

Obese individuals' perceptions of health and obesity and the lived  
experience of weight loss, gain, or maintenance over time

by

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## **Abstract**

**Background:** Obesity is associated with conditions that may affect Canadians' health status and strain the health care system. Obese individuals are subjected to stigmatization. Most public health programs to date promote weight loss. However, weight loss is rarely sustainable. Insight must be gained into the embodied, lived experiences and lifestyles of 'target' populations and their perceptions of and priorities concerning health and wellbeing to develop public health programs that enhance lifestyles and health.

**Purpose:** The purpose of my research was to use critical ethnographic research methods to explore obese individuals' perceptions of health and obesity and the impact of these assessments, as well as personal weight trajectories, on obese individuals' health perceptions, lifestyles, quality-of-life, and behaviours.

**Methods:** This study involved one- year ethnography. Data sources included field notes and repeated (every 3-4 months), audio-taped, semi-structured, qualitative interviews with research participants. Subsamples included obese and formerly obese individuals who were 1) pursuing weight loss to achieve health goals, 2) attempting to maintain weight loss, and 3) attempting to get/stay healthy through diet and exercise but were not concerned with weight loss. Participant observation occurred at sites identified by participants as essential to their embodied, lived experience.

**Results:** Three major themes emerged: the importance of function to health and quality-of-life; compulsion, addiction, and the need for validation; and social impacts of various weight trajectories and perspectives. Participants recounted multiple ways in which their ever-fluctuating bodies and related bodily attitudes profoundly affected their social lives and the degree of social acceptance they experienced in coping with their bodies,

participants often described highly compulsive food, dieting, and fitness behaviours and a constant search for validation of their health-related endeavours.

**Significance:** The dominant discourse regards obese individuals as ill. This perspective may produce disempowering public health initiatives. To achieve sustainable benefits for Canadians' quality-of-life, a greater understanding of what constitutes health and wellbeing for obese individuals, and how such factors may change over time and differing circumstances, is essential. This insight will contribute to a salutogenic and holistic approach to health, particularly in populations that may feel stigmatized as a result of health issues.

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## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.1 Summary**

Obesity [Body Mass Index (BMI) > 30 kg/m<sup>2</sup>] is associated with numerous health conditions that may negatively affect Canadians' health status and strain the health care system. Currently, 24% of Canadians are obese. This represents an increase of 8% and 10% for women and men, respectively, over the past 25 years, and this increase is particularly evident in young and middle-aged women (Shields et al., 2011). Overweight and obese individuals are often characterized as 'burdens' on the health care system and have increasingly been subjected to stigmatization and discrimination at work, school, and in social situations (Puhl et al., 2008; Heart and Stroke Foundation, 2010). Indeed, this discrimination appears to have spread globally (Brewis et al., 2011). Perhaps most damaging, rather than viewing health practitioners or public health officials as potential partners in improving quality-of-life, there is evidence of substantial weight bias among health care professionals (Schwartz et al., 2003). In addition to stigmatization and discrimination, interventions designed to ameliorate childhood obesity have been implicated in the development of eating disorders (Evans et al., 2008).

To counteract rising obesity rates, individuals frequently are encouraged to, and attempt to, lose weight. However, diet-induced weight loss activates somatic and

psychological ‘homeostatic pressures’ to induce weight regain. These mechanisms include hormonal alterations, reduced satiety and energy expenditure, and increased hunger (Maclean et al., 2011; Sumithran et al., 2011). These adaptations stimulate weight regain in over 90% of weight-losers (Ikeda et al., 2005; Gaesser, 2009). Furthermore, recent evidence suggests there are potential negative physical and psychological effects of weight loss, such as compromised immunity and skeletal integrity, low mood, and poor body image (Aphramor, 2005). Additionally, physically active overweight and obese individuals may have greater cardiovascular fitness than inactive individuals, regardless of weight status (Lee et al., 1999). Healthy habits improve mortality risk regardless of initial BMI, and it is obese individuals who benefit the most substantially, compared to those of a lower weight status (Matheson et al., 2012). Indeed, there is accumulating support that some excess weight may be protective in terms of mortality risk (Orpana et al., 2010).

The concept of health has also been co-opted as a marketing tool by the diet industry and by the appearance-conscious mass media (Martin, 2002). Thus, public health initiatives devoted solely to weight loss may erode the credibility of public health, as the line between health as a salutogenic, holistic approach to improving one’s life becomes immingled with mass media promulgated beauty standards. Among individuals who have failed to lose weight or who have suffered negative consequences from weight loss efforts, these past dieting experiences must be explored to understand the most effective methods of helping obese individuals with different weight histories live the most fulfilling lives possible.

Some scholars have grown increasingly critical of a narrow weight-centric approach to health and have begun to focus more on the benefits of balanced nutrition and physical activity, independent of effects on weight (e.g. Bacon 2010). However, to produce a truly positive and affirming health promotion strategy, it is necessary to incorporate the voices of ‘target’ populations themselves. Individuals who have struggled to live healthily as larger individuals, or whose efforts to adopt healthier lifestyles have both positively and negatively affected their health, are rarely provided with the opportunity to discuss perceptions of their own health and what they would prioritize in enhancing their wellbeing and quality-of-life. To develop healing partnerships between public health, medical practitioners, and ‘target’ populations, insight must be gained into the lived experiences of ‘target’ populations; the environments in which they live; the psychosocial, social, and material resources to which they have access; and most importantly, their own perceptions of their health and wellbeing and their priorities in enhancing these aspects of their lives. This understanding will allow for the development of greater trust between public health, health practitioners, and the individuals whom they serve, and may allow for the development of public health objectives and strategies that truly empower individuals and enhance lifestyles and health. Empowerment has been found to produce positive health outcomes in a variety of contexts (Wallerstein, 1992); however, until greater insight into these issues is achieved, there is potential for marginalization, resentment, entrenchment, and negative health outcomes. These effects may be compounded over time, as obesity, for many individuals, is a lifelong state.

Obesity is increasingly recognized as a chronic condition (Mauro et al., 2008). However, little qualitative research has focused on the lived experiences and health

perceptions of obese individuals over time. Similarly, given the high rates of weight loss recidivism, limited qualitative research has explored how lifestyles, quality-of-life, and perceptions of health and wellbeing may be altered over time by different weight loss/gain trajectories. This is especially important given that unlike the often static depiction of bodies in weight loss accounts (Levy-Navarro, 2009), wherein a once fat body passes irrevocably to a thin, idealized, and perfect state, bodies are necessarily fluid, adaptable, and changing (Longhurst, 2001). Individuals may experience subjective and objective periods of various sizes, from thin to fat. It is likely that differing weight histories and trajectories may alter understandings of the body. Quantitative studies have identified substantially calorie and fat-reduced diets, increased physical activity, and vigilant food and weight self-monitoring as behavioural adaptations of successful weight loss maintainers (Wing and Hill, 2001). Given these substantial lifestyle alterations, a more in-depth and thorough understanding of long-term effects of obesity and weight loss efforts on holistic health and lifestyles may allow obese individuals to make informed choices concerning their behaviours and aid in developing population and individual health strategies that promote a holistic and feasible approach to wellbeing.

## **1.2 Purpose and Research Questions**

The purpose of my research was to use critical ethnographic research methods to explore Canadian obese individuals' perceptions on health and obesity and to explore how these assessments, as well as personal weight trajectories, influence their health perceptions, lifestyles, quality-of-life, and behaviours, over time.

The research questions examined were:

1. How do obese people perceive health in general and their own health specifically?
  - a. What are participants' understandings of the relationship between obesity and health?
2. What do obese individuals prioritize in maximizing wellbeing and quality-of-life?
3. How do obese individuals' perceptions of healthy behaviours influence their daily lives?
4. Do obese people feel stigmatized? If so, what are their experiences in coping with stigma? Do they internalize stigma?
5. Are obese individuals' perceptions of health congruent with public health and biomedical assessments?
6. How do obese individuals' perspectives on and experiences with weight loss efforts influence their perspectives on health and quality-of-life?
7. Do obese individuals' perspectives on weight loss change over time?
  - a. Do obese individuals' perspectives on weight loss change as a result of different weight loss/gain trajectories?
  - b. Do obese individuals' perspectives on quality-of-life change as a result of different weight loss/gain trajectories?

### **1.3 Ethical Considerations**

The study was reviewed by the University of Manitoba's Health Research Ethics Board [HS16075(H2013:026)]. Informed consent was obtained from all participants (see **Appendix E**). A small honorarium (\$25 gift certificate) was presented to participants at each interview in appreciation for their time and effort. All efforts were made to ensure

the confidentiality of the study participants. Hard copies of data were de-identified and kept in locked filing cabinets in a secure area on the University of Manitoba's Bannatyne campus. For analysis and reporting, participants were assigned pseudonyms. Electronic transcripts were protected via password encryption and only the researcher and her supervisor had access.

## **CHAPTER TWO:**

### **Review of the Literature**

To understand the lived experiences of obese individuals, it is necessary to consider the high rates of bias to which they may be exposed. This discrimination is directly affected by causal attributions of obesity disseminated in popular, biomedical, and public health accounts. Weight bias and mainstream obesity discourse has direct and indirect effects on obese individuals' understandings of obesity, health status, and quality-of-life. Also essential in improving the health of obese individuals is a greater understanding of the chronicity of obesity and a more precise delineation of the health effects of fitness, diet, and fat.

#### ***2.1 Prevalence of Weight Bias***

Obese individuals experience high levels of weight discrimination and prejudice in social situations, health care settings, places of employment, and interpersonal situations (Puhl et al., 2008). This discrimination has now spread even to formerly fat positive nations (Brewis et al., 2011). Of particular concern for the health of obese individuals, there is evidence of high levels of weight bias discrimination among health care professionals specializing in obesity (Schwartz et al., 2003). These attitudes are extremely pervasive. Even obese individuals with a lower body mass index (BMI) stigmatize individuals with a higher BMI (Lewis et al., 2010a), and while one's own BMI may moderate one's anti-fat bias, obese individuals still exhibit significant anti-fat bias (Schwartz et al., 2006). Schwartz and colleagues (2006) surveyed an online sample that included over 4,000 individuals who varied in weight status from underweight to obese.

Forty-six percent (46%) of these individuals stated they would prefer to lose 1 year of life, 30% would prefer to be divorced, and 15% each would prefer to be unable to have children, be severely depressed, or lose 10 years of life, than be obese (Schwartz et al., 2006). These biased attitudes are, in part, caused from negative stereotypes commonly associated with obese individuals. These stereotypes include that obese people are worse, lazier, or less motivated than thinner people (Schwartz et al., 2006). Generally, individuals stated they preferred obese people less than thinner people (Schwartz et al., 2006).

Individuals have also been asked to report on their experiences of weight discrimination. Data from the 1995-1996 National Midlife Development in the United States found that the average prevalence of self-reported height/weight discrimination experiences was 5% for men and 10% for women. These experiences included discrimination occurring in institutional settings, such as education, employment, housing, services, and medical care, as well as interpersonal encounters, including name calling, harassment, and being dealt insufficient courtesy or trust (Puhl et al., 2008). Heavier individuals experienced substantially more discrimination with 40% of people with a BMI > 35 reporting experiencing discrimination. This was particularly prevalent among women and younger people.

A review of obesity stigma was undertaken by Sikorski and colleagues in 2011. The review examined studies reporting on nationally and community-representative data. These studies reported high levels of stigmatizing attitudes among the general public. Individuals' beliefs regarding obesity causation were also examined. To a limited extent, the influence of the obesogenic environment has entered public understandings of obesity

causation (Sikorski et al., 2011). However, the public still largely attributed obesity to individual, internal factors. This individualization of causation was the single factor most highly associated with promoting stigmatizing attitudes (Sikorski et al., 2011).

## ***2.2 Popular Accounts of Obesity: Personal Responsibility***

Media coverage of obesity emphasize that both the cause and solution of the obesity epidemic reside within individual actions (Puhl and Heuer, 2010). The individualistic framing of obesity in news reports contributes to the stereotyping of obesity as an individually-induced health and social burden. By contrast, experimental psychological research reviewed by Puhl and Heuer (2010) finds that more nuanced news reports, which speak to environmental and genetic contributors to obesity, reduce stereotypical perspectives and contribute to more positive attitudes on obesity. Unfortunately, the dominant message present in obesity media reportage remains one centred on individualistic etiology and cure (Puhl and Heuer, 2010).

Gard and Wright (2005) conducted a comprehensive review of the manner in which obesity was presented in academic research, media, and popular books in the United States, Australia, and the United Kingdom. Similar to Canadian media accounts, in which Holmes (2009) found that obesity was frequently referred to as an ‘epidemic’ or in similar catastrophic expressions, Gard and Wright (2005) found a seemingly unified perspective on obesity inducing a health crisis. Rarely, in media accounts or in the dissemination of scientific literature for lay audiences, is a nuanced, problematized report of obesity research presented that acknowledges the limitations of biomedical and epidemiological studies. Rather, studies are depicted in terms of absolute certainty, with

limited caveats, and in catastrophic language (Gard and Wright, 2005). In addition to referring to obesity as an epidemic or crisis (Gard and Wright, 2005; Holmes, 2009), a common figurative device in discussing obesity is to employ military or terrorism metaphors (Monaghan, 2008; Rail et al., 2010). This discourse effectively constructs obese individuals as targets in a war or even as domestic terrorists (Monaghan, 2008; Rail et al., 2010).

Lawrence (2004) examined how responsibility for obesity is framed in American news stories accounts of obesity since 1985. Currently, a framing debate is underway in American news stories. News accounts attribute increasing obesity rates to personal responsibility or to environmental factors, such as food policy issues. While the personal responsibility frame predominates, since 2003 a shift has occurred, with increasing emphasis on the socioeconomic environment, especially the culpability of the fast food industry. This shift, however, may do little to diminish the stigma experienced by obese individuals. As Lawrence (2004) articulates, even when acknowledging the risks for obesity produced by living in a fast food-saturated environment, there is a reluctance to accept that overweight individuals have involuntarily incurred this environmental risk. Thus, overweight and obese individuals are still presumed as being at fault for their body size.

### ***2.3 Discourse, Biopedagogies, Fat Narratives, and Bodily Understandings***

The accounts discussed above are components of mainstream obesity discourse. This discourse is presented as completely unequivocal and as being significant for every

individual (Davies, 1998). It has been articulated by O'Hara and Gregg (2010:433) as consisting of the following components:

Weight is within the control of the individual; weight is caused by a simple imbalance between an individual's energy intake and energy usage; methods for successful and sustained weight loss include focusing specifically on changing eating and physical activity patterns; and losing weight to achieve "healthy weight" status will result in better health.

Similarly, Rail and Lafrance (2009:178) describe the dominant obesity discourse as follows:

First, those who are obese can be talked about in derisive and derogatory terms; second, those who are obese are ill and in need of medical surveillance and control; and third, those close to those who are obese must take part in the medical surveillance and control or risk being assigned blame.

Given the condemning nature of such a conceptualization of obesity, the rise in obesity discrimination seems easily explainable. Researchers have begun to theorize about how obesity discourse is communicated and permeates throughout society often adopting a feminist post-structural framework. To understand these discursive relationships, researchers have examined what Wright and Harwood (2009) term biopedagogies. This combines what Foucault (1978) terms biopower, the governance and regulation of individuals and populations through practices associated with the body, and pedagogies, the multiple sites and strategies through which these practices are taught. These biopedagogies have come to operate through a variety of institutions and practices

to interpellate individuals to subscribe to obesity discourse and strive to achieve an ideal, 'healthy' BMI. How biopedagogies circulate in cyberspace (Miah and Rich, 2008; Jennings, 2009), in families (Burrows and Wright, 2004; Burrows, 2009; Fullager, 2009), popular culture (MacNeill, 1999; McPhail 2009, 2010; Warin, 2011); and especially in schools have been investigated (Burrows and Wright, 2004; Evans et al., 2004, 2008; Rich et al., 2004, 2010; Beausoleil, 2009; Isono et al., 2009; Leahy, 2009; Rich and Evans, 2009).

Various populations appear to have taken up at least certain aspects of this obesity discourse. They have thus been interpellated by the subject positions presented by such discourses and have constructed definitions of health that align with this discourse (Rail, 2009). Thus, Canadian youths believe that health is something one 'does' and not what one 'is'. Being a healthy subject, according to the youth in Rail's (2009) study, involved engaging in physical activity and eating right. Furthermore, they had largely internalized the orthodox view of health, which suggests that by following these actions - 'doing health' they could ensure they would not be 'too fat', or 'too skinny', and would 'look good'.

According to multicultural Ontario, female, and male youths, health is linked to not being obese, is an individual's responsibility, and is a moral imperative (Rail, 2009). While this suggests that these youths have internalized mainstream obesity discourse, this is not to suggest that individuals are merely receptors of obesity discourse. Rather, individuals are active agents who interact with received messages (Askew and Wilk, 2002). As discussed by Rail (2009), some adolescents appeared resistant to this pervasive discourse or, at least, problematized this discourse in their subject identities. The

adolescents perceived themselves as being healthy, while acknowledging their own inactivity and poor nutritional habits. Thus, understandings of health may have been internalized, but not to an extent in which participating in unpleasant or onerous activities would be voluntarily performed.

Indeed, the youths frequently discussed ‘healthy’ activities as being tedious and burdensome (Rail, 2009). As the youths admitted they had easy access to healthy activities, this raises issues for health promotion campaigns that focus on obesogenic environment causal explanations. Audiences apparently perceive healthful behaviours as particularly non-pleasurable. Some students in Rail’s study (2009) were also more actively resistant. They rejected or expressed ambivalence concerning the ascetic nature of some of their understandings of prevalent, healthist discourses. This was especially noticeable among students with a disability. These students may have felt particularly excluded or stigmatized by a health discourse that focused on activity and appearance norms (Rail, 2009). Occasionally, students also mentioned health in terms of positive attitudes or particular bodily feelings. Also important was how infrequently participants referred to health as not engaging in dangerous practices, such as smoking. The obesity discourse appears to have eclipsed these other health messages around not engaging in dangerous practices (Rail, 2009).

Ward’s (2011) multi-method study with Canadian children in a weight-loss program found that these youths, similar to those in Rail’s (2009) study, took up dominant healthist discourses about the moralistic criteria of various ‘lifestyle choices’ and the conflation of health and appearance norms. However, they also, albeit less frequently, exhibited resistance. This resistance included the internalization and

recounting of alternate discourses of body acceptance that likely originated in the self-esteem curriculum of the weight loss program (Ward, 2011).

A familiar focus on being physically active, eating healthily, looking good, and weight control were mentioned as essential for being healthy among young, female, Canadian Shia Muslims and South Asians (George and Rail, 2005; Jiwani and Rail, 2010). However, the Muslim sample placed a greater emphasis on feeling good about themselves (Jiwani and Rail, 2010). Burns and Gavey (2004) found that the equation of slenderness and health was evident among bulimic women's accounts of health. Wright and colleagues (2006) found that female Australian teenagers viewed health as a project of achieving and maintaining a slender body through diet and physical activity. Among the international samples of youth whose perspectives on physical activity and health are compiled in Wright and Macdonald's (2010) collection, healthism and a moral imperative to engage in physical activity was a common finding. The large men and women in the focus groups conducted by Tischner and Malson (2011) discussed the normativity of women's restrained eating, the need to only eat in private, and the stigma associated with largeness, including in health care settings. The self-identified overweight and obese individuals interviewed by Kwan (2012) maintained the primacy of diet, exercise, and weight loss to health, but protested the universal, rigid criteria of healthy weights and asserted the need for a greater focus on psychological health.

Mitchell (2006) interviewed fat Canadian women about their spatial relations and negotiations and possible understandings and affiliations with fat activism. Her findings reinforced the degree of stigma experienced by fat women, the public surveillance associated with being a fat woman and the multiplicity of experiences of fatness.

