience. *ANZ Journal of Surgery*, **73**(8) 594 – 596.
- Serdula, MK, Kettel Khan, L, & Dietz, W. (2003) Weight Loss Counselling Revisited. *Journal of the American Medical Association*, **289**(14) 1747.
- Sesko, A & Biernat, M. (2010) Prototypes of race and gender: The invisibility of Black women, *Journal of Experimental Social Psychology*, **45**(6) 1165-1172.
- Shelton, JN, Richeson, JA & Salvatore, J. (2005) Expecting to be the target of prejudice, Implications for interethnic interactions. *Personality and Social Psychology Bulletin*, **31**, 1189-1202.
- Shih, M. (2004) Positive Stigma: Examining Resilience and Empowerment in Overcoming Stigma. *The Annals of the American Academy of Political and Social Science*, **591**, 175.
- Shortus, T., Rose, V., Comino, E. & Zwar, N. (2005) Patients' views on chronic illness and its care in general practice. *Australian Family Physician*, **34**(5) 397 – 399.
- Silverstein, B., Peterson, B., & Purdue, L. (1986). Some correlates of the thin standard of physical attractiveness in women. *International Journal of Eating Disorders*, **5**, 898–905, in, Wardle, E. & Wardle, J. (2003) Internalization of Ideal Body Shapes in 9–12-Year-Old Girls, *International Journal of Eating Disorders*, **33**(2) 193–204.
- Simpson, K. (2002) Anorexia nervosa and culture. *Journal of Psychiatric and Mental Health Nursing*, **9**(9) 65 - 71.
- Smith, M. (2002) Stigma. *Advances in Psychiatric Treatment*, **8**(2), 317 – 325.
- Smuts, R. (1992) Fat, Sex, class, adaptive flexibility, and cultural change. *Ethology and socio-biology*, **13**, 523 – 42.

- Sobal, J. (1991) Obesity and socioeconomic status: a framework for examining relationships between physical and social variables. *Medical Anthropology*, **13**, 231 – 247.
- Sobal, J. (1995) The Medicalization and Demedicalization of obesity, in, Donna Maurer, D & Sobal, J (eds), *Eating Agendas: Food and Nutrition as Social Problems*, Aldine de Guyter, Hawthorn New York, 67-90.
- Sontag, S. (1978) *Illness as Metaphor*, Farrar, Straus & Giroux, New York.
- Spitzack, C. (1990) *Confessing Excess – Women and the Body of Body Reduction*, State University of New York Press, Albany.
- Staley, L. (2008) Big fat beat up, *IPA Review*, November, 24 – 28.
- Stangor, C., & Crandall, C. (2000) Threat and the Social construction of Stigma, in Heatherton, TF, Neck, RE, Hebl, MR & Hull, JG (eds.), *The social psychology of stigma*, Guilford Press, New York, 1–28.
- Starks, H & Trinidad, S. (2007) Choose Your Method: A Comparison of Phenomenology, Discourse Analysis, and Grounded Theory. *Qualitative Health Research*, **17**(10) 1372-1380.
- Steinbeck, K. (2002) Obesity: the science behind the management. *Internal Medicine Journal*, **32**, 237 - 241.
- Stern, P., Allen, M., & Moxley, P. (1982). The nurse as grounded theorist : History, process and uses. *The Review Journal of Philosophy and Social Science*, **7**(2) 200-215.
- Stern, P. (2007) On Solid Ground: Essential Properties for Growing Grounded Theory, in, Bryant, A & Charmaz, K (eds), *The Sage Handbook of Grounded Theory*, Sage Publications, London.
- Stewart S., Tikellis G., Carrington C, Walker K., O’Dea K. *Australia’s future ‘Fat Bomb’: A report on the long-term consequences of Australia’s expanding waistline on cardiovascular disease*. April 2008, BHRI, Melbourne, Australia.
- Strauss, A., & Corbin, J. (1990) *Basics of qualitative research: grounded theory procedures and techniques*, Sage Publications, USA.
- Stringer, K., Bryant, R., Hopkins, G., & Favot, D. (2007) Gastric Banding at the Royal Brisbane and Women’s Hospital: Trials and Tribulations of a public service. *ANZ Journal of Surgery*, **77**, 550 – 552.
- Streubert, H. & Carpenter Rinaldi, D. (eds) (2011) *Qualitative Research and in Nursing: Advancing the Humanistic Imperative* (fifth edition), J.B. Lippincott Company, USA.