However, her study and personal experiences, again, highlight the cultural and political ways in which individuals can recover from, and resist, disciplining obesity discourse. Such resistance was also displayed in the narratives collected in the seminal fat activist volume *Shadows on a Tightrope*, (Schoenfelder and Wieser 1983) which, while highlighting occasions of stigma and oppression, also recounted and facilitated the finding of fat community. This was similarly identified in Ellison's (2007) research on fat activists operating in Canada in the late 1970s and 1980s. These women demonstrated a complex form of resistance that sought to negotiate a space for fat women within feminine culture, according to traditional feminine norms and ideals.

The moralistic framing of particular foods has been incorporated into individuals' understandings of eating practices. For example, McPhail and colleagues (2011) found that Canadian teenagers placed a moral imperative on not eating fast food, or on eating the healthier options available from a fast food menu. Thus, Canadian teenagers viewed eating from Subway restaurant as healthier and more morally righteous food choice than consuming foods from a MacDonald's restaurant. Importantly, from a health promotion standpoint, this moralizing perspective did not necessarily inhibit teenagers' fast food consumption. Teenagers continued to consume fast food; however, specific fast foods fell under a 'bad' or 'good' rubric, and teenagers used this set of criteria in choosing which fast food to buy or in evaluating their dietary choices subsequent to a meal (McPhail et al., 2011).

Additionally, McPhail and colleagues (2011) did not find that lower income teenagers were any more likely to eat fast food than higher income teenagers. This casts some doubt on claims that poorer income individuals are more likely to consume fast

food, as they may not have fewer affordable options in their neighbourhoods. This is an example of an obesogenic environment argument (Egger and Swinburn, 1997; Swinburn et al., 1999, 2011). Obesogenic environment proponents claim that individuals' environments will predispose individuals' to developing obesity, primarily by facilitating unhealthy eating and sedentary living. However, empirical evidence supporting these propositions is lacking (e.g. Giskes et al., 2007; Schäfer-Elinder and Jansson Kirk et al., 2010). These arguments are also important to evaluate in light of their potentially unintended stigmatizing effects (Guthman, 2011; Kirkland 2011). The implications of the obesogenic environment argument are problematic in a number of ways. Firstly, it continues to make dietary intake a moralistic criterion. This disqualifies other, far more important ethical considerations in evaluating an individual's moral worth. Should individuals actively choose not to consume healthy food or engage in physical activity despite access to these resources, this may increase stigmatization against these 'deviant' individuals. This argument also suggests that the presumed elite standards of diet and physical activity (i.e. healthy food choices and regular exercise) are those to which all individuals should aspire. This discounts a variety of personal and cultural preferences and institutes a veiled form of paternalistic, condescending classism in judging individuals. Other forms of discrimination such as sexism or racism may also be conveniently masked in these arguments, with assumption-laden foci on 'target populations'. These claims also suggest a lack of agency on behalf of individuals, particularly those of a lower income, and presents a homogenous view of how lower income individuals may choose to live their lives (Guthman, 2011; Kirkland 2011).

## ***2.4 Risks of Stigmatization***

The deployment of stigmatizing language and strategies are sometimes viewed as a justified strategy in anti-obesity public health programs (Bell et al., 2011). Leahy (2009) discusses how a biopedagogical strategy frequently deployed in school anti-obesity campaigns relies on mobilizing sufficient disgust of an obese, unhealthy ‘other’ that it produces an affective, visceral response. Weight bias and obesity rates have increased concurrently (Puhl and Heuer, 2010). As reviewed by Puhl and Heuer (2010), stigmatizing obese individuals has not materialized in positive health outcomes or curtailed the obesity epidemic. Rather, research suggests that weight discrimination increases disordered eating and decreases physical activity, suggesting that stigmatization may augment levels of obesity, rather than prevent weight gain (Rice, 2007; Sykes and McPhail, 2008; Thomas et al., 2008; Puhl and Heuer, 2010; Sykes, 2011).

It is occasionally argued that the messages affiliated with weight control are identical to more positive and salutogenic messages of consuming a healthy diet and engaging in moderate physical activity (Blair and LaMonte, 2006). It is important to remember, however, that, exclusively measuring health benefits through weight loss may result in individuals engaging in unhealthy weight loss methods (Campos, 2011). Additionally, the catastrophic rhetoric used to describe the obesity epidemic has been suggested as a potential contributor to rising rates of eating disorders (Saguy and Riley, 2005). Interventions designed to ameliorate childhood obesity have even been implicated in the development of eating disorders (Evans et al., 2004, 2008; Rich et al., 2004; Beausoleil, 2009; Isono et al., 2009; Rich and Evans, 2009; C.S. Mott Children’s Hospital, 2012).

These risks are often downplayed by anti-obesity researchers who argue that far fewer individuals suffer from eating disorders than suffer from obesity (Saguy and Riley, 2005). They argue that obesity is a far greater public health concern and an emphasis on eating disorders is a form of classism. That is, excessive significance is given to eating disorders, which are more likely to affect white, upper-class women than obesity, which disproportionately affects poorer, minority women (Saguy and Riley, 2005). It is important to consider, however, the high risk of mortality associated with eating disorders (Arcelus et al., 2011), regardless of whom they affect.

In addition to adverse behaviours resulting from weight stigma, such stigma may also compromise physical and psychological health through stress-induced neuroendocrine dysregulation (Muennig et al., 2008; Puhl and Heuer, 2010). The independent effects of weight discrimination, and related potential body dissatisfaction, on health are evident in a study conducted by Muennig and others (2008). They found that the difference between ideal weight and actual weight had a stronger effect on mentally and physically unhealthy days than actual BMI in American adults. While further research is necessary, such pathways and outcomes would be analogous to those produced by racial discrimination (Puhl and Heuer, 2010). These health effects will likely be exacerbated by health care discrimination (Schwartz et al., 2003; Puhl et al., 2008), consequent inadequate care, and subsequent avoidance of health care providers (Puhl and Heuer, 2010).

Ernsberger (2009) reviewed the evidence on obesity, socioeconomic status, and mortality. In developed nations, poorer females have consistently been heavier than richer females since at least the mid-20<sup>th</sup> century. Increasingly, this same pattern has been

replicated in males. While common suppositions posit that living in impoverished neighbourhoods may predict obesity, it is equally, if not more likely, that obesity may increase the risk of poverty and downward social mobility. This downward mobility may operate through prejudice and discrimination affecting education, employment, income, housing, and health care opportunities (Ernsberger, 2009). Precedent has often been given to the hypothesis that poorer individuals tend to also be fatter, and thus their health is compromised. However, the pervasive risks of poverty on health persist in all weight classes. Thus, it may be that for heavier individuals the likelihood of poverty is what increases their risk for mortality, rather than that poverty increases an individual's risk of gaining weight and consequently impairing health. In longitudinal studies, the effects of obesity on cardiovascular mortality have a vastly stronger magnitude in higher income populations than in lower income populations. This suggests that the health consequences of obesity are amplified in populations in which weight stigma is pervasive (often of higher socioeconomic status) but ameliorated in more fat-accepting populations (Ernsberger, 2009). Thus, weight stigma, and its mediation through poverty, stress, and prejudicial health care provision, may be far more health damaging than previously thought (Ernsberger, 2009). Given the spread and increasing severity of weight stigma, this is a particularly worrisome and under explored relationship.

It is essential to recall that the oft-cited goal of losing 5-10% of weight (Aphramor, 2010) is unlikely to move someone from a state of obese to non-obese. Thus, obese individuals, despite following public health dictates, will still suffer stigmatization. Stigmatization may directly produce negative health impacts, or indirectly affect health through the discontinuation of seemingly 'ineffective' lifestyle changes or the adoption of

potentially harmful weight loss tactics. Even if an individual's obesity is 'cured', the effects of stigma may continue. Mustillo and others (2012) found that formerly obese adolescent girls continued to suffer from the lower self-esteem characteristic of chronically obese adolescents in their longitudinal sample. Also, an approach that focuses exclusively on weight loss promotes a number of issues, including conditioning individuals to live in a state of liminality. Individuals may put off potentially health-enhancing life goals until they lose weight, and both weight loss and these other goals may forever remain unfulfilled (Levy-Navarro, 2009).

Unlike the, at best, mixed results of using stigma to motivate weight loss, teaching body acceptance for coping with stigma and supportive, positive techniques for weight loss has produced positive results (Puhl and Heuer, 2010). This is similar to interventions that adopt a Health-At-Every-Size (HAES) approach. These interventions are weight neutral, but include physical activity, nutrition, and self-esteem-enhancing components. Such interventions were able to produce positive, sustained diet, behavioural, and cardiometabolic outcomes (Bacon et al., 2005; Bacon and Aphramor, 2011). While some size acceptance approaches are questioned as continuing to mandate a health imperative (McPhail, 2004; Welsh, 2011), such non-stigmatizing approaches seem preferred among obese participants in studies. De-stigmatizing and empowering programs that focused on overall lifestyle changes, rather than weight loss, were suggested by Australian obese individuals as an alternate to existing public health programming (Thomas et al., 2008). Fundamentally, it may be necessary to implement such programs as weight loss dieting has not proved effective as an anti-obesity public health strategy.

## ***2.5 Chronicity of Obesity***

A large body of evidence has begun to support the argument that obesity is a chronic state and has been reviewed by Bombak (2014a). In 1992, the American National Institutes of Health published the Technology Assessment Statement that concluded that voluntary weight loss and control methods do not work (NIH, 1992). The statement also emphasizes the potential risks associated with weight loss such as binge eating, fatigue, and loss of lean mass (NIH, 1992). Five years later, while certain developments had occurred in understanding the genetic, environmental, and metabolic contributors of obesity, little had changed in enhancing the efficacy of voluntary weight loss methods. More recent studies have confirmed that very few individuals are capable of sustaining weight loss over time (Ikeda et al., 2005; Gaesser, 2009). A conservative estimate suggests that over 90% of weight losers regain weight over time (Ikeda et al., 2005; Gaesser, 2009). Indeed, a comprehensive review of weight loss dieting interventions found that over two-thirds of participants regained more weight over time than they had initially lost (Mann et al., 2007). Given these high rates of regain, it is concerning to note that recent findings show that the weight regained does not replace lost bone or lean mass but instead is mostly composed of fat (Villalon et al., 2011; Beavers et al., 2012). Importantly, successful weight losers may be characterized by high levels of disordered eating behaviours (Green and Buckroyd, 2008).

Recent findings have also helped researchers to better understand the physiological and endocrinological changes that occur in obese individuals following weight loss. MacLean and colleagues (2011) provide a comprehensive review of the state of knowledge on post-obese biological alterations promoting weight regain in humans

and animal models. These changes suggest that following weight loss, biological processes exert comprehensive, redundant, and persistent mechanisms to restore energy reserve depletions and return to pre-dieting weights (MacLean et al., 2011). Such changes involve highly integrated alterations including reduced satiety; increased hunger; suppressed energy expenditure; a decrease in nutrient availability; enhanced metabolic flexibility; an increase in energy efficiency and storage in peripheral tissues; a decline in adipose energy depletion signalling from leptin and insulin; altered neural activity; and alterations in hepatic, adipose tissue, and skeletal muscle metabolism. In humans, similar sustained alterations have recently been demonstrated. Sumithran and colleagues (2011) found that 1 year following diet-induced weight loss, subjective hunger and circulating levels of ghrelin, gastric inhibitory polypeptide, and pancreatic polypeptide were all elevated among overweight and obese individuals who lost weight in an intervention. Decreases in circulating insulin, leptin, polypeptide YY, and cholecystokinin were also observed (Sumithran et al., 2011).

Due to these changes, successful weight losers must adopt substantial lifestyle changes to maintain weight loss. The American National Weight Control Registry (NWCR) includes individuals who have successfully maintained a 30 lb. weight loss for over a year. Registrants demonstrate high levels of dietary restraint; frequent weight and food intake monitoring; and regular, ample physical activity (Wing and Hill, 2001). A recent cluster analysis of NWCR registrants, however, documented that while the majority of participants were satisfied with their weight loss and highly active (Ogden et al., 2012), one cluster composed of over a quarter of participants struggled with their weight loss and were dissatisfied with this weight loss. Participants in this cluster also

experienced high scores on stress and depression inventories at the time they were surveyed, and retrospectively reported high levels of major depression prior to the weight loss. An additional cluster composed of approximately 10% of participants reported frequent skipping of meals and low levels of physical activity. Interestingly, these adverse psychosocial outcomes or maladaptive weight control methods were found in the clusters characterized by the greatest losses in weight (Ogden et al., 2012).

Mauro and colleagues (2008) discuss some of the common barriers to effective obesity treatment. One such barrier they identify is a lack of recognition among health care providers and patients that obesity is a chronic condition. Limited education is presented on this concept in medical school or residency programs. Patients and providers both tend to assume that weight loss is a cure for obesity and are willing to engage in and prescribe weight loss efforts. However, in order to counter the array of endocrine and neurobiological forces that promote weight regain, individuals may need to engage in surgical or often ineffective pharmaceutical therapies (Ladouceur, 2012), in addition to lifestyle changes. Surgery is only an option for severely obese individuals, and weight regain is possible even with these therapeutic supports (Mauro et al., 2008). Thus, few effective therapeutic options are available for obese individuals.

## ***2.6 Differentiating Pathways: Fitness, Diet, and Fat***

The complex interplay between health, obesity, and lifestyles was reviewed by Bombak (2014a). To better understand underlying cardiometabolic risk in Americans of various weight classes, Wildman and colleagues (2008) examined data from the NHANES from 1999-2004. They determined the prevalence of overweight and obese

adult individuals who are metabolically fit and normal weight adult individuals presenting with cardiometabolic risk clustering. The authors found that over half of the overweight participants (51.3%) and approximately a third of the obese participants (31.7%) were metabolically well, and nearly a quarter of normal weight individuals (23.5%) revealed cardiometabolic risk clustering. These cardiometabolically unhealthy but normal weight individuals were more likely to be older, have a larger waist circumference, and be less physically active than their healthy normal weight counterparts. Similarly, the cardiometabolically healthy overweight and obese individuals were more likely to be younger, have a smaller waist circumference, be more physically active, and be of non-Hispanic black race/ethnicity than their unhealthy, equivalent weight status counterparts (Wildman et al., 2008).

In the American Bogalusa Heart Study, the children participants experienced a rise in obesity over the years 1974-1993, however, their rates of hypertension decreased (Freedman et al., 2012). This would indicate that despite fears of chronic disease risk, as a result of obesity levels, these risks are less prevalent than assumed, possibly due to better diets, more physical activity, and medication.

May and colleagues (2012) also present a complex view of cardiometabolic health in American adolescents from the NHANES from 1999-2008. Obesity stabilized during this time at approximately 20%, prevalence of prehypertension/hypertension, borderline-high/ high low-density lipoprotein cholesterol, also did not demonstrate changes over this time period (May et al., 2012). Prevalence of pre-diabetes/diabetes, however, increased substantially, by 14%, over this period. Given the stabilization in obesity over this time, this again suggests a severance from the seemingly unassailable link between increasing

obesity and elevation in diabetes risk. Importantly, while 61% of obese adolescents and 49% of overweight adolescents had at least 1 cardiovascular disease risk factor, 37% of adolescents of normal weight also had at least 1 cardiovascular risk factor. This paper poses a number of issues. One of these issues, as acknowledged by the authors is that a large proportion of American adolescents, of all weights, would likely benefit from healthy lifestyle interventions. It is also essential to consider the dynamic biology and bodies of children. For example, Marcus and colleagues (2012) studied middle-school children over a period of 2.5 years. They found substantial alterations in BMI risk category over this period. For example, 12.7% of overweight students entered the obese classification, and 13% of normal weight individuals entered the overweight classification. These increases in weight states coincided with increases in cardiometabolic risk factors (Marcus et al., 2012). In contrast, a large proportion of children's weight status and cardiometabolic risk decreased over time. Over a third (35.7%) of overweight or obese adolescents shifted to the normal weight category and experienced concomitant improvement in cardiometabolic risk (Marcus et al., 2012). Whether the weight changes produced said benefits, or other underlying alterations resulted in the improved cardiometabolic outcomes, the study suggests the mutability of children's bodies, and the danger in catastrophizing the 'childhood obesity epidemic' based on young persons' current sizes.

### **2.6. 1 Fitness and Diet**

Increasing evidence suggests fitness may affect health independent of weight status, and that obesity and fitness are non-mutually exclusive (Bombak, 2014a).

Overweight and obese individuals who are physically active may have greater cardiovascular fitness than inactive individuals, regardless of their weight status (Lee et al., 1999). In American adults of various weight classes, healthy lifestyle habits (re: moderate drinking, not smoking, regular exercise, and fruit and vegetable consumption) significantly decreased risk of mortality for all individuals, irrespective of initial BMI. Obese individuals benefitted the most from the adoption of healthy lifestyle habits (Matheson et al., 2012). In fact, obese individuals who adopted all 4 healthy lifestyle habits, had the lowest risk of mortality compared to every other weight strata/lifestyle combination (Matheson et al., 2012).

Obese individuals who engage in moderate intensity physical activity for 150 minutes per week have half the death rates and lower rates of cardiovascular disease than their unfit, normal weight counterparts (Blair and Church, 2004). Physical inactivity has a biologically plausible, temporally consistent, and dose-dependent relationship to risk factors, chronic morbidity, and mortality (Blair and Church, 2004; Kokkinos et al., 2011). In Katzmarzyk and Lear (2012)'s systematic review on the effect of physical activity on chronic disease risk factors in obese individuals, only modest benefits for obese individuals with respect to chronic disease risk factors were evident. However, even in intervention groups without a dietary component, significant improvements were produced in some studies in blood pressure, insulin, glucose, triglycerides, C-reactive protein, and cholesterol measures (Katzmarzyk and Lear, 2012).

Furthermore, cardiorespiratory fitness (CRF) may be as relevant a predictor of mortality as diabetes mellitus and other cardiovascular risk factors, and it may be a stronger predictor than BMI, obesity, or abdominal obesity (Kokkinos et al., 2011). Low

CRF has a stronger effect on these outcomes than physical inactivity (Blair and Church, 2004). Both CRF and obesity were found to affect self-rated health (SRH) among adolescent Portuguese girls. However, the association between obesity and SRH was eliminated in multivariate statistics, suggesting that CRF may mediate this relationship (Mota et al., 2012). In California, among school children involved in a prevention program, fitness improved, while obesity rates did not (Aryana et al., 2011). Over 6 years, American adults who experienced changes in fatness and fitness displayed alterations in their risk for incidence of metabolic syndrome, hypertension, and hypercholesterolemia (Lee et al., 2012). This reduction in risk persisted even when fatness was controlled for fitness, and vice versa, although these adjustments attenuated the relationships (Lee et al., 2012). Given the high rates of weight regain, it is essential to consider that even in individuals with weight regain, healthy sustained eating and activity patterns have produced sustained cardiometabolic benefits (Bacon et al., 2005; Bacon and Aphramor, 2011; Blüher et al., 2012).

Studies such as these, which provide findings that seemingly contradict existing obesity epidemiological orthodoxy, are termed obesity paradoxes (McAuley and Blair, 2011). The original obesity paradox was that obese individuals with cardiovascular disease are more likely to survive than their normal weight counterparts. Other obesity paradoxes identified by McAuley and Blair (2011) that being of overweight status (BMI 25.0-29.9 kg/m<sup>2</sup>) may be protective in relation to mortality compared to being of normal weight; that a large component of overweight and obese populations may be metabolically healthy; and that being physically fit, even when obese, may eliminate the association between obesity and increased mortality (McAuley and Blair, 2011).

The beneficial effect of a healthy diet on health outcomes and mortality, independent of weight measures, may soon also be recognized as an obesity paradox. Healthy diet was related to a significantly reduced risk of all-cause and/or cardiovascular disease mortality among American, German, and British samples (Zyriax et al., 2005; Kant et al., 2009; Akbaraly et al., 2011). Joseph and colleagues (2011) have hypothesized that physical activity may also improve eating behaviour by inhibiting hedonic urges for over-consumption. This inhibition operates through neurocognitive developments, which are induced by physical activity and improve capacity for goal-oriented behaviours, inhibitory control, and executive functioning (Joseph et al., 2011). Such studies may also explain the seemingly contradictory results that insufficient fruit and vegetable consumption is not always associated with obesity (e.g. Fransoo et al., 2011). Obese individuals may still consume a diet high in nutritious quality, without experiencing weight loss.

### **2.6.2 Adipose Tissue Effects on Health**

The above studies indicate that overweight and obese individuals may be physically fit and cardiometabolically healthy. This supports the hypothesis that two separate mechanisms are at work in obesity-related conditions, as delineated by Bombak (2014a). One pathway relates to excess adipose tissue, particularly visceral adipose tissue, affecting health, and another pathway influences health through lifestyle factors, such as physical activity and diet, independent of fat and size. Of consequence in this regard is recent research into adipose tissue and its functioning as an endocrine organ. Adipose tissue develops in numerous parts of the body, mainly between muscle and skin,

although it is also present surrounding internal organs (Sethi and Vidal-Puig, 2007). These different depots have different metabolic profiles. Adipose tissue functions in providing mechanical support, insulation, and as a storage site for excess fuel (Sethi and Vidal-Puig, 2007). This fuel is stored as triglycerides and released as fatty acids in response to hormonal and sympathetic signalling. Additionally, adipose tissue releases its own endocrine signals, such as leptin. These signals include adipokines and other cell types that help regulate food intake and energy expenditure. These cells have effects on numerous body systems and functions including energy homeostasis, blood pressure, and the immune system. The dysregulated activities of these processes form the physiological underpinnings of numerous obesity-related morbidities including Type II diabetes mellitus, hyperlipidemia, hypertension, and coronary heart disease (Sethi and Vidal-Puig, 2007).

Thus, obese individuals, particularly individuals whose weight is distributed primarily abdominally, may suffer health risks associated with the endocrine actions of adipose tissue. However, independent pathways relating to healthy dietary consumption and CRF may provide obese individuals protection from adverse health outcomes (Bombak, 2014). This may aid in explaining the obese paradoxes that overweight or obese individuals may not suffer from increased mortality risk in certain populations and may be metabolically healthy (McAuley and Blair, 2011), whereas some thinner individuals may be metabolically compromised despite their ‘normal’, ‘healthy’ BMIs. Sociocultural and economic circumstances are also important. The effects of discrimination, downward mobility, and stress may influence obese individuals’ health in concert with, and beyond, the effects of diet, fitness, or adipose tissue.

## ***2.7 Healthcare Providers' Perspectives on Obesity***

Bombak (2014b) recently reviewed providers' views on obesity, and the following section draws from this review. Biomedical research nearly invariably posits obesity as a health crisis (Gard and Wright, 2005). Weight bias is moderate to high among healthcare professionals and trainees, including those specializing in obesity or nutrition-related practice (Schwartz et al., 2003; Edelstein et al., 2009; Puhl et al., 2009; Swift et al., 2013; Bombak, 2014b). In a recent systematic review on physicians' views on perspectives on treating adult obesity (Hayden et al., 2008), physicians believed it was important to treat obesity (Hayden et al., 2008). They were confident in their skills respecting obesity treatment, although obesity knowledge among the physicians was actually limited. Physicians believed they were largely unsuccessful in treating obesity but attributed this to patient non-compliance and lack of motivation, which coincides with their general view of overweight and obese individuals as lazy (Hayden et al., 2008). Similar results were attained by Foster and colleagues in 2003 in 2 nationally representative American surveys (n=5000). Physicians felt treatment for obesity was ineffective; had negative views of obese patients' appearance and compliance; attributed obesity causation to lifestyle factors; and sought greater compensation in delivering obesity treatment (Foster et al., 2003). Physician attitudes respecting childhood obesity are comparable to those for adult obesity (van Gerwen et al., 2009). Physicians believe treating childhood obesity was important and provide lifestyle advice and dietitian referrals. However, they also feel they are unsuccessful in treating obesity, largely as a result of non-compliance and lack of motivation of patients (van Gerwen et al., 2009).

Reimbursement appeared to be less of an issue in the studies reviewed by van Gerwen and colleagues (2009).

Studies have also presented more nuanced views of clinicians' attitudes relating to obesity treatment (Bombak, 2014b). For example, physician's BMI may mediate physicians' likelihood of counselling obese patients. Among primary care physicians, weight loss discussions was more likely to be initiated by physicians who believed clients had a higher BMI than themselves (Bleich et al., 2012). Normal weight physicians were also more likely to feel confident administering said advice, to feel physicians were responsible for serving as normal weight role models, and to doubt patients would trust weight-related advice from overweight or obese clinicians (Bleich et al., 2012).

Similar to other studies, physicians in New York State expressed frustration in attempting to treat obesity (Epling et al., 2011). This frustration was based on the extent to which obesity-contributing factors were outside their control, low sense of self-efficacy in treating obesity, and a perceived lack of reimbursement. Interestingly, a more derogatory view of obesity causation, relating to lifestyle factors, was held by rural physicians than non-rural physicians. Non-rural physicians tended to focus on psycho-behavioural factors, such as weight cycling, restaurant eating, or inadequate nutrition information (Epling et al., 2011). Another study conducted in New York City involved a chart review and patient survey, and its results suggest little focus on obesity in practice (Davis et al., 2006). It was found that physicians were relatively unlikely to enter an official diagnosis of overweight or obesity on a patient's chart, to advise weight loss, or refer to a dietitian (Davis et al., 2006). However, these practices were more likely to occur for obese than overweight patients, although they were not affected by

comorbidities or frequency of visits (Davis et al., 2006). This generally contrasted with patient wishes who wanted to lose weight and receive physician advice and referral to a dietitian.

A qualitative study on German physicians' and patients' views on obesity management found that doctors were concerned with a potential over-emphasis on obesity (Heintze et al., 2012). Both physicians and patients emphasized the need for multi-disciplinary approaches to obesity management, the excess burden on primary care centres, and emphasized respectful trusting relationships between practitioners and patients (Heintze et al., 2012). The need for more services and professional involvement, delivered by physicians or other providers, either separate from or within a primary care setting, was also referred to by both groups (Heintze et al., 2012).

A recent debate in the *Canadian Family Physician* journal has highlighted that practitioners may be developing a more critical view on the orthodoxy of advocating weight loss for every obese patient (Bombak 2014b). Bosomworth (2012) presents a review on possible negative mortality, morbidity, and quality-of-life outcomes of weight loss, and prescribes that metabolically healthy obese individuals should strive to remain weight stable, not to gain or lose weight. An accompanying editorial encourages promoting self-acceptance and healthy lifestyles for obese patients, as weight loss is nearly impossible (Ladouceur, 2012). Havrankova (2012a, b) presents the argument that weight loss as a public health goal is futile and contends that the focus should be on preventing obesity. Garrel (2012a, b) posits that obesity prevention is largely outside the practitioner's purview and argues instead for obesity treatment. The treatment proposed, however, involves fairly modest goals. Garrel (2012a, b) adopts the Edmonton Obesity

Staging System for guiding obesity treatment (Sharma and Kushner, 2009). Based on these guidelines, Garrel (2012a, b) supports urging weight loss only in obese individuals who have comorbid conditions; physicians should work with obese individuals without comorbid conditions to prevent weight gain. Treatment of obese individuals with comorbid conditions would involve treating these comorbidities, setting realistic weight goals with patients, and warning them of unsafe weight loss methods.

The Edmonton Obesity Staging System (EOSS) was developed to aid in making treatment decisions for obese patients in clinical practice (Sharma and Kushner, 2009). An individual's stage, from 0-4, is based on the presence of any obesity-related risk factors, comorbidities, including psychopathology, and functional limitations. At Stage 0 or 1, in which an individual is metabolically healthy or displays only subclinical risk factors, individuals are counselled only to prevent further weight gain through diet and physical activity (Sharma and Kushner, 2009). Further stages, at which patients present with either severe psychological or physical health issues and/or significant impairment of functionality or quality-of-life, more aggressive obesity treatment would be initiated. This would include treatment of comorbidities, and behavioural, pharmacological, and surgical treatments for obesity (Sharma and Kushner, 2009). The EOSS presents a more nuanced view of obesity than mere anthropometric measures. It allows for the possibility that some obese patients may be healthy and not benefit from treatment (Bombak, 2014b).

Dietitians are also viewed as a key factor in obesity management (Bombak, 2014b). Physicians are more likely to refer to dietitians than to gastric bypass surgeons or to prescribe medication (Hayden et al., 2009). Dietitians agree on their primacy in obesity

treatment (Barr et al., 2004). In a sample of 514 Canadian dietitians, about 90% felt obesity contributed to ill-health and a large majority felt obese individuals should be encouraged to lose weight (Barr et al., 2004). However, they also emphasized the importance of health measures other than weight in obesity treatment, and the majority advised their clients against weighing themselves (Barr et al., 2004). Indeed, many dietitians were positively disposed toward a HAES approach; however, there was variation in plans to adopt more structured eating plans and abandoning weight loss as a goal. Some also argued that certain (larger) sizes exceeded healthy limits (Marchessault et al., 2007).

In examining clinician perspectives on obesity, what appears to be essential, therefore, is the establishment of trusting and respectful relationships between clinicians and their obese patients (Bombak, 2014b). These relationships must be sustained in light of obesity's likely intractability. A greater understanding of clinicians' and obese patients' health perspectives, perceptions, and priorities over the lifecourse is paramount for achieving these aims.

### ***2.8 The Need for Obese Individuals' Perspectives***

The literature thus suggests that obese individuals experience substantial stigmatization and exist in an environment saturated with non-problematized information concerning the health risks of excess weight. This information is often presented in a manner that assumes control for health resides in the individual and that achieving wellness constitutes a moral imperative. To a greater or lesser extent, individuals appear to have adopted this discourse and allowed it to influence their perspectives and

lifestyles. Individuals' health perceptions may be influenced by pervasive mainstream weight discourse but also be mediated by somatic understandings of wellbeing. As evidence suggests that obese individuals may be healthy, obese individuals may not absorb popular obesity-related messaging, based on their own somatic signalling or knowledge of their lifestyles. Individuals may also have differing priorities regarding wellness that supersede weight concerns, such as an emphasis on experiencing pleasure or mitigating income-related food insecurity. Regardless of the health risks associated with obesity, a greater understanding of how obese individuals feel concerning their health and quality-of-life, what obese individuals regard as their priorities concerning health, and what they feel would most benefit their quality-of-life and wellness is necessary. These views may also alter over time as different weight trajectories are experienced, and this is essential to consider given the chronicity of obesity. In crafting public health messaging, programs, and policies, such knowledge will be essential in creating effective and ethical interventions.

**CHAPTER THREE:**  
**THEORETICAL FRAMEWORK**

**3.0 Theoretical Framework**

This study drew from a number of theoretical perspectives. The study was undertaken utilizing a critical obesity perspective. Critical obesity studies arose amongst increasing dispersal of information on the ‘obesity epidemic’ and its effects on individuals’ health and healthcare systems (Gard and Wright, 2005). Critical obesity scholars have challenged the epidemiological and biomedical research underlying sensational media and medical portrayals of obesity (e.g. Gard and Wright, 2005; Campos et al., 2006). The moralizing nature of obesity discourse has been examined, as has its potential to mask other forms of socioeconomic, racial, and gender discrimination (e.g. Guthman and DuPuis, 2006; Warin et al., 2008; Colls and Evans, 2009; McPhail, 2009, 2010; Guthman, 2011; Warin, 2011). The effects of the dominant obesity discourse on individuals’ discursive understandings of their bodies have also been studied by researchers utilizing a post-structural, feminist perspective (e.g. George and Rail, 2005; Rail, 2009; Jiwani and Rail, 2010). How dominant obesity discourse is disseminated in a variety of contexts has similarly been explored (e.g. MacNeill, 1999; Burrows and Wright, 2004; Evans et al., 2004, 2008; Rich et al., 2004, 2010; Miah and Rich, 2008; McPhail, 2009, 2010; Wright and Harwood, 2009; Isono et al., 2009; Warin, 2011).

This study contributes to critical obesity scholarship by examining the effects of the prevalent obesity discourse on the lived experience of obese individuals and their health perceptions over time. The present project will consider a number of contributors

to the discursive context in which obese individuals live including stigma, healthism, and bio-citizenship. The biopedagogical transmission of this discourse and its resistance, internalization, and effects on individuals' lived experiences, health perceptions, lifestyles, and wellbeing will be explored. The longitudinal study design also allowed for an emphasis on the body's natural fluidity, contingency, and adaptability (Longhurst, 2001), which is essential to consider given the underexplored area of obesity's chronicity and weight fluctuations' impact on health, self-concept, and wellbeing.

Considerations of stigma were drawn from Goffman's (1963) conceptualizations of discredited and deviant spoiled identities. Obesity often constitutes a discredited spoiled identity, as obesity is a highly visible, non-normative state. This stigma is compounded by presumed moral deviance in a healthist environment. Recent developments with respect to stigma and moral experience will also be considered (Keusch et al., 2006; Yang et al., 2007). This includes incorporating that which is "most at stake for actors in a local social world" (Yang et al., 2007:1525) within the social dimensions of stigma. For example, this may involve stigma impeding life chances, financial and life opportunities, and the fulfilment of individual or familial role functions (Yang et al., 2007; Kleinman and Hall-Clifford, 2009). This view of stigma also considers the manner through which stigma is sociosomatic and how through psychobiological, moral-somatic, and moral-emotional pathways, stigma may have direct physiological consequences (Yang et al., 2007).

Healthism proposes that medicalization now extends to lifestyles and has come to re-constitute the pursuit and achievement of health and wellbeing as moral imperatives (Crawford, 1980). An obese body serves as a visible confession of apparent pathology;

even in situations in which ill-health is not present (Davies, 1998; Jutel, 2009; Murray, 2009a). Thus, in a context of healthism, in which health is a social and moral imperative, an obese body is also automatically labelled as socially deviant (Goffman, 1963; Crawford, 1980; Foucault, 1991; Lupton, 1995). This will compound the stigma experienced by obese individuals, who already are considered discredited based on their non-compliance with appearance norms (Goffman, 1963; Bordo, 1993). To atone for their deviance respecting health and appearance norms, obese individuals are expected to attempt to normalize themselves by obtaining a body more in keeping with health and ascetic standards (Murray, 2009a). In addition to healthism, this study will employ Foucault's (1978) biopower, the governance and regulation of individuals and populations through practices associated with the body, and Halse's (2009) related extrapolations of bio-citizenship. Bio-citizenship expands on Rose and Novas's (2005) concept of biological citizenship in which an individual's social, electronic, and political affiliations and alliances are constituted based on their various bodily considerations such as illnesses and genetics. Bio-citizenship arises when the body is merged with the political, cultural, economic, and social roles and functions of a citizen of the state (Halse 2009). Halse (2009) directly applies bio-citizenship to weight maintenance. Responsible bio-citizens are prepared to assume responsibility for their own health to benefit themselves and the common good. Within the current public health environment, in which obesity discourse is predominant, a virtuous bio-citizen is one who prioritizes and is conscientious in achieving and maintaining a normal BMI. Obese individuals are automatically labeled as unhealthy and as deviant bio-citizens by virtue of their size.

The use of Goffman (1963), a structuralist, and Foucault's (1978) post-structural notions of biopower may appear jarring, given post-structuralism's focus on a reality constructed from discourse. While Goffman contends that individuals may be influenced by their external contexts, Foucault posits that subjects are constituted in and through discourse. Subjects are thus not the centre of discourse and cannot be understood without consideration of discursive mediation.

However, Goffman and Foucault's dual use in this study was complementary and productive, and they have been used (without acknowledgement of contradiction) by critical obesity scholars in the past (e.g. Throsby, 2007; Drew, 2011; Parr and Rasmussen, 2012; Knutsen et al., 2013). As obesity is a necessarily highly visible condition, Goffman's (1963) understandings of societal discretization based on non-normative bodies and the presumed deviance that underlie this non-normativity allowed for an emphasis on how individuals' entire identities could be "spoiled" merely via their size. This is evident, for example, in fat persons' immediate discrediting in medical encounters based solely on their size (Jutel, 2006; Murray 2008a). Furthermore, the term stigma was brought up independently by research participants, suggesting familiarity with the societal effects of their 'excess' size.

Outside of critical obesity studies, the concurrent use of Foucault and Goffman has been considered. Agger (1991) argues that Foucault, with his greater focus on discourse, language, and meaning adds to this visceral understanding of deviance a historicized and politicized lens, and allows researchers to understand the experiential and meaning-based context that constructs such deviance. Likewise Hacking (2004) contends that Foucault's more abstract view of discourse allows for an understanding of

how institutions develop and meanings are normalized. In contrast, Goffman's focus on mundane communications demonstrates how such ideas may be taken up and incorporated into oneself in everyday life (Hacking, 2004). Furthermore, Foucault (1978) allows for the possibility of resistance, albeit within discursive fields, which coincides well with Goffman's (1963) discussion of stigma management. That is, both authors are valuable in exploring how individuals with certain non-normative attributes live within contexts shaped by particular relations of power and knowledge creation. Clarke (2008) contends that Goffman's conceptualization of stigma, being largely based on others' construction of deviance and normality suggests a more constrained forerunner to Foucault's more all-encompassing social theories. According to both theorists, the construction of abnormality is not located within an individual's inner being, but rather a product of how others view said individuals and what constitutes normality in a social sphere (Clarke, 2008). Thus, while this study uses both Foucault and Goffman as key theorists, it does so acknowledging the theoretical tension inherent in their usage and proposes further theoretical grappling in this area as a rich future possibility for critical obesity scholars.

The use of these theoretical concepts allowed for a greater exploration of obese persons' perceptions of health, moralism, and stigma; the inter-relations of these factors; and these factors' effects on obese individuals' lives and health perceptions.

## **CHAPTER FOUR:**

### **METHODS**

*4.1 Design – Critical ethnography with repeated in-depth interviews* - This study involved 1 year of ethnographic participant observation and in-depth repeated interviews. Data sources included field notes and audio-taped, semi-structured, qualitative interviews with research participants.

*4.2 Study Participants* – Participants included men and women 18 years of age and over who self-identified as obese or formerly obese. Obesity was explicitly stated as inclusion criteria in recruitment posters. This was intended to avoid the conflation of overweight and obesity that commonly occurs in obesity discourse (Gard and Wright, 2005). It was hoped that obese individuals would recognize this study as relevant specifically to them. Furthermore, this study was interested in obese persons' own understandings of health and the influence of health-related discourse and interactions on such understandings, including the clinical and pathological labelling of obese. As such, this study intended to make audible the “telling silences” in obesity research discussed by Warin and Gunson (2013). Rather than attempting to ‘soften’ the terminology in order to ‘protect’ participants from associating with a stigmatized condition, I intended to make clear that the goal of the research was to better understand what people labelled as obese thought of this label and to explore other aspects of their health and lives. This is thought to have contributed to potentially new findings in critical obesity studies, given the focus on a

clinical term and the medical affiliation of the researcher, rather than recruitment through more politicized or appearance-focused terminology.

To allow for a robust analysis, maximum variation was sought in participants' perspectives on health, obesity, and weight loss. Subsamples included 1) individuals who were pursuing weight loss to achieve health goals, 2) individuals who were attempting to get/stay healthy through diet and exercise but are not concerned with weight loss, and 3) individuals who did not prioritize diet and exercise in their conceptualization of healthy living. Subsamples consisted of a minimum of 5 individuals. Recruitment was conducted through posters at numerous community sites, many affiliated with health and fitness activities, as well as through hospital employee mailing lists.

**4.3 Data Collection** – Data collection occurred in 2 phases. The first phase included interviews with all participants (n = 15). The second phase introduced a qualitative, longitudinal component. Three follow-up interviews, at 3-4 month intervals, were conducted with 5 participants who represented diverse perspectives on obesity and health and experiences with weight loss efforts and provided especially rich data. Interviews were conducted based on interview guides. For initial interviews, all participants were interviewed based on the same interview guide (see **Appendix A**). Subsequent interviews involved interview guides specific to each group, and interview guides for repeated interviews were iteratively constructed based on themes identified in previous interviews (**Appendices B-D**). Interviews were audio-taped and transcribed verbatim by a professional transcription agency. Participant observation over the course of 1 year

occurred at multiple sites identified by participants as essential to their lived experiences and health as obese individuals.