- Stsar, S. (2007) Living Grounded Theory: Cognitive and Emotional Forms of Pragmatism, in, Bryant, A & Charmaz, K (eds), *The Sage Handbook of Grounded Theory*, SAGE Publications, London.
- Stuber, J., Meyer, I. & Link, B. (2008a) Degher and Hughes (1999), Stigma, Prejudice, Discrimination and Health. *Social Science & Medicine*, **67**(3) 351-357.
- Stuber, J, Galea, S & Link, B (2008b) Smoking and the emergence of a stigmatized social status. *Social Science & Medicine*, **67**, 420–430.
- Swanton, K & Frost, M (2007) *Lightening the load: tackling overweight and obesity*, National Heart Forum, UK.
- Teachman, B. & Brownell, K. (2001) Implicit anti-fat bias among health professionals: is anyone immune? *International Journal of Obesity*, **25**, 1525–1531.
- Tebbel, C. (2000) *The Body Snatchers: How the media shapes women*, Finch Publishing Pty Limited, Australia.
- Thesen, J. (2005) From oppression towards empowerment in clinical practice: offering doctors a model for reflection. *Scandinavian Journal of Public Health*, **33**(Suppl 66) 47–52.
- Thomas, S., Hyde, J. & Karunaratne, A. (2008) Being 'fat' in today's world: a qualitative study of the lived experiences of people with obesity in Australia. *Health Expectations*, **11**(4) 321–330.
- Thomas, S., Karunaratne, A., Lewis, S., Castle, D., Knoesen, N., Honigman, R., Hyde, J., Kausman, R., & Komesaroff, P. (2010) 'Just bloody fat!': A qualitative study of body image, self-esteem and coping in obese adults. *The International Journal of Mental Health Promotion*, **12**(1) 39-49.
- Thone, R. (1997) *Fat - a fate worse than death? Women, weight and appearance*, Haworth Press, New York.
- Thuan, J. & Avignon, A. (2005) Obesity management: attitudes and practices of French general practitioners in a region of France. *International Journal of Obesity*, **29**, 1100–1106.
- Throsby, K. (2007) How could you let yourself get like that?": Stories of the origins of obesity in accounts of weight loss surgery. *Social Science & Medicine*, **65**(8) 1561-1571.
- Tweddle, E., Woods, S & Blamey, S. (2004) Laparoscopic Gastric Banding: safe and modestly successful. *ANZ Journal of Surgery*, **74**, 191 – 194.
- Urla, J. & Swedlund, A. (1995) The Anthropometry of Barbie: Unsettling Ideals of the Feminine Body in Popular Culture, in, *Deviant Bodies*, Terry, J & Urla, J (eds) Indiana University Press, USA.

- Urquhart, C. & Fernandez, W. (2006) Grounded theory Method: The researcher as blank slate and other myths – Epistemological and Philosophical Issues in Information Systems, Twenty-Seventh International Conference on Information Systems, Milwaukee, Paper retrieved from http://www.waikato.ac.nz/data/assets/pdf_file/0017/51632/APA_Referencing_6th_ed.pdf
- Valenti, L. (2009) Overweight and Obesity, in, Britt, H & Miller, GC (eds), *General Practice in Australia, health priorities and policy 1998 to 2008*, General Practice Series 24. Cat. GEP 24. Canberra: AIHW.
- Valentine, C. (1994) Female Bodily Perfection and the Divided Self, in, *Ideals of Feminine Beauty: Philosophical, Social, and Cultural Dimensions*, Callaghan, K (ed), USA, Greenwood Press.
- Wadden, T., Anderson, D., Foster, G., Bennet, A., Steinburg, C. & Sarwer, D. (2000) Obese Women's Perceptions of Their Physicians' Weight Management Attitudes and Practices. *Archives of Family Medicine*, **9**, 854-860.
- Walker, J., Payne, S., Smith, P. & Jarrett, N. (2007) *Psychology for Nurses and the Caring Professions* (3rd ed). Open University Press, United Kingdom.
- Wang, S., Brownell, K. & Wadden T. (2004) The influence of the stigma of obesity on overweight individuals. *International Journal of Obesity*, **28**, 1333–1337.
- Wann, M. (1999) *Fat! So?: Because you don't have to apologize for your size!*. Ten Speed Press, USA.
- Webb, C. (1992) The use of the first person in academic writing: objectivity, language and gatekeeping. *Journal of Advanced Nursing*, **17**, 747-752.
- Weiner, B., Perry, R. & Magnusson, J. (1988) An Attributional Analysis of Reactions to Stigmas. *Journal of Personality and Social Psychology*, **55**(5) 738-748.
- Weiner, B. (2006) *Social motivations, justice and the moral emotions: an attributional approach*. Lawrence Erlbaum Associates, Inc., Publishers, USA.
- Weiss, M. & Ramakrishna, J. (2006) Stigma Interventions and research for international health. *The Lancet*, 536 – 538.
- Weiss, M., Ramakrishna, J., & Somma, D. (2006b) Health-related stigma: Rethinking concepts and interventions . *Psychology, Health & Medicine*, **11**(3) 277- 287.
- Wellman, N & Friedberg, B. (2002) Causes and consequences of adult obesity: health, social and economic impacts in the United States. *Asia Pacific Journal of Clinical Nutrition*, **11**, Supp S705 - S709.
- Wesley, J. (2002) Growing up Sexualised: Issues of Power and Violence in the Lives of Exotic Dancers. *Violence Against Women*, **8**(10) 1182 - 1207.