This study deployed a multi-sited ethnographic design, as an individual's life is not experienced in a single location or in isolation, particularly for an individual who is embodying the visible, and often marginalized, state of obesity. This method allowed participants to be followed from one relevant site to another and provided a greater understanding of the embodied lived experience of obese individuals. It helped identify and explore where obese individuals seek and receive acceptance; where they experience discrimination; and where they pursue wellness, fulfillment; and potential bodily modification. The approach also facilitated the study of obese individuals' interactions in these environments and how their perspectives and utilization of such sites change over time. As rapport grew, through the repeated interviews, participants were asked as to the locations of these sites, and these sites were used for participant observation. Such an approach epitomized Marcus's (1995) 'follow the people' technique of conducting multi-sited ethnography. Following every interview and participant observation at sites, detailed field notes were immediately taken and then added to participants' summaries electronic summaries. These field notes were then incorporated into all subsequent analysis stages.

#### ***4.4 Thematic content analysis***

Data sources were analyzed following the method of qualitative, inductive content analysis described by Elo and Kyngäs (2008). Detailed electronic and paper-based audit logs were maintained throughout data collection, analysis, and interpretation phases. Data

sources were read repeatedly and data were coded based on a coding list constructed based on the literature review, the theoretical framework, and issues brought up in interviews. In part, this code construction process resembles Wright's (2004) discussion of drawing on previous researchers' mapping of a pertinent discursive field. Relevant new codes, which were continually encountered, were added to this list throughout the coding process. Every individual's narrative was summarized for each interview phase and overall. All 7 research questions were then answered independently for each individual participant. These individual responses were then compared and contrasted with other participants' responses respecting the research questions, and patterns were sought in these responses according to participant characteristics, weight trajectories, and attitudes respecting weight. Overall summary responses were then prepared for each research question.

Data were then grouped into themes, based on recurring issues that emerged and transcended single research questions. Analysis was conducted in an iterative manner, concomitant with on-going interviews. Themes from earlier interviews were incorporated into subsequent interview guides. This capitalized on the longitudinal study design, the repeated interviews, enhanced rapport, and increasing researcher and participant reflexivity.

## CHAPTER FIVE

### RESULTS OF ONE-TIME INTERVIEWS

#### *5.1 Summary of participants*

Recruitment was highly successful. The researcher was contacted by potential participants as late as 7 months following initial recruitment efforts. After beginning Phase 2 interviews, these individuals were turned down for participation. Individuals who felt they had never qualified as obese by biomedical standards or individuals who were not 18 years-of-age or older were excluded. Only 2 potential participants did not meet inclusion criteria. Numerous contacts reported their weight or BMI without prompting, suggesting the extent to which these measures have permeated cultural awareness.

The participants who provided the richest data with respect to various weight-related trajectories and attitudes were selected for subsequent phases.

**Table 5.1: Participant Characteristics**

Age (Range)	Sex (n)	Household	Ethnicity	Occupation	Weight Goals
30s-60s	Female=13 Male=2	Partner=8 No Partner=7 Has children=8	White (n=12) Other (n=3)	HC=6 HC-U=2 HC-P=5 Other=2	WL=7 ML=3 A=5

HC = Healthcare employee; U = Unemployed; P = Healthcare Peripheral  
WL = Weight loss; ML = Maintain weight loss; A = Accept current weight.

#### *5.2 Understandings of Personal Health*

The majority of participants described their health in largely positive terms. When asked specifically about personal health, participants tended to answer in narrower terms

(i.e. diagnoses, clinical biomarkers) than when discussing general thoughts on health.

This was particularly evident in those with a narrow definition of health, such as participants extremely pre-occupied with weight loss.

Approximately one-fifth of participants mentioned having diabetes and discussed weight, food, and nutrition's effects on blood sugar. They also mentioned embodied awareness of these effects. The same participants were likely to relate having high blood pressure. Experience with gastroesophageal reflux disease (GERD) was referred to by a number of participants. Suffering from mood disorders (i.e. depression, anxiety) or related symptoms was mentioned by about a third of the sample, and this was roughly split between those adopting a more biomedical view on dominant weight ideology and those who were more doubtful of this perspective. Nearly a third of participants discussed a history of disordered eating or weight preoccupation. The most common health complaints described by participants related to functioning and mobility issues and consequent pain. It was this aspect of their health that participants, including those with less weight-centric views on health, felt was most often affected by changes in weight. Amongst others, Hannah, Megan, Joanne, and Matilda all discussed weight alterations' impact on their functionality:

*Yeah, I do. I never used to, and that's something I've started noticing lately, that I feel like... I can tell when I've put on weight because I feel... like it's more difficult to do simple things like... I feel like... I have less energy.*

*Or I feel like... it's harder to climb that flight of stairs or if... I can just sense it. And in my body too I can feel like... I have like lower back pain and I can tell-, when it starts to creep up again I can tell oh, I must've put on some weight. Like I feel like my body is trying to get used to that new weight. And then it gets used to it and then it will change and then it reacts to that change. – **Hannah – Woman 30s***

*My mobility is better. Like I've lost... it was up last week, I've lost about 25 pounds now on Weight Watchers over about a 20-week period. So I find I have-, my energy level is better, certainly my mobility level is better. – Megan – Woman 50s*

*I think it would be quite possible. I figure if my weight was anywhere from 40 to 50 pounds below what it is right now then I could-, there were many things that I can't do now that I could do again.-Joanne, Woman – 50s*

*I am kind of getting to that point where the extra weight is probably a little bit harder for my joints, and that's only been recently where I am noticing I am feeling like my hips hurt, and I am starting to wonder if that's more just because of the amount of weight I am carrying as opposed to I slept funny - Matilda, Woman – 30s*

Thus, in describing the relationship between weight and health, functional fitness was the most frequently mentioned aspect of health that participants' connected to weight differences.

Some participants, particularly those with more holistic or less weight-centric health views, considered effects of other, non-weight-related factors on mobility/functioning. Such factors included aging, attitude, and behaviours. One participant, who experienced diabetes remission, attributed this less to her weight loss and more to physical activity. Katrina and Amelia highlight non-weight-related factors that they feel hinder or assist in their functionality

*I do have a few health issues and challenges, but you know what age [40s] you're going to have some health issues sometimes, and depending on what your family history is you know you come by them honestly. - Katrina, Woman – 40s*

*Up until three years ago and for the 20 years before that I was constantly in the healthcare system. And I think a lot of it was weight-related and a lot of it was physical symptoms, but I think there was an emotional component behind the physical symptoms. Not that the physical symptoms weren't real but... You know, at the very most when I really heavy I think at one point I was taking 11*

*prescription medications on a daily basis. And now I take two. And one of those is probably still weight-related but the other one isn't.*

*I think going to the workouts has been the bigger part.*

*Because even, you know, at times in the last two and a half years my weight wasn't that much less than it was at the heaviest that I was at. And... yeah, it wasn't that much less. And yet I still was healthier than I was. - **Amelia, - Woman 50s***

The focus on function and mobility also related to another major concern of some participants, growing older:

*But I have over the last ten years become much more desirous in believing that the healthier you are today the longer you are tomorrow.*

*And it doesn't mean the older you get, the less you do, the older you get, sometimes the more you can do.*

*And it is very slowly catching up in the fact that we [friends] are much more adventurous than we were 20 or 30 years ago.- **Harry, Man – 60s***

*What's most important to me, I don't want to die young - **Daisy, Woman – 50s***

*Well, being able to just live a long and healthy life... and I don't want to have like issues with blood pressure and heart disease and diabetes and be on all this medication by the time I'm like 45 or something ridiculous – **Pauline, Woman – 30s***

*So I have a [partner] and we ... I wanna live like a long time with him and I want us to not have a lot of limitations.*

*I'd really like for us to need to be mobile and active and not dependent on society or family and friends to get around and do our lives. So it's more like long term I'm thinking, that's what I wanna do ... And I've said I wanna be able to do my job as well as I can and there's a huge physical aspect to my job – **Rachel, Woman – 40s***

Therefore, while participants tended to privilege the relationship between weight and functionality, other issues were recognized as contributing to variations in functionality.

Some feelings associated with weight changes appeared less related to embodiment and more to guilt or valorisation related to weight changes:

*Oh, yeah I... When-, if I gain even a pound, or if I eat wrong-, I know I've eaten wrong...I just rack myself out over the coals.*

*You feel it completely, you can't do anything, you're bloated. And you just feel like what's life worth living – Christine – Woman – 50s*

*Yeah like I mean I am really anxious...I still weigh myself every single day, and my weight is kind of tied to my self-esteem, like I can see how weight disorders form because like I remember I would be losing weight, you know I would lose like 20 pounds, and then I would go up a pound, because well like you can't always go down...*

*And I would just be like oh, like I would just be so fed up and frustrated with myself and so it's like I could see how like people get anorexia when you get depressed over getting like one pound, even though you have lost 19. – Todd, Man – 30s*

*It's you know you lose all the weight and you're proud and excited and then you gain it back, see now I'm going to get sappy on you...and you get really disappointed and you feel ashamed and embarrassed because you know everybody is watching and keeping tabs- Daisy, Woman - 50s*

*Uhm... Well, I think there is a stress if somebody steps on a scale and their weight's gone up a pound. Like never mind 5, 10 pounds. Like one pound can be really upsetting. Like I know I've been upset by it.*

*Because I think that's a lot of what makes it fall apart, is that you run into some adversity and the adversity sort of takes control. And then all of a sudden like you're playing to that instead of to what you wanted to do. You're fighting against the extra pound on the scale than concentrating on something more positive. – Joanne, Woman – 50s*

Individuals who had experienced disordered eating or weight preoccupation felt their health suffered the most at lower weights and/or when they were participating in disordered- eating practices:

*When I was at a bit of a larger size that I would have a bit more energy, you know I'd still love my favorite foods, but didn't necessarily feel the cravings for them as strongly, you know would wanna exercise, but I would often have a bit more of a feeling like oh it'd be so nice to go for a walk, the sun is shining, not today, but you know on different days ... No that wouldn't ... Versus a oh my God, I still haven't exercised today and its already 2, like what the ... So you know I felt*

*a little bit more natural, more kind of comfortable in myself, which felt more healthy, but at the same time, not fitting into the clothes that everybody else would want to ... Kinda having family members sorta look over at my shoulder at what was on my plate or what wasn't on my plate. So it felt ... Yeah it felt ... Hard to say whether healthy or unhealthy, but what was hard is to really feeling kind of how other people were looking at me and trying not to let that affect my own...whether I felt healthy or unhealthy. – **Melissa, Woman - 30s***

*I definitely felt ... I felt less healthy at times ...But what is probably most surprising to most people, it was when I was very thin. So and that was ... At that time they were actual physical things that were taking place ...Due to poor eating ...And physical activity and ... Yeah so I experience loss of my period, hair...*

*When I was not stable and not in a positive place with my body image and myself and not feeling that health-at-every-size was a viable option for me, it really kept me up at nights, because it becomes a demon, right. Trying to lose weight at all costs becomes all-encompassing and obsessive, for me.*

*It's something that no longer keeps me up at night, which is a real freedom...And contributes massively to a quality-of-life. Because that ... Obviously impacts my personal life...You know my relationship with my spouse, my relationship with my friends and family – **Clarissa, Woman – 40s***

*The weight loss yes, that was, I definitely, like I had a lot of low energy, my blood pressure was actually a lot lower, like it was 60 over 40 and my doctor said you really need to start eating and maybe increase your salt intake or something right. - **Matilda, Woman - 30s***

Participants, therefore, felt that weight, but not weight exclusively, affected their ability to function, a major component of their health. Not all participants believed weight loss had a positive impact on their health. Individuals with disordered eating histories believed being at higher weight statuses benefitted them overall.

### 5.3 Understandings of Obesity

#### 5.3.1 Obesity as a Chronic Disease

A central discourse of obesity is its construction as a disease. Participants rarely referred to obesity as a disease. When participants did so, it was deployed seemingly in an attempt to lessen personal culpability. For example, Christine emphasizes stress and time restrictions as major contributors to her disease, obesity:

*Every little thing in society adds up to the obesity. It isn't just overeating. It's not sleeping. It's not... having-, it's a money issue too. We live on the north side and we're strapped for money, so my husband and I didn't take dates-, you know, like monthly dates or... And that's important. And even that just relieves a little stress and... And I think that it's not just the person whose obese that needs help; it's the whole community that needs to recognise it as a disease. And the doctors don't recognise it as a disease. – Christine, Woman – 50s*

The chronicity of obesity was evident in the stories told by participants of their weight trajectories, their struggles with weight maintenance, or their resignation regarding their weight status:

*So it's not really about me anymore, I have accepted who I am, I work as best as I can to stay as healthy as I can, I don't always do the best jobs and as a result I have some health issues – Katrina, Woman 40s*

*I tried quitting smoking I think three times before I finally did it. And I'll go to Weight Watcher meetings and I'll think why the hell is she here? She's like so thin. And then they'll get up and they'll talk and they'll say well, you know, I took off 110 pounds and I've kept it off for like 15 years. And I'm thinking that's probably why they've kept it off, it's because they're still going to meetings or they're checking in once a month or...*

*And I think this time if I can manage to lose the weight I'm not going to-, once I've put on 10, 15 pounds I'm going to start to do something and... you know, more strictly watch my calories and controlling things and maybe increase my exercise and not let it get to the point where it's... you know, it's just so insidious that it's just kinda you turn around and you think how did I get here. - Megan, Woman 50s*

*I'm so afraid of becoming what I used to be, that I think that that's the best way to keep an eye on it right, like it's just every day weigh yourself, and you know other articles I have read says whatever you do don't weigh yourself because you're going to get discouraged, you know don't weigh yourself every day, like weigh yourself like once a week, and like I disagree, because I'm like I think you need to know you know if you're going in the wrong direction you need to know like right away when you're going off in the wrong direction. - **Todd, Man 30s***

In discussions of their and others' struggles to maintain weight loss, participants framed obesity as a chronic, persistent concern.

### **5.3.2 Contributors to Obesity**

In articulating their understandings of obesity, participants also discussed what they felt caused obesity. Numerous factors were referenced as increasing susceptibility to obesity, such as addiction, emotional eating, and psychological conditions. This was especially evident in those individuals who more thoroughly internalized biomedical obesity constructions. However, individuals who expressed doubt over obesity discourse also referenced these contributors to obesity:

*When I saw the ad, I thought yeah I'm fat, and everybody tells you and observes it, and there is so much for people who are anorexic or bulimic, but there's not for people who are fat, you know what I mean, being fat isn't a choice, it's psychological and it's an addiction and there's nothing for fat people out there, like you can't go to the doctor or go to like, you go to counselling because you're anorexic or bulimic, but there's nowhere to go for counselling because you're fat, and it's not fair, and it's not right, so maybe this will change that. - **Daisy, Woman – 50s***

*I mean they're... They lock up tobacco. You know, you have to be over 18 to buy tobacco. We're dealing with a similar public health issue here, I'm kinda thinking maybe we are. – **Amelia, Woman – 50s***

*I became highly socially stressed, physically stressed, mentally stressed and it was just like the easiest way to deal with stress was to have something to eat. – **Harry, Man – 60s***

*Cause I do feel like, maybe I do have an eating disorder, maybe I do have an issue with food, I don't like binge and purge...I don't, you know I am obviously not anorexic, but I do feel like it's hard for me to control it, I keep telling myself like I don't need to eat because I'm not hungry. – Pauline, Woman – 30s*

*Like why do I have this crazy drive in my brain that I can't stop and it's connected to sweets and chocolates and ...And really a lotta chocolate. Yeah it's like I'm looking for something to turn off my angry brain ...- Harmony, Woman – 50s*

Emotional and psychological coping and loss of control concerning food was thus a common theme amongst participants, regardless of their views on standard weight discourse. Importantly, many participants made reference to other compulsive attitudes with respect to food, physical activity, or weight loss behaviours. While the use of the term 'compulsive' on the part of the researcher may suggest pathologization, it reflects participants' discussions of these issues. Participants described weight maintenance behaviours as "OCD" (i.e. obsessive-compulsive disorder), as being "obsessed", as "eating disordered", or powerfully described feelings of intense anxiety regarding weight changes. Eating behaviours were described using terms such as "addiction", "psychological issue", "and disease". Participants described feeling out of control or eating until they achieved a state of "oblivion" or "drunk[eness]". Thus, it was participants relating their experiences in terms of pathology and not a construct of the researcher.

In some cases, transference of compulsive behaviours seemed to occur from one area: food – to another – physical activity or calorie counting. For example, Amelia discusses her replacement of food as a coping mechanism with exercise:

*My drug of choice is food. Now it's exercise. – Amelia, Woman – 50s*

*I tend to be a collector of... collector of awards in the past where I would aim for a goal and I would just keep on hammering and hammering away at it until I got something out of it. Like doing... so many miles and say if I had run two miles this week I wouldn't allow myself to run less than two miles the following week.*

*Because getting obsessed with... with trying-, with improving something even though it doesn't need to be, or trying to keep up an artificial standard of... I did this much of this and therefore I must do this much plus one. – Joanne, Woman – 50s*

*But that caused such great anxiety that I would actually lose sleep or I would lay awake at night and think of what ... Like calories and calorie deficits and how I could get to a point where ... You know how much I could lose if I lost weight over a certain amount of time and by what time. So if I lose a pound a week, how many weeks will it take me to get to this weight?*

*I seem to be addicted to like people telling me I'm doing a good job - Rachel, Woman – 40s*

*I was also pretty like almost borderline OCD with counting calories, I found a couple of little programs online that you could use that you could put in all your food and it would tell you at the end of every day like how many calories you had, and I didn't care about salt or carbs or anything like I just looked at calories and you could enter like all your walks that you did, so it would show you like you ate this much, you lost this much, you need this much to just exists.*

*I got to the point where like I wouldn't eat anything if I didn't know how many calories were in it, and you know I tried to keep it as low as I could... I cut out all my soft drinks and I cut out like all kinds of snacks and fast foods and just kind of lived on a pretty basic...I always ate the same thing because I knew how many calories were in it, because that way I wouldn't have to refigure out how much that meal was. - Todd, Man – 30s*

These quotes demonstrate that while participants may have discussed their compulsivity as contributing to obesity, these characteristics also manifested themselves in other areas of life, including weight loss efforts.

Even when acknowledging the effects of factors like stress on obesity, some participants still individualized its causation. For example, Harry had lost weight but was still technically obese. Despite this, he held strong views on personal responsibility and obesity:

*But again I've come to the conclusion that size matters and that being obese, overweight or unfit and i.e. unable to perform the daily tasks in a consistent manner is...disease.*

*I don't think of it as a human right or a civil right, I think of it as a cost of ... To the taxpayer. The healthier we are, the less medical funds we'll pour into taking care of people.*

*There should be a tax that says if you're gonna eat this stupidly, pay now so we can have a pool of money later to take care of you. - **Harry, Man – 60s***

This was especially interesting given that Harry disclosed he had both diabetes and high blood pressure, conditions thought to be the most strongly related to obesity.

For participants who had previously experienced disordered eating or weight preoccupation, addiction, disease, or psychological states were less often referenced than metabolic effects of dieting. These participants had often been exposed to alternate weight-related discourses, such as the HAES movement. They often attributed their present size to irreversible damage done to their bodies by food restriction at a young age:

*That was a fairly dark time in my life. And then ... And I think that ... I don't know if it continues to do so, but I think it really messed up my ... My metabolism to go on such a restricted diet at such a young age. – **Rachel, Woman – 40s***

*My not having eaten, which of course was a huge mistake that at 16/17 you don't realize the implications of having done that to your system, because my system generally I think it always thinks it's starving, it hasn't quite you know ever realized, although I did the three meals at set times and try to kind of get my body back into a rhythm of understanding it would get food. – **Matilda, Woman – 30s***

Participants who experienced disordered eating thus viewed their compulsive previous weight loss efforts as producing their current size. Interestingly, while

ostensibly blaming dietary restriction for their size, this still positioned individuals as not necessarily culpable for their current weight.

#### ***5.4 Relationship between Health and Obesity***

Participants could broadly be divided nearly in half based on their views on biomedical constructions of obesity and health. About one half of participants evinced at least some doubt over biomedical conceptualizations of health and obesity or emphasized holistic definitions of health. The other half of participants were more accepting of biomedical notions of obesity as a pathologized state or a contributor to future disease, although inconsistencies were present in all broad categorizations. Participants' views on obesity and health are depicted in Table 5.2.

##### **5.4.1 'Risky' Obesity**

The internalization of the standard biomedical constructions of obesity was particularly evident in participants' concern over the future. This concern was often present despite current good health:

*Well, cons-, even though I am quite heavy, my weight-, my health is actually pretty good. I just had a check-up less than a month ago and had the full workup of my blood, was checking everything. And everything was really great; my doctor is... actually she said she was really happy. But I mean I work as a nurse, so I know like... It's not going to always [laughs] be that way, it's... It's something that I need to get into check so that it doesn't get worse. But health-wise I'm actually pretty healthy. – Hannah, Woman - 30s*

*I think it's just a smoking gun [laughs]. I'm on no medications; my blood pressure was like 100 on 50 before I gained a lot of weight, so now it's up to like 120 on 60-something [laughs] so I had a lot of room to move. My [siblings] are both on blood pressure medication. So I haven't had any problems with sugar so far but I guess that it's probably just the Russian roulette dodging the bullet till...you develop diabetes. – Megan, Woman – 50s*

Thus, obesity was viewed as an omen of future ill health. Participants that more readily internalized obesity discourse also generally were more likely to express an interest in losing weight or were currently in the process of losing weight.

#### **5.4.2 Holism or Doubt**

Some participants' views on health incorporated very broad parameters or reflected a sense of doubt over standard views on obesity. Some participants had adopted a HAES perspective. For example, Clarissa stated:

*They need to open up ... You know we know that mental health is as important as physical health and if a physician could step back and just remember that and I think if we can work towards a greater mental health and you know and that includes like working with body acceptance and not...the body and the self so much, health will improve ... Physical health will improve.*

*I feel like right now healthcare with weight and this is directed at people of all sizes and I feel like doctors really have ... And public health have really done a disservice to people in general by focusing so much on weight, because it had made everybody crazy. – Clarissa, Woman – 40s*

Matilda's career informed a view of health that transcended a size-based approach:

*Well as a [health-related career] I tend to look at the entire picture of health, which is I have a home, we you know I have a place to live, I have enough money to feed myself decent food, I have good relationships with family, which are all things that keep me mentally healthy, all that kind of stuff going, and allow me to be nutritious and all those things. So I think just my socioeconomic status in the world helps me to maintain health. – Matilda, Woman – 30s*

Similarly, Melissa's description of health incorporated a broad range of factors:

*I would define that ... Or I think of health in terms of the amount energy and vitality that you feel that you have. I try to really think of it in ... You know in all ways, like the physical and emotional and ...*

*That ideally you know that if to be healthy in all those ways, hopefully your quality-of-life would be high, that you're enjoying life and feeling good about yourself, your relationships, your ability to connect to others, yourself and others ...*

*Versus you know lower health with you know not having as much energy, not you know feeling quite as vivacious or you know not having the same sense of satisfaction from relationships or not as emotionally satisfied with yourself, then that would be a more negative quality-of-life.-Melissa, Woman 30s*

Some participants seemed dubious with respect to certain claims commonly made regarding obesity, weight loss, and health. These participants also mentioned encounters with stigma, as well as their high activity levels. These exposures and their activity levels (despite obesity) may have contributed to their doubt:

*Well, and I'm staring that down as-, although I'm still technically obese, but I know that I'm pretty close to healthy.*

*And I know I don't get any grief from doctors anymore about weight-related issues. But I've got this very healthy body for 55-year-old, [laughs] but I still feel unhappy and lost and lonely and all those things are still there. – Amelia – Woman 50s*

*If that's the health threat, if that's the health threat you need to lose weight or you will die, because I have been told this, and thus far I haven't died yet – Katrina, Woman – 40s*

Individuals who expressed doubts with respect to the dominant discourse and/or relied on very broad health definition had often experienced disordered eating, weight preoccupation, or continual weight cycling. Some of these doubtful participants did acknowledge some risk associated with obesity, but added nuance regarding effects of aging, lifestyle, or lack of benefit accruing from weight loss:

*I do get more annoyed when it comes to medical professionals, especially if it's my nurse practitioner who I see, because I have seen her for years, my medical status hasn't changed in years, and she continues to send me right for blood work every six months to test my liver functioning, to test my thyroid, to test my diabetes, like if I'm becoming diabetic, and so I get that she's just making sure that this are staying stable but at the same time I feel like why, why do we always*

*have to focus on whether or not I'm the same weight, because it's not actually healthy for me to lose a lot of weight, it's not going to make much difference.*

**Matilda, Woman – 30s**

*Re: Advising Clients on Healthy Lifestyles: Now I've started doing it again to sort of actually articulate what we think ...Is a reasonable weight gain in pregnancy, because there's now different standards set by Health Canada that I think I agree with that women who are already obese can stand to gain a lot less weight than people who have a lower BMI. So somebody who is 5.3 like me, who's 120 ... 120 pounds before pregnancy, can gain 25 to 35 pounds, that's fine. And then someone who ... Who is like me and close to 200 pounds, if I were to gain ... You know that I can actually stand to gain a lot less weight ...In this pregnancy. So I have ... I talk about that, but I also contextualize that within a discussion about ... I also say like healthy people can come in all sizes. I'm a lot healthier than you know the skinny crack addicted person on Main Street, right so like there's a lot of ways to be healthy, this is one of them. And I use myself as an example, because ...I know that I'm an example of a healthy, larger person. And I say I do not care what you weigh, as much as I care that you are eating as healthy as you possibly can in your pregnancy, that you are exercising moderately or continuing an exercise program that you already have. **Rachel, Woman – 40s***

Importantly, all participants appeared to largely accept Western biomedical health definitions. Many worked in healthcare, consulted standard medical texts or other information sources, and saw biomedical healthcare providers (in addition to any allied health professionals). Thus, participants would still place authority in science and medicine. They would view their own doubts or the adoption of HAES as scientifically-informed alternatives to standard biomedical approaches. Or, they may believe that science has not arrived at an accurate understanding of obesity. Faith in biomedicine seemed evident in both doubtful and biomedical-faithful participants' desires for a pill, fix, or cure for obesity:

*So I can't help me so how am I going to help them, but there needs to be, there has to be, somebody has to figure out how to make this work, and fix it, that's got to be you, so fix it, make it better, so that little kids don't have to grow up thinking about nobody is ever going to want me, that's what I think. - **Katrina, Woman – 40s***

*I wanted you to tell me you had a miracle cure that you were going to offer me for being so nice for coming ....*-**Daisy, Woman – 50s**

*I mean there is no cure for obesity except shutting off our brain. Give us the drug ... That's my take on it.*

*So yeah we want that pill too.* **Harmony, Woman – 50s**

Participants, then, while believing in the efficacy of Western biomedicine, also may have holistic understandings of health or may have problematized the catastrophic approach to weight often taken by biomedicine based on their personal experience.

### **5.4.3 Ambivalence Re: Weight and Health**

Some participants' views on health were more ambivalent. For example, Rachel referred to herself as “pretty darn healthy”. Her only real concern with respect to her weight was its potential impact on her newly-found, highly-fulfilling career:

*And really the only thing about my health that is a problem is potential future issues caused by extra weight, probably on my joints.*

*I mean I came late to [career], but it is a job that I really, really love ... Like really crazy love. And I find it rewarding on so many levels and challenging on so many levels and every day is different and I love it. And I thought wouldn't it suck if like my knee or my knees or my hips or my back prevented me from doing my full job ...*

*I think this is probably one of the first times that I've actually been personally motivated to be healthier, it's not an external thing. I mean my job is an external thing, but my job has become such an intrinsic part of my identity ...* - **Rachel, Woman -40s**

Still, Rachel also referenced health risks presumably associated with obesity:

*It certainly is associated with increasing health risk, cardiovascular and diabetes and stuff like that and that there's you know plenty of people who are obese, right so we know that.* – **Rachel, Woman -40s**

Throughout her interview Rachel also repeated some variation of “no one wants to be obese”, at least 3 times:

*But there's nobody who wants to be obese you know and there's always ... I know what the reasons are for me being obese, people always have reasons, they always have a story, but just to stigmatize and shame someone because they're obese, I mean everybody's aware of the abundant healthcare issues ... Health issues that are involved with being this overweight, so yeah ... So that's what I see. – Rachel, Woman -40s*

Another example of such ambivalence appeared in Pauline's interview when she referenced the value of self-acceptance, despite her overall goal to lose weight:

*I think loving yourself, when you love yourself you care what you do to your body, you care about your mental health, like being aware of your needs, and what that may mean for you to live a healthy life is important, so like for me for instance, this morning on my way to work I thought geez you know I just haven't been feeling so good lately about myself and just general things that have been kind of coming up and I just don't feel like I even can appreciate who I am and what I look like right now, and I really has to just happen to the more simple things, like I'm always grateful for having another day – Pauline, Woman -30s*

In a single interview, therefore, participants could shift from being more, or less, accepting of common concerns regarding weight and health.

A further example of such ambivalence occurred among those with more conventional views on obesity. These individuals did not necessarily view size or fatness as unhealthy. Fitness or positivity could mitigate weight-related poor health. Daisy described a friend who she viewed as a fat yet fit individual. This friend enjoyed a high quality-of-life in part derived from her high level of physical activity, positivity, self-acceptance, and great degree of social support:

*She ran and walked, she ran on a treadmill, and walked, she was very active, no diabetes, high blood pressure, nothing, no fat diseases at all, she was a healthy fat person, and I pretty much was too, like I had none of those things either, but I didn't do anything...she had a quality-of-life.*

*How active she was and she had a very good marriage and great kids and you know she was very at peace with herself...it didn't slow her down or stop her from anything right you know– Daisy, Woman – 50s*

Harry's primary concern was not with obesity, per se, but with fitness, which he defined as capacity to carry out everyday tasks.

**Table 5.2 Participants' Views of Biomedical Obesity Definitions by Participant Number**

Ambivalence	Rejection	Chronic /Maintenance Struggles	Disease	Addiction/Stress	Risk
4*	10*	3	1	1	2
9*	13	7	8	2	3
	14*	8	12	4	5
	15	9		5	6
		10		6	7
		11		8	8
		13		9	9
		15		11	11
				12	14

\* Some talk outside energy balance equation - sleep, stress, genes, or eating disorder affecting metabolism

Regardless of their overall attitude concerning weight and health, many participants' views on health and obesity were still highly complex and variable.

## ***5.5 Health and Quality-of-Life Priorities***

### **5.5.1 Different Perspectives**

Individuals with different weight loss trajectories tended to adopt varying views of biomedical obesity discourse. Most participants still hoped to lose weight apart from those who had previously experienced disordered eating or weight preoccupation. Thus, it appears an extreme or traumatic experience is required to adopt a size acceptance view. However, some individuals were merely more doubtful of biomedical obesity discourse, and this often seemed to relate to past experiences with weight cycling or the chronicity of their obesity. Experiencing stigma, improving fitness without necessarily losing

substantial amounts of weight, or knowing someone who was ‘fat but fit’ also produced doubt or resistance regarding popular obesity discourse in some individuals. Sometimes individuals who experienced weight cycling attributed these patterns to their own behaviour, currently not trying to lose weight, an addiction, or metabolic irregularity.

In general, however, having a more doubtful or HAES-view of obesity discourse, which aligned well with chronic obesity or perpetual weight cycling, also suggested comparatively broader views on health and quality-of-life. In contrast, those individuals who were less doubtful of biomedical obesity discourse often had narrower views on health, although somewhat broader perspectives on quality-of-life. Believers in biomedical obesity discourse tended to emphasize common energy balance equation factors – i.e. food, exercise, and functioning. In terms of weight trajectories, these individuals also were more likely to be currently losing weight, maintaining a weight loss, or attributed any ‘failures’ in this regard to their own behaviour or external factors. For example, Megan, who was currently losing weight, attributed her weight cycling to her own behaviours and a series of car accidents:

*I was in three car accidents within a four-year period...So the stiffer I got the sorer it got to move, the less I moved the more I ate, the more I eat the heavier you get, you know. It's just the proverbial... yeah...Circle of-, yeah. Yeah. So that probably had a lot to do with it. I had gone, joined a gym and just watched what I ate probably... that was probably about eight years ago, and taken off 65 pounds and felt much better. Was slowly putting it on but then these three car accidents within the four-year period of time, I just piled the weight on. - Megan, Woman 50s*

Daisy was currently regaining weight lost through bariatric surgery. Her approach to health and quality-of-life varied only in her incorporation of mental health considerations:

Re: greatest contributors to health: *Diet and exercise*  
Re: what would most improve individuals' quality-of-life: *Diet and exercise and counselling*. – **Daisy, Woman 50s**

Todd had a relatively narrow perception of health and quality-of-life. In endeavouring to maintain a 100-lb. weight loss, Todd invariably focused on diet and exercise with respect to health and quality-of-life, which he viewed as synonymous end-goals:

Interviewer: *So you noticed that, and do you feel that you are in better health than when you were heavier?*

Participant: *Absolutely... Yeah... Like I mean it's just... I still look at the calorie information on everything I eat, and so I mean that alone has probably made a significant difference.*

Interviewer: *Okay and what would you say are sort of most important things for you with respect to health, and define health as broadly as you like?*

Participant: *As broadly as I like... I think when it comes to health like I think it's just diet and exercise, like I don't believe in pills, I don't believe in like the supplements and stuff that people take, and I think ultimately the key to a healthy lifestyle is you just got to be active, like humans were meant to be chasing deer's with spears and you know always on the move and [eating them] not going to the store, eating and sitting on the couch or chair for 24 hours so you have to be active and you have to be healthy and... My philosophy.*

Interviewer: *And how important do you think health is then to your quality-of-life?*

Participant: *For me it's very important, like just after everything I went through, just the thought of how hard I had to work to lose it, trying to stay healthy is really important.-*

Interviewer: *And so what do you do now to promote your health, so you're playing sports?*

Participant: *Yeah I do ultimate [Frisbee] usually two or three nights in the summer, I do floor hockey once a week, I still try to go for a walk, at least four kilometers a day, it's a lot easier in the summer, but it's kind of nice being downtown because you can take the tunnels so... but you know I've got a dog so... it makes it a little bit easier to get those walks in.*

Interviewer: *And what do you do to promote your quality-of-life?*

Participant: *Do you mean like just...?*

Interviewer: *Anything, anything social, anything that you enjoy doing?*

Participant: *Probably like the sports is probably the most enjoyable thing, like my [partner] got me into ultimate and that's pretty much the only sport I really play, so I enjoy it, like that and a bit of floor hockey, just pick up games and stuff like that. - **Todd, Man – 30s***

The broadness of participants' views on health therefore was a good indicator of their reception to orthodox obesity discourse. More restrictive conceptualizations of health tended to be held by those who were currently losing or hoping to lose weight or maintaining such a loss.

### **5.5.2 Health Priorities**

Function and mobility was the most common health factor referenced by participants. They were frequently mentioned by those both dubious, and accepting, of biomedical constructions of obesity:

*I think your quality-of-life is the most important and being able to just do your activities of daily life and not-, being able to live pain-free. – Megan, Woman 50s*

*Be able to do things that need to be done without hurting myself in the process, is probably the major thing. – Joanne, Woman 50s*

*I want to be able to play with my son, I want to be able to chase my son, he gets so excited when you go chasing after him, or when he can chase after you, or you know just spontaneously get up off the floor and go you know catch a rolling ball down the hallway or whatever and I find that I have troubles doing that with him. And I, like I just don't have the stamina and I want to have that. I'm like way too young to be living a sedentary lifestyle, and that's not what I want so I want to be able to have energy. - Pauline, Woman 30s*

*And when I think of health I don't necessarily ever think of my weight in relation to whether or not I am a healthy person, I'm not...like they test me all the time, oh your BMI is 34 we should test you for diabetes like why, I have no symptoms but go ahead here test me, so like I am not prediabetic, I have low blood pressure, it's actually low enough that the doctor usually goes your blood pressure is a little low, and it's always like that, so I don't' have a lot of the symptoms that they associate with being an overweight symptom so I don't usually consider my weight, for sure as part of my health picture, more being able to do my activities of daily living, being able to be active with my child, being able to participate fully, like if my [partner] says lets go skating on...right like the fact that I can just get up and go that without having to take into consideration*

*something right so for me that's generally how I measure if I'm feeling healthy or not. - Matilda, Woman 30s*

Socioeconomic factors were mentioned by those currently experiencing hardships or those who had done so in the past:

*I would love to do the classes, but they cost a lot. And because of my situation, because I don't feel good all the time to come to the classes... Like right now I could take a... you know, an ice cream scoop, and it would feel good if I could just scoop all-, my whole... this whole side and... So-, and some days there's more... Like today's a pretty good day for me. And then you have... But the classes cost and... But they have free... they have free swims where... And a lot of it comes to transportation too. I could get down here. I don't have a drivers licence right now because my eyes are sort-, because of the stroke my eyes are sort of bad. So to get transportation down here from the North End... And they don't have enough-, we... we have the pool out in the North End, but we have no work facility. – Christine, Woman 50s*

Matilda had viewed the effects of socioeconomic status on health in her career:

*I see lots of women who are in the 50's who have been so sick for so many years that they have had no quality and it's based mainly on their socioeconomic status which leads to many things, like mental health issues and addiction issues and all that kind of stuff as well, but often they're homeless which is...the lady I have to go see today, you know I get a page, I'm like she had a pregnancy lost, but she's homeless and hasn't eaten in three days, so can you come see her about that instead of the loss, so yeah I think absolutely the quality-of-life is affected if your health is not there. – Matilda, Woman 30s*

Other individuals mentioned socioeconomic issues more as a general barrier for healthy living. They seemed to relate this to others in general, not themselves, in particular:

*I don't know why... a big thing, I think, for some people is I don't know why some of the weight loss programmes aren't covered by private insurance plans...You know, they'll cover everything else, all the health risks when you get too heavy and, you know, if I don't take off weight they'll cover my insulin when I become diabetic and they'll cover my cholesterol pills and all that other stuff, but nobody will reimburse me to go... Like I can afford it, because I'm single I make a good salary. But I'm sure there's people out there that can't...And I don't know*

*why some of the gyms-, like there's public gyms. YOU know, I don't know if more people would go if they promoted-, if you were over a certain BMI if they offered a free membership and then once you got down to a certain weight you would have to start paying. - Megan, Woman 50s*

Mental health was generally prioritized by those more doubtful of biomedical conceptualizations of health, weight cyclers or those with chronic obesity, and/or those with some experience of mental health issues:

*Re: public health recommendations: I guess it would be to really search within yourself to find out what the root of the problem is, if you're experiencing some sort of underlying emotional issue about something that may have happened to you, or is affecting you currently, is there stress related to that, and maybe get some help for that, I mean and I've done therapy before, and I'm currently doing it now, but again it hasn't been regular-**Pauline, Woman – 30s***

*Re: public health recommendations: They need to open up ... You know we know that mental health is as important as physical health and if a physician could step back and just remember that and I think if we can work towards a greater mental health and you know and that includes like working with body acceptance and not [inaudible the body and the self so much, health will improve ... Physical health will improve. - **Clarissa, Woman – 40s***

*I wanna be able to do my job as well as I can and there's a huge physical aspect to my job of being able to be up and upright for ... As much as 24 hours at a time and ... And so being healthy for that is really important and there's all those components of health, which just recently like weight has like sort of come to the forefront because of [recent career-impacting injury]. So it's my mental and emotional health, my psychological health, my ... Like all aspects of my health ... So not just my weight. - **Rachel, Woman – 40s***

Pleasure and social health factors were more often viewed as a component of health in those with a more doubtful view of biomedical obesity constructions, who were also the most likely to experience chronic obesity or weight cycling:

*Not only the numbers ... That the ... Like folks are fond of to measure health ... That is important to me, but also my daily life enjoyment. - **Clarissa, Woman – 40s***

*I would define that ... Or I think of health in terms of the amount energy and vitality that you feel that you have. I try to really think of it in ... You know in all ways, like the physical and emotional and ... That ideally you know that if to be healthy in all those ways, hopefully your quality-of-life would be high, that you're enjoying life and feeling good about yourself, your relationships, your ability to connect to others, yourself and others...- **Melissa, Woman - 30s***

*I would like to be able to do the things that I want to do physically. I struggle with mental health issues, and maybe that will always be a struggle. What matters to me most about health... is to have relationships and enjoy relationships and enjoy activities and have a body and a mind that let me do those things.- **Amelia, Woman – 50s***

Less doubtful individuals did mention the importance of positivity and sociability with regard to quality-of-life and sometimes emphasized the importance of enjoying physical activity:

*If I can't find an activity to keep me motivated and healthy and happy then I'm really sunk. – **Harmony – Woman 50s***

*Like if you really hate doing aerobic exercises, that's fine, no one says that you have to do that to lose weight. You can do something that you like that is healthy, health promoting, and can contribute to losing weight. There's all kinds of things. If you like to dance there are dance classes, you know. That's something that I like to do, I like to dance. But I find the classes very intimidating because there's no one like me in those classes.-**Hannah – Woman 30s***

*I don't want to live my life sitting on the couch either, I want to do things with [relatives], like when I first lost my weight and everything I would go bike riding my [relatives] couldn't keep up with me, I would leave them at a park, keep going, come back, pick them up at the park and go home kind of thing...but you want to be able to do all those things, you want to be able to fit on the rides at the X and you know do...and enjoy life because how much fun do you have sitting at home, I spent a lot of time sitting at home, eating, being fat, doing nothing...- **Daisy – Woman 50s***

Social health was also mentioned as a recommended public health priority:

*Just be around people that can influence you to make positive choices, and to support you and maybe that support might be just words of encouragement, or even going with you to the gym, going with you for a walk, or giving you that extra push when you just don't have the motivation. – **Pauline, Woman 30s***

*I feel like everybody in Canada should have like... a balance of real communication, like face-to-face communication or family time or... I feel like we're pulling away from that, and I feel like there's going to be a big jump in mental health issues because of that. -Hannah, Woman 30s*

*And I think we need to go back to... to... I mean when I was a kid we had-, even the schools. There was always an end of the year carnival or... you know, and it was for the whole community, it wasn't just for the school kids.*

*I believe if-, as adults, if we do all we can to improve our health and that the kids that we're bringing up... And there's not enough... there's not enough family... parenting... there's baby and moms, a lot of that. And if you're not into sports then what are the-, if there's sports, you know, in grade school, if you had your kids in sports they make community of that sport. But only that sport. But there's some people who have asthma and who different problems or money problems that they can't put their kids in sports, and they can't travel or they have to go to work. And then for that group there's absolutely nothing out there for the families. And I don't know, it's just...- Christine, Woman 50s*

Functionality and mobility was considered critical to health by all participants.