- Wilde, M. (1999) Why Embodiment Now? *Advances in Nursing Science*, **22**(2)25–38
- Wilde, M. (2003) Embodied knowledge in chronic illness and injury. *Nursing Inquiry*, **10**(3) 170–176.
- Wiles, R. (1994) I'm not Fat, I'm Pregnant: The Impact of Pregnancy on Fat Women's Body Image, in Wilkinson, SK &Kitzinger, C (eds), *Women and Health: Feminist Perspectives*, Taylor & Francis, London, 33 - 48.
- Willis, K., Daly, J., Kealy, M., Small, R., Koutroulis, G. & Green, J., Gibbs, L., & Thomas, S.(2007) The essential role of social theory in qualitative public health research. *Australian and New Zealand Journal of Public Health*, **31**, 438-43.
- Wimpeny, P. & Gass, J. (2000) Interviewing in phenomenology and grounded theory: is there a difference? *Journal of Advanced Nursing*, **31**(6) 1485 – 1492.
- World Health Organisation (2003) *Diet, Nutrition and the Prevention of Chronic Diseases*, Geneva, World Health Organisation: 1 - 71.
- World Health Organisation (2010) *BMI Classification*, accessed 25 March 2010, http://app.s.who.int/bmi/index.jsp?introPage=intro_3.html
- World Health Organisation (2009) *Global health risks: mortality and burden of disease attributable to selected major risks*, accessed March 22 2010, http://whqlibdoc.who.int/publications/2009/9789241563871_eng.pdf
- Wolf, N. (1997) *The Beauty Myth*, Vintage, Canada.
- Wright, J. (1999) Female nurses' perceptions of acceptable female body size: an exploratory study. *Journal of Clinical Nursing*, **7**, 307–315.
- Yang, L., Kleinman, A., Link, B., Phelan, J., Lee, S. & Good, B. (2007) Culture and stigma: Adding moral experience to stigma theory. *Social Science & Medicine*, **64**, 1524–1535.
- Young, L. & Powell, B. (1985) The Effects of Obesity on the Clinical Judgments of Mental Health Professionals. *Journal of Health and Social Behavior*, **26**(3) 233-246

Appendices

Appendix A

Are you a Large Bodied Woman?

LARGE BODIED WOMEN (above Size 16) are invited to participate in a PhD research project. Interested women will be asked to discuss their personal health stories, with emphasis on their experiences of healthcare and interactions with healthcare providers.

Please contact Danielle if you would like to know more about taking part in this University of Tasmania PhD project.

Phone: 6226 4750 (Work)

Email: dwillia2@utas.edu.au

All information will be treated as confidential. Women wishing to participate will not be identified at any stage of the project. This research has been given ethical clearance by the Human Research Ethics Committee (Tasmania) Network. February 2006

Appendix B

Cover letter accompanying Information Sheet

Danielle Williams

School of Nursing and Midwifery

University of Tasmania

Dear

Thank you for expressing your interest in becoming involved in this research project. I would like to take this opportunity to briefly introduce myself.

Over the past four years I have worked both as a registered nurse within the hospital setting, and as an Information Officer, Project Officer and Research Assistant. I commenced my PhD in April 2003 at the School of Nursing and Midwifery, which I undertake on a part-time basis.

I have wanted to undertake research in this area for some time. Although possessing an interest in the social experiences of large women as a consequence of my own identity, my interest in this topic really began when I started working as a registered nurse.