Generally, if not intrinsic to good health, social wellbeing was viewed as essential to quality-of-life. Other factors, such as mental health, pleasure or enjoyment, or socioeconomic status tended to be emphasized by participants who valued broader health aims or experienced these issues personally.

Overall, those individuals holding a largely biomedical view of obesity had a narrower view of health than those more doubtful of such conceptualizations. While evincing narrower health constructions, believers in biomedical obesity discourse had fairly expansive quality-of-life definitions. Amongst the more doubtful participants, there were broader definitions of both health and quality-of-life and more unique components to these definitions.

### 5.5.3 Quality-of-Life Priorities

Participants discussed multiple factors they felt affected quality-of-life. All participants felt health was a major contributing factor to quality-of-life. However, participants were asked this directly, and this may have affected results. Some participants seemed confused by the question, in terms of differentiating between the terms. Thus, participants' definitions of health and quality-of-life appeared to overlap a great deal.

Re importance of health to quality-of-life:

*Mm. Yeah well in my own mind that I would ... I wouldn't use them as synonyms, but I think of em very ... I think of them in kind of a similar way ...-*  
**Melissa, Woman – 30s**

*I would say it's probably... probably second. I would say relationships are first... You know, whether they're going well and things like that. And then I would say health is probably... Well, actually health is probably equal to relationships I would say. -*  
**Megan, Woman – 50s**

*It's number one over money. Because if you've got your health, you've got a better outlook on life. You can say, oh, well, I can go... You just... You're not always down, oh, I don't have the money to do this. Because if you're tired you think oh, I'm too tired, I don't have the money, we're so poor. But if you've got your health and you can think straight and you've got a good outlook on life and you're happy, you can say, oh, well, it isn't that bad. The people in Iran or Iraq or... where the Tsunami was, look at them. If they can do it, I can do it too. ...-*  
**Christine, Woman – 50s**

Others may have mentioned socioeconomic factors more abstractly; however, Christine's response demonstrates the potent impact these issues had on socioeconomically disadvantaged participants' quality-of-life.

Quality-of-life seemed to suggest a broader definition for participants, including those with narrower definitions of health, who tended to hold more biomedically-oriented

conceptualizations of obesity and health. A diverse number of factors were brought up by participants including balance, simplicity, relaxation, and spirituality:

*I would say work/life balance ... That's a good one. It should have a health component, a spiritual component, psychosocial activity, friends, family ... I don't have family, so whatever. And yeah you have to be able to make your own fun. -*  
**Harmony, Woman – 50s**

*Self-care of any kind, whether that's taking a moment to meditate or take a bath or whatever ... Showering every day. Or whenever possible ... Like ... Exactly, exactly. But in general I think finding a general enjoyment in life is an extremely important part of your health. -*  
**Clarissa, Woman – 40s**

*I try to think differently like I mean I grew up like I said in an unstable environment which you know caused me to often be a very negative thinker, so you know I... my spirituality, and I go to church service every Sunday, so just thinking more positively about life, probably does contribute to better quality-of-life as well, aside from you know physical factors. -*  
**Pauline, Woman – 30s**

Similarly, in discussing recommendations for health and quality-of-life, Joanne mentioned a particularly interesting hypothesis of obesity causation:

*Hmm... I think just having the freedom to... to do more moving around in general and... not-, anything pretty well that would... give people a bit of quiet in their lives rather than being sort of like... sort of locked down and being bombarded with stressors such as a work assignment or a TV blaring. That's one of the things I notice a lot in restaurants. They've all got these TV screens and they've... with a soccer game on the screen and a football game on that one and a commercial about beer on that and... I mean while the VLTs are binging and banging and bombing away in the background and... And there's some music. I think a lot of it is sensory overload. I think... I don't know. I think it's possible that maybe just being overloaded with data causes people to try to create some kind of quiet, either by eating or just not moving. -*  
**Joanne, Woman – 50s**

Teaching, learning, and mental pursuits were also frequently mentioned. This was especially (but not exclusively) evident amongst those more oriented to HAES approaches, more dubious of biomedical obesity discourse, and/or weight cyclers not currently losing weight. This was also evident in the pleasure participants exhibited in

introducing the researcher to various fitness and food-related activities during participant observation such as yoga, aerobic kickboxing, group resistance training, personal gym routines, baking, menu planning, and grocery shopping. These pursuits were viewed as independently rewarding or rewarding in the manner in which they facilitated social connections:

*I would promote quality-of-life on ... Not only on appearance, on ability, so appearance, ability, agility, I would promote quality-of-life based on intellectual pursuits. I would promote, irrespective of the age, the concept of believing in the growth of your philosophical person - **Harry, Woman – 60s***

*I am like active in many aspects of the job that I love, so there's like the care provision and then there's the supporting of the ... Of the profession and educating new midwives and there's all these different things that sort of branch out from that. - **Rachel, Woman – 40s***

*Yeah no I do a lot of learning, that's sort of where keeps me stable and sound and I like to do lots of different things, so I have taken up many different crafts, I have recently crocheted, this winter I went a little crazy with the crochet. - **Matilda, Woman – 30s***

Positivity was more frequently referenced by participants who experienced chronic obesity, weight cycling, or had endured an eating disorder:

*I think loving yourself, when you love yourself you care what you do to your body, you care about your mental health, like being aware of your needs, and what that may mean for you to live a healthy life is important, so like for me for instance, this morning on my way to work I thought geez you know I just haven't been feeling so good lately about myself and just general things that have been kind of coming up and I just don't feel like I even can appreciate who I am and what I look like right now, and I really has to just happen to the more simple things, like I'm always grateful for having another day that I can wake up and breath and have life and always grateful to have been blessed with a child so I think that just being thankful for what you have and to appreciate who you are no matter what you look like on the outside, it really is what matters on the inside, and be just very grateful for the small things, because again I have to remind myself too that maybe I might not be here tomorrow, why am I going to sit here and fret over all the things wrong with me today, when it could very well be my last, like I just sometimes think that way, so that I can kind of change my focus from thinking so negatively to okay you know what it can change, and maybe you*

*might not have the energy today and you might have it tomorrow like...so.* -  
**Pauline, Woman – 30s**

*...So you know quality-of-life is a bunch of things right and when you can achieve a bunch of these things you know and the more you achieve the better your quality-of-life becomes but when then circle is so big that you can't connect one to another, to another one, that quality-of-life is not as great as it could be right, but when you can achieve...check, check, you know the circle gets smaller, and I don't know maybe I'm crazy but that's how I look at it.*

Interviewer: *So what kind of things then would you include in your circle that you have achieved?*

Participant: *Well the confidence to go forward and do things, that's a big one, that's a huge one.* - **Katrina, Woman – 40s**

Clarissa felt the focus on weight hindered individuals' ability to maintain positivity:

*And it's almost like to the point where people can't even be happy for one another, like oh you do dance, that's awesome, that's so exciting, oh have you lost weight? You know and we can't just let that sort of thing go. And I think we need to move to a place where we can.* - **Clarissa, Woman – 40s**

Social supports and interactions were probably the most frequently referenced contributor to quality-of-life outside of health. Individuals also emphasized potentially negative aspects of social connections, as well:

*Quality-of-life is having non-sedentary activities with your friends.* -  
**Harry, Man – 60s**

*I feel like people are so disconnected. And growing up we didn't even-, me and my siblings, we didn't have cell phones until we were like in our twenties when we got our own phone...So with that like we were so close, we get along, we can hang out. People are always surprised and they say you hang out with your siblings? I'm like yeah, like... don't you? They're like no, like...It's just... to me that's weird, and so I've... Seeing the people whoa re younger, who are so into their phones and... But then they feel like they don't have friends or they feel like they're alone or lonely. I feel like it's because we're so stuck in this technology thing.* - **Hannah, Woman – 30s**

*I would also say too like surround yourself with people who are going to love you no matter what. And ignore or edit your life of the people who are going to put you down, cause if they're gonna put you down, cause you're obese, they're*

*gonna put you down, cause you're something else, it's not worth it. Yeah I've taken like pruning shears to my life on several occasions and then yeah ... -*  
**Rachel, Woman – 40s**

Physical activity was referenced as a source of quality-of-life for some individuals with more holistic views on health and those prone to weight cycling. Individuals with a more biomedical perspective, and/or who were currently losing weight, or maintaining lost weight, viewed it from a utilitarian perspective. That is, the ultimate goal of physical activity was weight loss:

*And if you can find movement that brings you joy, you know whether that's riding your bike or dancing or ... You know we're not all going to jog or be runners, you know and ... We don't all enjoy it and some of us downright hate it and so why do it ... When you can find something else that is so much ... It brings you so much more happiness to do it. First of all you're much more likely to do it ... And secondly you actually enjoy it and have fun doing it too. -*  
**Clarissa, Woman – 40s**

*I get out and I try and walk and my office partner and I have kind of made a pact with each other that will try and remind us to get every 20 minutes and go do something, even if it's just to walk down the end of the hall and come back, just because we sit, sometimes, some days we just sit there all day and that's boring for one, and by the end of the day you're more exhausted because you did nothing. -*  
**Matilda, Woman – 30s**

In terms of improving quality-of-life and health, a number of participants advised the adoption of a broader, more holistic approach to health or a HAES perspective:

*I think it's hugely important ... To not be limited in what your idea of what health is.  
And the reason I say that is because there's so many different contributing factors, your sleep impacts your health, your ... What you are eating, are you happy with what you are eating ...  
I really believe the most helpful approach is to have a holistic approach to health. An all-encompassing approach, for everyone. It's just gonna benefit everybody in the long run.  
Absolutely, mental health, physical health, all of it. -*  
**Clarissa, Woman – 40s**

*Mm-hm. I really wish there was a lot more of a health at every size approach, in my own perspective and I certainly don't have the data or the studies or anything to back this up, but I think the more that we push you know diets...and like oh don't let your child become ... You know a member of the obesity epidemic that's you know gonna ruin society and squash the world or anything. The more fearful we become of that the more restrictive that we become, the more we teach our kids to be very fearful of becoming fat. It becomes all of a sudden the world's worst thing, the more we really push exercise is you know you gotta do it or you're gonna get real fat. - **Melissa, Woman – 30s***

*I think not focusing on the weight piece and just focusing on the be active, eat healthy meals, take breaks, take time for yourself, take time for your family to socialize, if you don't have those things find those things, become community active, there are places you can go that you can like there's lots of different types of groups for different people so there's usually a way to become active and to become involved in your community. And I think once people are more involved and are not focused on whether or not they weight a certain amount because we can't change people who advertise, that's a bigger issue, but if our society could focus more on just people and what they're actually doing as opposed to what they look like, that might be helpful. - **Matilda, Woman – 30s***

Participants' definitions of quality-of-life were often broader than their descriptions of health. Central to most participants' conceptualizations of quality-of-life were health and social wellbeing. Also mentioned were mental and spiritual pursuits and physical activity; the latter again suggestive of participants' emphasis on functional capacity.

## ***5.6 Priorities' Effects on Lifestyles***

### **5.6.1 Physical Activity**

Participants' prioritization of functional health was further apparent in participants' lifestyles. Overall, participants were very conscious of health-related behaviours. All participants were, or had been, very active. Interestingly, among the very few not currently active, none were individuals with a more dubious perspective on

obesity discourse; rather, all inactive individuals were openly hoping for weight loss. Their current lack of activity was attributed to lack of motivation or excess stress.

Exercise was often discussed in terms of caloric deficits, according to an energy balance model of obesity. However, some participants also described exercise in terms of enjoyment and emphasized its benefits independent of effects on weight:

*I would say that physical activity is pleasurable for me ...Not always pleasurable to start, but definitely pleasurable once I get started. Like I actually ... Like I try to live with as much joy as my dog does, right. So like I sort of look at how joyful she is when I come home and joyful when we're going for a walk and joyful when like she's playing with her toy and I'm like okay that's the space I wanna be in...*  
*You have to move your body ... I would say cause I move my body and I don't worry too much about the weight all the time, but moving your body just helps your spirit* -**Rachel, Woman – 40s**

*I went to the [fitness club] and did the [class] thing, and the girl that ran it...she's amazing we're still really good friends and I ran for a year, and I think I put on maybe ten more pounds after that but I was running and building muscle and active and that so I didn't think too much about and I ran for a year, and two weeks before my 50<sup>th</sup> birthday I ran a half marathon in [city] ... Yeah I was so excited, bawled like a baby at the finish line, my trainer was there and she had bought me this necklace with runners on it and all that, it was very touching...*  
*...Don't you feel better? Spring comes you go you walk, you garden, you putter, don't you just feel better because you're out and you're busy.- Daisy, Woman – 50s*

*I teach [fitness class] ...and first of all what always surprises me is the wide range of body shapes that shows up and because it's not just people my size ...Its people who are much, much, much smaller than I am and people who are larger than I am and you know it's a wide scale. But the thing that allows me to enjoy it the most is that I've been teaching for several years and I've had students that have been with me for several years now and I've watched them come to a place of comfort in their bodies. And that's amazing and just being able to accept and not put a limitation on themselves, because that's what yoga is a lot about or in our class anyway is that the limitations are often there because of what ... It's something we heard when we were three years old ...Or when we were ten years old and that just continues to play in our head, but through practice and you know ... A practice of letting go, we can let go of some of those old tapes, right. And like all those stories we tell ourselves that aren't necessarily true and to start stepping out and suddenly be surprised and appreciative of what our bodies can actually do. - Clarissa, Woman – 40s*

*Actually, I think I started to get endorphin kicks from my workouts, so then I started to get such a rush of calm from the workouts that I started to feel lost if I wasn't going almost every day. So... you know, such a... a positive feeling from the workouts that I-, and I knew it was a good one to follow up with and - let myself go with. And then once I started the boot camps there's a lot of engagement with the instructor...And because I'm often lonely I feel like that engagement is something I really look forward to in addition to -- how it calms me* -**Amelia, Woman – 50s**

Finding comfortable settings for physical activity was important to participants:

*Right? So it's kind of intimidating and kind of like... you don't-, you're doing something that's making your body move in all sorts of ways that is not attractive, and you feel like everyone's going to see this. So maybe if there were group classes that-, so one you're in a group where you're going to have support. And then if that group were people who are like you or of a certain weight like you, that you don't feel like you're the only one...Yeah, it is. It makes you feel worse about yourself like... And so maybe you just don't want to be in that environment anymore. It's not that you don't want to be there or you don't want to work out, but if that's what you're seeing and if what you're seeing is making you feel so bad, you don't want to be there. So if there was maybe a-, like you said, a more safe environment or a more... I don't know, an environment where people are more like you. – **Hannah, Woman – 30s***

*I was walking with colleagues that I work with and like and they just don't get that that's hurtful, so we're walking and they're walking...I don't walk fast, I walk slow, but I can walk far, so but I walk slow, and three of them were walking ahead of me and they look back and I went keep going I will right behind you, you know but they don't get that that's hurtful or you know it's a different kind of bullying, it really is, they don't get that that's what that is, or that's how I perceive it right, I'm doing the best that I can, bully for you that you can walk fast, wow good for you...like here's your gold star right, but how about if...you know and they're having a discussion and conversation about something work related and because I can't walk as fast as they do, I'm missing on, and so those things continue to happen, but if that's how you want to be hey you go for it right. At some point you have to tell me or you know your program won't run correctly. - **Katrina, Woman – 40s***

*Yes, it is. They're fantastic. It's a small community gym, and they are 100% about health promotion; there's no upselling of products, no pushes to buy this extended deal. It's like, you know, what do you want and need and we will tailor our programme. Like they don't budge on their fee structure and their policy but they're all about healthy lifestyles. And it's a gym that's attended by a lot of healthy seniors. Very few young, power bodies sort of types...And they have really, really good staff. So... So that's-, but you know, I'd like to take it out into*

*the world at some point and... and do something more social, sociable. I'd like to meet people and... But I still feel that... fat girls can't play. And I still feel I'm fighting that image in my mind. - Amelia, Woman – 50s*

All participants who were maintaining weight loss had very high levels of physical activity:

*My normal day is an hour in the morning at the [fitness facility] ...And one hour of physical exercise in the sense of weights or not necessarily free weight, but machine weight...And one hour of Aquasize a day. I'm one of the weirdoes I have these 14 inch arms that I will use, they're from my elbow to my hand and they're 14 inches wide and I do that and all the other bits ...I have the hands, I wear rapid feet ...Little fins and I've actually engaged in boxing underwater, I do underwater sit-ups, I do 25 a day ...Or I go down to the bottom of the pool and hold onto the rails and do sit-up push up ...Things ... And I can hold my breath now for three minutes. – Harry, Man – 60s*

*During the summer I lived in [neighbourhood] and I would bike to work and I work in the [neighbourhood], so it's like a 16 kilometer bike ride, there and back, so 32 K round trip, and it got to the point where it was like you know what I should have a bag of chips because I biked 36 kilometers you know so in a way it's you almost get like this entitlement which you know is bad because doing the whole weight loss thing like I kind of trained myself to think like if you eat a chocolate bar you know that's an hour and a half that you would have to walk and it's just not worth it, . – Todd, Man – 30s*

*At this time, for the last few months I've been doing boot camp four times a week, which is like a circuit training...Mostly weight training, with some Tabata or interval training thrown in. Where I work out it's almost always one-on-one with the trainer, so it's very individual to me, although sometimes there are one to three other people in the class with me and that's fine too. And... Until the middle of February I was doing two workouts a week on my own as well, but I got quite ill in February and I haven't quite got my strength back to that yet...And... Oh, so I do the boot camp or my own workout, which would be more strictly a cardio like a long, slow cardio. And then I do an hour of stretching after I've done the workout. So I'm there for two hours doing that. And then I just last week started a yoga class once a week, which is an hour and a half. So that's my workouts. - Amelia, Woman – 50s*

Most participants considered physical activity an important component of their lifestyle and were concerned with finding a comfortable venue in which to undertake

their activities. For some, the significance of this engagement in activity transcended a focus on exercising solely to burn calories.

### **5.6.2 Food**

#### **The ‘Right’ Foods**

Nearly all participants discussed some aspect of the importance of food in their lives. For those very focused on weight loss, this often revolved around attempts to restrict eating. Others, however, emphasized pleasure in eating or preparing food or dimensions of presumed health of food that transcended caloric value, such as an emphasis on non-processed or organic foods:

*And just eating better, I think for me the more I educate myself on healthy foods, the more inclined I am to want to try them, so if I see that a certain food includes this vitamin and that vitamin and having that abundance of particular vitamin does this this and this for you, then I’m more inclined to want to try it, I mean when I was growing up I never knew what squash was, like spaghetti squash, acorn squash and all these different vegetables, and didn’t know what they tasted like, zucchini and eggplant and all those things because we couldn’t afford that. – **Pauline, Woman – 30s***

*We don’t buy, we make a point of not buying things that have a lot of preservatives, we try to just do fresh fruits, I do a lot of my own cooking and baking and we don’t buy frozen prepared stuff. And that, and I grow a garden every year, so I like to, and I go to the farmers market and do the organic – **Matilda, Woman – 30s***

*That I love to cook and eat and I’m really good at both of those things and ... So that’s a big part of my activity every day to day. Planning and shopping and cooking and eating ... I love all that part of it - **Rachel, Woman – 40s***

The researcher participated with Rachel in one of her meal-planning days. During this full-day event, Rachel researched recipes (often from low calorie-style websites), planned all her meals for throughout the week, devised an electronic shopping list, baked

bread, and shopped at a butcher's and a large chain grocery store. The meticulous care Rachel took in the healthfulness of her food and her careful self-monitoring was evident. Also apparent, though, was a sense of passion, pride, and enjoyment, which helped explain why such a busy individual would dedicate a whole day off from work to preparing her eating for the week.

### **Weight loss Dieting**

Regardless of perspectives on weight loss, 'dieting' was often discussed in terms of doubt of efficacy or benefit. For example, Megan attributed her lack of success in the past to the non-sustainability of previous dieting attempts:

*I think it's just... lack of commitment. And it's making changes, like going on restrictive diets that aren't life changing... You know, rather than changing your eating habits. Like now I'm very, very concerned about portions. And I really watch that...- Megan, Woman -50s*

Similarly, previous dieting efforts had not proven sustainable for Joanne: *Well, for one thing they either didn't taste good or they just weren't a way that I could see myself eating for the rest of my life... I had actually a bad reaction I think... back in the 1980-ish I had tried the Atkins Diet and I actually lost 20 pounds, I guess mostly water weight, almost right away. But as soon as I went back onto eating semi-normally, like I actually got quite sick... And it's almost like my metabolism had been shoved into some bad place, and from that pretty well I... all of a sudden my energy was gone. And this persisted afterwards. And I have no idea what exactly what happened there, but like something went terribly wrong at that point. ...- Joanne, Woman -50s*

Clarissa had adopted a HAES approach, in part due to damaging past dieting experiences:

*As soon as I started to really start to accept and dive into that Health-at-Every-Size approach, it was that recognition that eating a wide variety of foods is important ... And not limiting that ... And especially for myself where I have a history of limiting food extremely and/or bingeing excessively ... So I'm coming to a point and having a relationship with food where nothing is off the table and allowing myself to have this neutral ... And an appreciation for it, is very different*

*and new ...Because until then it was very contentious ...So because even if you are ... When I was excessively limiting, it was very contentious and when I'm excessively bingeing, also ... Because there's no mindfulness or no appreciation for what's going in to my body in that point, it's just ... And it's not even about the food. So to be in a place where I actually appreciate and enjoy it, it's quite nice. Clarissa, Woman -40s*

Experiences with weight loss had also made Katrina sceptical of dieting and the weight loss industry:

*...Like the industry about weight loss is just so huge and people are making millions of dollars on the suffering of people but I don't really see that there's a permanent solution, because I've lost lots and lots of weight over the years, gained it all back, lost lost lost...and gained it back, so clearly there is something that causes that to happen now, is that genetic, is that...what is that – Katrina, Woman – 40s*

Still, participants often discussed calories and caloric deficits, suggesting a high level of internalization of the energy balance model of obesity. This made dieting and alternate 'lifestyle changes' difficult to concretely distinguish:

*I'm working still off and on with calorie logging through an application on the Internet. Because I'm still trying to lose a bit more weight. But I recognise that restricting food intake isn't a long-term solution. And I know that coming off the restriction, which always happens, is a perilous time for gaining it back. Because I've been restricting and... what this application, I find, is a little different from other things that I've worked with is that I can tailor it to very, very slight weight loss...Like one or two pounds a month...And I don't want to lose weight any faster than that. I mean although it's lovely too, but I just know it's not the right solution to this, and that it'll be easier for me to stop logging and try and maintain a healthy weight. And it ties in with the exercise that I do, so I log my exercise in it also and... just trying to figure out, not just-, like what I like about that application is it's not just calories, it's logging macronutrients and certain vitamins and minerals also.- Amelia, Woman – 50s*

*I got an iPod for my birthday or Christmas two years ago and I have an app on there called My Fitness Pal and My Fitness Pal is an app that's on the iPod, but it's also computer based, so its web based as well, that allows me to track my food. Now tracking food used to be a trigger for me for some reason, either I've grown out of that weirdness about tracking food being a trigger for eating disorders or tracking food this way, where they do the math for me ...But I*

*seem to be able to do okay with it. So what I do is I have ... I keep track of my food almost every day and I keep track of my exercise almost every day, so when I'm striving to have a certain caloric deficit, I don't really care what the caloric deficit is, but they sort of ... I'm able to set or they suggest a calorie level that will put me in a caloric deficit based on my daily activity level and I sorta eat within that...* -**Rachel, Woman – 40s**

*Yeah it seems like ... Like I'm being good a lot of the time, but even though small slips will still give me a pot [belly] ... For me to stop the train and turn it around I have to make radical, radical changes.* -**Harmony, Woman – 50s**

Approaches varied slightly in terms of timing or prioritization, but ultimately all participants emphasized diet and exercise as essential to weight loss efforts. Participants who focused on trying to limit stress eating, emotional eating, or addiction to food found great difficulty in not indulging in these 'vices':

*So I you know I'm kind of staggering in following through with those goals. It depends I guess on how I feel, like if I would feel really crappy on a Monday then I say okay that's it I am done, I am starting today, and then it last until maybe Thursday and then I'm like oh well you know, like I start justifying that oh I had like such a rough day I'm super tired I only had like five hours sleep, I am going to have this piece of cake and just chill. So it almost depends on what type of day I'm having, was it stressful, did I get enough sleep the night before, that really will depend on whether I exercise or not and what I decide to eat that day.* – **Pauline, Woman – 30s**

*Well I feel that for me to stay at my weight at 1,500 calories a day, which is what it works out to, is just totally unfair. And I'm fine with it most of the time and I wouldn't say I'm hungry, fat people are never hungry, that's ridiculous. I have a binge mechanism in my brain that I can't turn off all the time. It's like a freight train inside that are moving in one direction or the other, I'm either dieting and just doing great and losing weight and I'm on the top of the world or I've just gained ten pounds and I'm miserable. And every time I turn around I've gained another pound and another and another. And you can't stop it.* - **Harmony, Woman – 50s**

*Yeah they're good yeah. But it surprises me how people can just say no I'm not eating that and not eat it, it's like really. To me it's like coke, crack coke you know what I mean, if it's there I have to have it, I think about food all the time, I think about sweets all the time, until I have to go buy something because I am so obsessed with it that it's all that's on my mind.* - **Daisy, Woman – 50s**

*So I'd go home, throw something together, but if you-, and fast food... it's carbohydrates. And then going right to bed and not getting any exercise. That's no good. And that's what led to... is why I'm not getting down. It's not because I'm lazy or don't know what to cook. It's that I'm too tired to cook. And I need-, and because I can't get disability to stay home to take care of my health, to take care of my family. Because if I-, if something were to happen to me they would have to literally take over for [Daughter]. She cannot function on her own. And it's not... And her doctors say oh, mom, it's just you saying that. No. You come to my house and you see her lay in her bed all day. And then if I'd go to work and wouldn't be on her to stay up all day, and we'd go to bed-m, and then she's up all night and then you're half up and... And if you don't get the proper sleep and... then you just eat whatever and you eat to stay awake. And if there's ice cream there, well... there's ice cream there. Fills you up. Gives you a rush so you can go on for the next 20 minutes. - **Christine, Woman – 50s***

In contrast, HAES proponents focused more on the balance they found with food:

*Like I wanna treat my body well, so I try to look at foods that'll you know keep me healthy, but that I enjoy, having a variety of food - **Melissa, Woman – 30s***

*I used to give talks to community ... To schools ... On weight preoccupation and ... Weight preoccupation is the best way to put it, for [medical organization]. And what we used to tell kids and what I still firmly believe is that if all I ate were watermelon all day, it wouldn't be very satisfying and it probably wouldn't be very good for, right ... And if all I ate potato chips, the same balance, the same unequal ... Balance, so it's like important to ... Choose from everything. - **Clarissa, Woman – 40s***

Food was important to participants, although what constituted an appropriate healthy approach to food varied substantially. Some participants were concerned primarily with limiting caloric consumption, while others emphasized variety or homemade meals. For some participants, food, its consumption and preparation, was also a form of pleasure; this, in addition to its 'healthiness', was highly valued.

## Dieting Cycle

A cycle seemed to exist for weight loss attempts. Individuals who were currently losing weight or maintaining lost weight tended to believe most strongly in obesity discourse. This was particularly true if these individuals had no previous weight regain experiences or were able to explain away past 'failures'. Continual weight regain cycles, however, led some individuals to doubt obesity discourse, particularly if they engaged in unhealthy weight loss practices. Experience of disordered eating or weight pre-occupation and exposure to the HAES movement resulted in some individuals rejecting weight loss as a goal. However, the desire to lose weight could be re-triggered even in these individuals, if they found themselves losing weight again. Both Amelia and Rachel lost weight through physical therapy following accidents:

*I fairly aggressively started my rehab to get back to work... And then I you know I lost like a fair bit of weight after that, it was probably 10/15 pounds, right ... But I got really fit. And that really changed a lot of my perspective on it, whereas before I'd been like you know there's health at lots of different sizes, I'm healthy, you know there's a lot of things [inaudible] I'm healthy, I'm extremely healthy cardiovascular wise ... I'm extremely healthy, you know my blood pressure is awesome, my blood sugars are awesome, like everything else is really great, it's just the weight. But when it started to perhaps to be a potential factor for my muscular skeletal, endurance in my job ...*

Interviewer: *So would you say that you're actively trying to lose weight or to be healthy?*

Participant: *More trying to be healthy than lose weight...But being healthy the way I'm doing it, the losing weight seems to a nice side effect. - Rachel, - Woman 40s*

*I feel I could be even healthier if I lost more weight, in conjunction with training... So that the... If I stay at this weight and train I will get healthier from a fitness perspective...And I'm confident in that. If I stay at this weight... If I lose weight and train, then I'll get even more healthy. That's my belief.*

*I started in more of a rehab situation. And he built a programme for me, so I saw him once a week and I did work out two or three times a week on his programme. I did that for about... nine... nine or ten months. And then I hired a personal trainer to build me a programme, which was cardio and weights together...But then as of last May I really hit dedication to this, and since May*

*I've worked out at least three times a week every single week. Except when I'm really sick, like once.- Amelia, - Woman 50s*

Participants were likely to emphasize how current weight loss attempts differed from previous attempts and would prove to be more sustainable:

*So there's like this ... So I'm really like interested like sane, sustainable approaches, as opposed to ... Cause I've done the thing where you can lose a heck of a lotta weight you know that's not sustainable. You know like these incredibly restrictive diets for me and I would argue for a lotta people are not sustainable, it can't be done - Rachel, - Woman 40s*

Participant: *I'm very, very concerned about portions. And I really watch that... that carefully. I was less concerned with it in the past. The way the programmes worked.*

Interviewer: *And you think that's a more sustainable change that you could maintain over the long run?*

Respondent: *Oh definitely. - Megan, - Woman 50s*

*...Last May I was 20 pounds heavier than I am right now, and not nearly as healthy. And so I can see that this has been the progress from just showing up and doing the work. And for most of that time I wasn't tracking what I was eating...And yet I was still losing...Very slowly, but... And getting healthier, so that was cool.- Amelia, - Woman 50s*

This suggests, depending on the efficacy of these dieting attempts, that this cycle of weight loss/gain may continue indefinitely for participants.

Daisy exemplified some of these themes, although she had a unique weight trajectory having undergone bariatric surgery. Her decision to have surgery was motivated by effects on mobility and sociability but not comorbid conditions. The surgery resulted in life-threatening complications, and Daisy has regained a substantial amount of weight. Daisy regrets the surgery, but continues to desire weight loss, this time achieved through diet and exercise:

*You know so from a medical point of view it's not the wisest thing to do. If you don't have health issues related to obesity, like I didn't have high blood pressure diabetes, nothing like that, you really need to suck it up and deal with it you know, deal with why you're big and start eating properly and exercising, and lose it properly, the normal way. If you have health issues gastric bypass surgery could save your life you know so you've really got to...really got to weigh it out, and working in a hospital I thought I knew it all, because I researched it to death, and I really was sure, and that, but it's...you can't prepare yourself for it, you can't, it's so drastic.*-**Daisy, Woman – 50s**

Overall, a primary determinant of participants' reception to standard obesity discourse was participants' current weight stage; if an individual was recently successful in losing weight, this may even override a past history of weight loss recidivism.

### **5.6.3 Mental and Social Health**

Mental health and social wellness were also components of wellbeing prioritized by some participants. Mental health hygiene, particularly with respect to stress, sleep, and anxiety was mentioned by a number of participants, especially those with mental illness experience. These individuals also tended to have broader views on health:

*Mentally I work very hard at maintaining really good mental hygiene, getting enough sleep, which is interesting in my job, keeping a low stress level as much as possible, which is also a challenge in my job. And just taking very good care of myself.... Mentally and emotionally.* - **Rachel, Woman – 40s**

*I... I'm very intentional about sleep the last year too...And... And part of that is driven by what I think is good information that I got through books, that sleep controls... adequate sleep reduces stress levels and stress hormones, and over the long term helps weight control.* - **Amelia, Woman – 50s**

*You know, just generally trying to keep my environment clean and relatively simple. Because I find stress is... like a bit of a trigger for me.* - **Joanne, Woman – 50s**

Maintaining strong social networks, including the elimination of negative social contacts was also prioritized. Participants discussed the relationship of these factors to body weight, health, and quality-of-life:

*Well, I try to be sociable, I try to go out and do things. As much as I can, because of how much I work. I've got quite a big family so... like lots of siblings so I spend time with them and... I just try to keep busy.* - **Hannah, Woman – 30s**

*I try to keep in contact with friends and family, make sure that I stay active in things. And go out when I'm asked sort of thing. It's easy to say no, I don't feel like going out sorta thing. So I really make an effort because I live alone to try to stay active in things.* - **Megan, Woman – 50s**

*...And you know the lessening of stress and that could mean to me like just excluding even certain variables like it could be even family members, like for me it's family, you know I've had to let go of some relationships because they were just unhealthy for my mental health, and I do find that when your mental health is affected too that can cause for you know overeating right...I do have constant battles with you know my mom, my sister, my brother, like it's always those three that have always been negative for me, and you know now I just, I have very limited contact with them, or no contact at all. And that's hard, you know it's hard because this is your family, this is all that you know, this is who you grew up with but now because I have my own family and I have a child that I need to look about, that I don't want to be influenced in a negative way ...so yeah that does affect me, and it does affect even other aspects of my life, like my relationship as well, if I'm down well my partner is wondering what's going on and even though I can express to him what the issue is it still has an impact on the whole unit right, so if my son sees that I am emotional then he's going to obviously feel that, then my partner doesn't know what to do better and then I am sitting there with a bowl of ice-cream at 10 o'clock at night.* - **Pauline, Woman – 30s**

Thus, for participants with broader views of health, mental and social health was prioritized. For participants with narrower views on health, these mental and social priorities were more often considered with respect to quality-of-life than health priorities.

### **5.7 Stigma**

Many participants described experiencing stigma. Stigmatizing situations took place in a variety of settings and contexts, including healthcare, workplaces, interpersonal

situations, media depictions, clothing stores, and public places in which eating occurred or space was an issue:

*It's really interesting, you know sometimes when I'm running outside, people have rolled down their windows and you know and called me fat or laughed at me ... Which is interesting, cause I used to live like right in Osborne Village and you can run downtown and no one has ever said anything. The homeless people will ask you for money, but they're super nice about it... Well and the strange thing is its always people in their cars, I'm like hey I'm the one running here, like what the bloody hell. I was rollerblading one time, someone rolled down their window and said to be careful cause I'll squish the wheels.*

*And then some of it's just a little bit more into the surface, like trying to buy clothes, everything's \$5 more expensive if it's got that plus size label on it. The short are all of a sudden four inches longer, the pockets aren't as good, which is really interesting I don't know why fat people don't need pockets, I'm not sure quite exactly that happens. Needs to be a whole special store for you know a certain size, they're as fashionable, you will not find underwear that don't come up to your nipples ... That's an exaggeration, but it feels like it ... **Melissa, Woman - 30s***

*Uhm... Well, I think in general, yeah, because I have a pronounced limp, and if you're heavy and you have a limp, people laugh at you. Like even the small children. You know, you're going to school and you're taking your kids to school and then they... you don't know what their- some parents aren't very educated about... Well, in general people aren't educated about it. They just think fat people are lazy and they don't have the willpower or they can't do it. And that's always the situation. We have stress in our life. –**Christine, Woman-50s***

*...But it's always you know you feel guilty if you eat because people are watching you because everybody knows you had the surgery and know you lost weight, but you want to eat like everybody else, and it's a birthday and somebody brought in cupcakes or you know something really good at [Cafeteria] that day or something but you know everybody watches and everybody comments and it's...I left the department I worked in for seven years because I knew that's what it would be like, and it didn't matter though because this is a small hospital everybody knows everybody talks, everybody watches because God forbid you don't know what you're eating yourself right, so it's a daily, it's a daily struggle it doesn't go away. **Daisy, Woman - 30s***

I accompanied Daisy to a lunch eaten near her workplace. The visibility of the environment to others, and certainly to coworkers was plain. She offered directions to the serving staff regarding quantities, was careful in applying salad dressing to her meal

(after discussing its caloric value), removed the skin off her chicken, and mentioned changes in her diet post-bariatric surgery. She discussed embarrassment on prior eating occasions wherein she was unable to sit at booths, again emphasizing the heightened visibility that often accompanies eating at a larger size.