Working in the health profession led to my interest in the experience of large women in health settings. After establishing that there is very little research that doesn't focus exclusively on the aesthetic aspect of overweight/obesity; the psychological effects of negative body image; eating disorders, or the medical implications of

overweight/obesity, I decided to undertake a project that would discuss with large bodied Tasmanian women their experiences of health care.

Once again, thank you for your interest in this project. Please find attached the project information sheet and a consent form (which I will collect at a later meeting should you wish to become a participant in the study).

Please contact me if you would like any further information.

Regards

Danielle Williams

dwillia2@utas.edu.au

Appendix C

Information Sheet

Large Bodied Women's engagement with health care

Chief Investigator	Dr. Judy Sankey
Other Investigators	Dr. Margaret Barrett
Danielle Williams (Researcher)	

This research project is being conducted through the School of Nursing and Midwifery at the University of Tasmania, to fulfil the requirements of a PhD undertaken by Danielle Williams.

This project aims to understand large bodied women's engagement with health care,. Large bodied women living in Tasmanian communities will be invited to share and describe their stories and experiences including interactions with providers of healthcare, as well as their experiences of their own health. For the purpose of this study healthcare will encompass a range of environments including hospital stays, general practice and specialist visits.

If you decide to participate in the study, you will be asked to sign a consent form. This form will declare that you understand the potential risks of the project, your rights as a participant, and the responsibilities of the researcher. You will then be asked to meet for an interview with the researcher (in a setting of your choosing). The interviews will last for approximately one hour, and will be recorded on an audio tape and subsequently transcribed by the researcher. Interviews will begin with a simple question (eg 'can you tell me about your experiences of healthcare?') and will develop from that point. You may be contacted a second time in order to verify information from the first interview. After interviews, you will then be given a chance to review the final interview transcript and preliminary analysis. You may choose to revise the transcript during this meeting.

After interviewing has finished all women who have participated in the project will be invited to attend a forum, offered as an opportunity to debrief and discuss your involvement in the study. This will be an optional forum, and will only proceed if participants express interest in this idea. Another information sheet will be issued to women who would like to attend. All information will be treated as confidential and your anonymity will be protected during the interview process and the writing of the results. You will choose a pseudonym at the beginning of the research and all your information will subsequently be recognised by this pseudonym.

If there are any questions that arise during interviews that cause discomfort or embarrassment you may choose not to answer that question. Similarly, if you wish to withdraw from the study at any stage you may do so without penalty. You may also ask that the interview transcript/audio tape be returned to you. This research has been given ethical clearance by the Human Research Ethics Committee (Tasmania) Network. If you have any complaints about the manner in which the project is being conducted, or any concerns of an ethical nature please contact the Human Research Ethics Committee (Tasmania) Network:

Executive Officer: Amanda McAully 6226 2763

If you have any further queries regarding this research, please contact the researcher or the chief investigator:

Danielle Williams: Dr Judy Sankey Dr Margaret Barrett
6226 4736

Appendix D

Consent Form

Large Bodied Women's engagement with health care

This research project is being undertaken through the University of Tasmania's School of Nursing and Midwifery to fulfil the requirements of a PhD. This project aims to understand large bodied women's engagement with health care, including interactions with providers of healthcare. Large bodied women living in Tasmanian communities will be invited to share and describe their stories and experiences.

Participants will be asked to take part in an interview which will last approximately one hour, with the possibility of a second interview if necessary. Participants will then be given a chance to review the final interview transcript and preliminary analysis. Project participants will be provided with the opportunity to attend a forum, which will offer women the chance to debrief and discuss their involvement in the study.

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1. I have read and understood the 'Information Sheet' for this study.
 2. The nature and possible effects of the study have been explained to me.
 3. I understand that I may have to recount experiences that could cause emotional distress. I understand that I am under no obligation to answer any question, and that I can conclude the interview if I wish.
 4. I understand that all research data will be securely stored on the University of Tasmania premises for a period of 5 years. The data will be destroyed after a 5 year period.
 5. Any questions that I have asked have been answered to my satisfaction.
 6. I agree that research data gathered for the study may be published provided that I cannot be identified as a subject.
 7. I agree to participate in this research project and understand that I may withdraw at any time without consequence. I understand that if I choose to withdraw from the study, I may elect to withdraw any

information supplied to that date. I understand that any information that I have disclosed will be written up and returned to me.

Name of participant

Signature of participant

Date

Statement by Investigator

8. I have explained this project to this participant and I believe that the consent is informed and that she understands the implications of participation.

Name of investigator

Signature of investigator

Date