Childhood stigma and stigma that occurred in interpersonal relationships seemed particularly prevalent and damaging:

*And I got you know bigger curves than are acceptable for a ballet dancer certainly and it was really shocking to me and my mother was also sort of not crazy about me starting to weigh more than her already as a teen, although I was certainly probably more muscular than she ever was or ever will be. And so that sort of started me on a road of ... That was when ... Ballet was sort of what broke the bubble of like the childhood innocence around you know just like free activity and loving life and being active ... That was a fairly dark time in my life. And then ... And I think that ... I don't know if it continues to do so, but I think it really messed up my ... My metabolism to go on such a restricted diet at such a young age.*

*I know examples, I remember them when I was young of where I was suddenly seen and identified and treated as a fat person, the way things changed for me and that is more painful than the day to day experience that I have now. So yeah, it would be nice to let all that stuff from my childhood go. –Rachel, Woman-40s*

*So in that relationship we had started off that way and then I had gained weight, I had actually only gained about 25 pounds, but he kept, just kept...his insecurity, which took me a long time to realize, it was his insecurity about being seen with someone who is not as attractive as he thought he deserved, would lead him to be very very like just nasty in the way he would talk to me, making comments about you know nobody else is going to want to date you and like...nobody would want to see you naked, I don't want to see you naked, you don't even seem like you care that you're getting fat, you're disgusting, and at one point I had lost a bit of weight, just randomly because I don't try, so I must have just been busier or doing something, or forgetful about eating while I was studying or whatever, and he was like oh you're losing some weight, oh this is great, you know this summer if you keep this up I will buy you a new bikini and you know I will show you off, I was like...and that was actually when I went okay F-You, where's the cake...well not cake, chips in my case, I am more of a salt person...I was like I'm just going to eat, I have given up, this is about you and your issues and has nothing to do with me, I am perfectly healthy and I'm going to eat if I feel like eating, but yeah he was horrible. - Matilda, Woman-30s*

*...You spend your life if you're like me right and you grow up as a heavy person, you know you...and as a teenager you grow up because you see all these beautiful people and you don't think you're beautiful because you're overweight, and you think I'm never going to find happiness because I am overweight, nobody is ever going to want me, and in fact when my marriage broke up, my ex left saying look at you you're fat with two little kids, nobody is ever going to want you, so you know sometimes I find an inkling of braveness, so I said right back, shout right back, on my worst day I wouldn't want you back, but every now and then that braveness jumps out otherwise you know there's always somebody who is pushing you down, pushing you down, pushing you down, he was one of them, that supervisor who retired she's another one, right there's always somebody who is going to have in the back of their head oh God what's this fatty want or...you know what I mean, there's always somebody who doesn't think openly to say you know what's this person about, and just think about the perception of what is the size, and size is not right, it doesn't fit in with society today, and it's wrong, it's very wrong... somebody has to figure out how to make this work, and fix it, that's got to be you, so fix it, make it better, so that little kids don't have to grow up thinking about nobody is ever going to want me, that's what I think. **Katrina, Woman-40s***

Stigma could have profound effects on participants' lives such as contributing to developing eating disorders, affecting career advancement or post-secondary schooling, and dissolving relationships:

*Re: Motivation for childhood disordered eating: I don't know necessarily, but my...I had a foster mom and she used to constantly tell me I was chubby. And it drove me up the wall, and I would be like I haven't eaten in three weeks how could I possibly be chubby and she would like grab my hips and stuff and go look at you you still got all your baby fat, and I was 92 pounds...on my 5.2 frame, so you know it definitely was thin, so that more than anything it was just irritating and then my overeating came from another person being you don't seem to care that you're getting fat and it was like no actually I don't...and forget you I'm going to eat more, so that was a dysfunctional relationship I had. **Matilda, Woman – 30s***

*I go for interviews...or apply and go for interviews even in this health care facility where I work in, I have not been able, in five years I have not been able to...understand I love my job, but like I would like to advance in my career, and here I am, I'm still five years in and I haven't been able to advance, so I sometimes think that that is part of it, how somebody looks at you and perceives you to be lazy, stupid, not really intelligent enough to figure out how to lose 50 pounds, do you know what I mean?*

*... it's easier to just say oh I guess I come off as too fat, too stupid. But that, you know self-confidence was never my strength as a young person and so sometimes like I didn't go to university when I was 18 because I thought I was not smart enough, surely I am not smart enough because I am so fat, I must be stupid too right. It's a way of beating yourself up because you can't get passed yeah...-*  
**Katrina, Woman – 40s**

*I lost a lot on my life from being heavy. I lost marriage to my child's father, I lost my career, I lost the pleasure of social interaction, I... I've had to deal with embarrassment and humiliation like every time my ass got stuck in a chair in a restaurant and everything like that and, you know, people glaring at me when I get on an airplane because they don't want me to sit next to them because I'll take up too much space. Uhm... Why does anyone think I chose that? Like this is... It's a response to how much I was hurting. From things that I couldn't even deal with in my life. And maybe now as I deal with them it's easier to let the weight go. But you know... medical health professionals maybe need to just stop and think that there's a back-story that they don't know. And respect that they can't make a judgement looking at this person. That there's a lot going on that they're not going to know about, they're never going to spend the time to find out. And to just go in with that assumption that this person needs compassion and help and support. That's what I think.-***Amelia, Woman - 50s**

Individuals more doubtful of obesity discourse generally had more anger regarding the stigma they experienced. However, less doubtful individuals also expressed anger regarding stigma they encountered:

*...Everybody tells you, people like to tell you you know you've gained weight or you're getting fat or whatever, they think you don't own a mirror or a scale that you're not aware that your clothes don't fit anymore, and you had to go shopping and it's like really you think I don't know this...but people have to point it out all the time, and it annoys the crap out of me...*

*...Do you think I don't have a mirror or a scale, like why do people have to tell you, you know and they do it, and it's hard, it's really tough and there's nothing out there, like people think oh that you can go to LA Weight Loss or Weight Watchers, do you think we don't know, fat people know what to eat and what not to eat, that's not why they're fat, it's not lack of knowledge, you know they don't get it, people don't get it...and it sucks and I don't want to be told all my life that I'm fat.-*  
**Daisy, Woman - 50s**

*...I know from when I was at the bedside and stuff there was lots of comments. I worked emergency [redacted] for about 18 years. About when you'd go to lift people or transfer somebody from the ambulance stretcher to the bed and stuff and... oh yeah, great, I got another fat one, I'm going to break my back*

*sorta thing or comments like that that people would make. Or great, it's going to take another four to lift this one over here and...*

*Now I probably would be much more sensitive to it at this weight. And I'd think oh my god, is that what people are going to say to me if I ever get in a car accident? Like I've thought of that, oh my god, if I get in a car accident or ever end up in ICU they're going to be saying oh, I need four more people to move her over onto the other bed...I think I probably would say something now actually.*

*...you know, men, it's funny how some men would consider dating-, when you ask them their dating preference and stuff-, like we used to talk about this stuff in emerge. Men would say well, they'd date a smoker but they wouldn't like it. They'd hope to get them to quit, but they wouldn't date somebody that was overweight, that was fat. They drew the line there. - **Megan, Woman - 50s***

Hannah also worked at a hospital and described similar thoughts on stigma:

*And I'm very conscious of that, like I try to be clean, wear nice clothes, you know, wear make-up, have my hair nice. To kind of like show that I care about... despite that this is my size I do care to like present myself in a good way. So in a hospital like there are some people who are like... you know, bariatric patients or... or quite heavy patient, and for that reason it impacts how good their self-care is. So they may come in and they may have like sores or they may have... I don't know, like dirt patches in places. Or they might have un-, greasy hair or they might... you know, their hair care might not be the greatest because they can't reach certain places or... So then you kind of hear... like oh, like gosh, you're so big, how could you get so big or... you know, she can't even stand. Like not just-, like not outright like... not outright insults but you can tell there's judgements there... Yeah. Which like makes me feel bad for them. And for me too because like there might be someone who weighs like-, who on the scale weighs the same as me or even a bit less than me but the way that they... their body is proportioned they look heavier than I do maybe. And so they might say something as a reaction about this person and then I take it personally because like, well do they think that about me? – **Hannah, Woman - 30s***

Daisy's quote above relates to another common theme referenced by individuals.

Individuals resented others' referencing their size. They expressed both awareness and occasional (seemingly transitory) forgetfulness of their size:

*... I think a lot of people are really ignorant about what actually goes on in a fat person's brain. First of all, a lot of people are completely ignorant of the fact that we actually know we're fat. You know like you don't actually have to tell us... We're pretty much aware of that fact... -**Clarissa, Woman 40s***

*And you know that's relative, even me...I know I have mirrors, and I have looked in the mirrors and I know that I have a weight challenge problem and...but I don't know that I see it the same way that other people see it, until I look at a picture, and then I see but in the mirror I don't see it the same way that other people see it, even today, even today I was just...before I left, well before I trek all the way over there I better go to the bathroom, so I was looking in the bathroom and oh those pants look pretty good on you, and then it dawns on you that you know you don't see it the way that other people see it and I know that, but I don't know how to fix that.*

*... I really am at a point in my life where I don't care...*

*The challenge though becomes that when you go for a job interview, you are very conscious of how are people looking at you and do they think because you're fat you can't do this job, that's something I have become very aware of, when I go on job interviews, I have an incredibly super crazy busy life...I need people to see that what a body looks like does not mean that I am stupid or I'm lazy or I don't know how to do it, or right...I do a lot, I'm...it's taken me a long long time to recognize that I am not as dumb as people would like to believe that I am.*

*Well I often think that they don't realize I have mirrors at home, but then again I have a different self-view and maybe that's part of my problem, you know how an anorexic sees fat, I look in the mirror sometimes and I don't see fat... But is that wrong, should I be, should I look and zero in on oh that butt is big...*

**Katrina, Woman 40s**

*I must have this weird sort of body dysmorphia, but not the usual one where people ... I think that I'm actually sort of a tall, thin person, like I actually imagine myself to be taller than I am, I'm [short] but I never feel short, ever, unless I go to a tall person's house and everything's up on top of the fridge and I never really feel like ... I don't feel ashamed about my body, I feel fairly confident in my body. I think I move with confidence and I think I act with confidence and so I don't really, you know ... - Rachel, - Woman 40s*

Individuals more doubtful of obesity discourse related stigmatizing encounters with healthcare providers. This may have contributed to their doubt regarding biomedicine:

*And the doctors don't recognise it as a disease. They don't recognise diabetes as a disease. And obesity leads to diabetes, and now I have type 2 diabetes. They-, well, I think they see it as laziness or... just... They have too many-, the doctors have too many patients to take the time to-, the paediatricians are pretty good. But even-, like my doctor for myself had-, they give you 15 minutes because they have a quota to make so they get their money, and it's just a revolving circle.*

*And they don't know you. And then they sorta-, in my situation they laughed at me and said well, why doesn't your foot work? Why doesn't this work?... Well, I felt like they did... Behind-, like they were sort of keeping it in like... she's just a fat old lady. So I went through like six, seven doctors. Because when... I'd get completely depressed and mad. And if one doctor didn't help me I'd go to another one. So now my file-, like nobody knows my history because I've been to so many doctors, and that isn't right - **Christine, - Woman 50s***

*When I was in my thirties I was on long term disability with chronic fatigue syndrome. And I was heavy, for sure, at that time. So I had to make rounds to specialists, and sometimes those reports back to my physician were shown to me. And I think... I'm just still enraged 20 years later about when the examiner would write "This [30+] obese female presented to my office for examination". Or something to that effect. So I have a name and I have an age... and a date of birth, I guess that's my age. These are primary identifiers, and you want those at the top of a medical report... This is-, we're talking about the same person here. Is obesity or ethnicity... there are many other things that are important for medical health practitioners because they're complication factors or they change diagnostic profiles, whatever. Like I know that that's information that has to be shared. But in the first line? Like I couldn't believe it. How about down with here are the symptoms, here are the complicating factors, here's the differential diagnosis, dah, dah, dah. But I saw that more than once. I had an internist who was just... so mean to me. I've had neurologists who were mean-, like doctors... mean doctors. I don't know if they're just mean or they're only mean to overweight people but sometimes I just felt so discourage and disrespected with medical providers. I just found it appalling that that would be the first thing that they used to describe me... And I know-, like this one that struck me the most was a specialist, and when I went on to read his report it was quite respectful of the things I was doing to try and get better, that my illness was legitimate. Because chronic fatigue syndrome was often seen as flaky and not legitimate. But by putting that up in the first line I felt marginalised. - **Amelia, Woman - 50s***

*All of my life from the time I was a young person, and I have a lot of ... I've had some residual impact on my body from being an athlete and that included... issues and joint issues and I'm extremely strong and physically fit, but there was one physician I saw for my right knee which I injured as a figure skater when I was younger and he could not see beyond my weight. And actually didn't offer me any solutions or help and all he suggested was that I lose weight and become more physically fit. Yet at the time I was in the gym two hours a day ... And probably at my physical peak ... But he just was completely unable to see beyond it, even though at the same time he had a resident in the room with him and she was completely well what are we gonna do for her, because she's so fit and strong and he just completely ... No she's not, she's fat ... Like he just completely wiped out ... Anything she had to say... And that's one instance. Another is the ... Turning everything into about fat. So if you have a stomach ache, it's about you being fat... If you have anything ... A rash, it's because you're*

*fat...Like everything becomes about your weight...Even if you go in because you have a bad cough, it turns into a lecture about how you really should be losing weight. - Clarissa, Woman - 40s*

Only one participant felt stigma could potentially be motivating:

*He got fat, so his girlfriend said to him, lose the tummy or lose me ... Aah you're crazy ... No goodbye, she walked out on him...Boy did he ever go back two years ago, now it looks pretty good. Interestingly enough the more he worked, the more she was around...So ... You know sometimes men take the strangest motivation. - Harry, Man - 60s*

Still, Harry's views regarding stigma seemed ambivalent, considering his recounting of his own experiences:

*I remember back when I was ... I believe grade 8, somebody called me fat, so I broke his nose. Nobody else in the class ever thought about that a second time, because it was an instantaneous response, so it was like bang smash...what I was doing...Yeah definitely. I remember when I was in my early teens, so let's say ten to 15, okay. People who were abnormally slender ... My view then ... Were somewhat judgemental about my size. I've always been what you see is what you get...I remember one of the cheerleaders at school, she was also the head prefect and the head girl in our school said the reason she dated me is I was totally unconcerned about who I was. I said what do you mean? She said well you know you're you, you don't make any pretentions about anything else and I say well I'm big and she goes, well yeah you're big, but I could lift ... When I was 16 years old I could lift 240 pounds over my head and walk. I can still do it today...So ... But there was a lotta people you know ... You're big, well I am big ... But who do you want as a linebacker tonight...*

However, Harry also viewed "size" as not equivalent to 'obesity', which may complicate his views:

*But yeah you know obesity is not a size, you can be 5 foot 2 and 40 pounds overweight with ease or you a can be 6.4 and again that's ... the muscle to fat ratio ... - Harry, Man - 60s*

Those maintaining lost weight and men discussed stigma less frequently and with less anger. However, as there were only 2 men in the sample and both were weight-maintainers, this pattern must be viewed with caution. While it may suggest a gendered

response, it may also result from weight maintainers being somewhat averse to discussing stigma or encountering it less frequently. A larger sample of men or weight maintainers in the study would have helped to more clearly elucidate these patterns.

Another common theme regarding stigma involved comparing the stigma of obesity to the stigma of smoking. Participants felt the stigma attached to obesity and smoking were similar and produced by similar attitudes. However, the stigma attached to obesity was perceived as more substantial, given obesity's high visibility factor, and this produced some resentment. Participants who had quit smoking viewed this as a net benefit to their health, even if they had subsequently gained weight. Some also referenced tobacco as an addictive substance, similar to how they perceived food:

*...I am beginning to think that you know smoking and obesity they really kind of on that smoking thing, once they get that one conquered they're coming after me, such as studies and so on and so forth, so either I'm a part of this, on the outside looking in, I don't want to be on the outside looking in, I want to be part of the solution, so that I'm not the person going yeah...the smoke girl going yeah yeah I can still smoke...I don't want to be that person, so that can be another check I can find I can fit in. - **Katrina, Woman - 40s***

*... Maybe you don't have to take her that seriously because she's overweight or she's obese...She's chosen to be unhealthy. And I know there are other illnesses than weight issues that are marginalised; it's not just this one. And I throw out smokers with lung cancer as maybe a similar... you know, you chose this weight and therefore you chose this illness and therefore why should we help you. - **Amelia, Woman - 50s***

*Well, -and it's much more prevalent because weight is a very visible thing. You know. Like I've been with people where someone that's morbidly obese, 350, 400 pounds, will be walking by and they'll say oh my god, she-, if I ever get that big sort of thing. And yet, you know, they'll walk by people that are smoking and not say a thing...Like when I think of health I would rather be this weight and not smoking than be smoking a pack of cigarettes a day... And I've heard lots of times the comments that were made by the people in emerge and stuff were the smokers. They make comments about oh, look at her, she's getting so fat, you know, and I think mm hmm, she's not smoking.*

*But I mean lots of times you can't tell if somebody's a smoker. There's no way to hide if you're overweight. - **Megan, Woman - 50s***

Overall, levels of stigmatization were high in the sample. Stigma occurred in inter-personal relationships, public encounters, and healthcare settings. These experiences were often damaging and were deeply resented by participants, although men or weight loss maintainers may recount slightly less exposure and indignation.

## **CHAPTER SIX**

### **RESULTS OF REPEATED INTERVIEWS**

#### **6.1 Changes over Time and Weight Trajectories**

Five (5) participants exemplifying widely divergent weight perspectives and trajectories were contacted for 3 additional interviews. These interviews were conducted on a seasonal basis. The participants were picked based on providing particularly data-rich interviews and for exhibiting a wide range of weight trajectories, living circumstances, and perspectives on weight.

Iterative analysis of previous interviews was used to construct interview guides based on emerging themes identified in the study. During the third interview, conducted in fall 2013, participant observation was formally conducted by the researcher. Participants chose sites or situations for this observation that they considered relevant to their lives as obese persons. Sites included fitness classes and centres, grocery stores, restaurants and cafeterias, and participants' homes. This participant observation enhanced rapport and facilitated participant articulation and provided the researcher with a greater understanding of context. Furthermore, it allowed the researcher to witness the manner in which participants and others' nuanced embodied activities may play out in everyday lives, and through various encounters, brought out new foci of questioning.

Throughout the interviews and participant observation, a number of interrelated themes were reinforced. New issues were brought out in later interviews and issues discussed in prior interviews were discussed in greater depth. Important themes included the importance of function and mobility; the centrality of obsession, compulsion, and

validation in participants' lives; the effects of weight trajectories and perspectives on social relationships; and evident fluctuations in mood and acceptance over time.

## **6.2 Function and Mobility**

The importance of function and mobility remained salient for participants in these later phases. Past and recent injuries majorly impacted all the repeated interview participants' lives. Christine described the pain she endured from a childhood car injury:

*My back, the leg and I was...I'm limping like mad and, but if I didn't go [to the interview]...and this is what the government says that if you can do that, if you can do that, you're all right. You don't need help. But they don't see me on the weeks like this week when I was completely dizzy and just ate and ate and ate. Well, I didn't just ate and ate and ate, but I ate stuff that I shouldn't have. -*

**Christine, Int 2, Woman – 50s**

*Re resuming running: ... I have something wrong with the ligament in my foot. I tried running again, and I ran for about three weeks, I guess, and it just got so bad I couldn't even -- like I couldn't pick my foot up -- like you've got mud on the floor. If I pick my foot up like this it hurts so bad. So I got it checked and it's a ligament in my foot. And they say it can take up to six months to heal. So I haven't been doing that [running]. - Daisy, Int 2, Woman – 50s*

Indeed, over the course of a year of interviews, 4 out of 5 repeated interview participants sustained new injuries that affected their highly active routines and subsequent moods.

Another important related issue that maintained its importance in these later phases was aging and its potential effects on mobility and functioning, future care, and appearance:

*So that's been a profound change in trying to focus on health habits. Yeah, and then, I mean, I'm [40+] old. I have at least 15 more years in my job till [eligibility for early retirement]. And if I'm going to keep doing this [work] until I'm 59 or longer. I look at other people who are like 60 years old and I'm like*

*okay so I need to be as fit or fitter than they are. Or I need to accept that I will be in a lot of pain. Because my knee hurts now because I broke my knee two years ago, my knee hurts now. Like what can I do to make sure that my knee is not a source of constant pain by the time I'm 60? –Rachel, Int 2 Woman – 40s*

*And on Friday's I used to say okay I'm going to lose 50 pounds and go to Weight Watcher's and do it and be done. And then gain it back...and do it again and that. But yeah, as I get older it's harder to --. - Daisy, Int 2, Woman – 50s*

*And my strength is continuing to improve and will continue to improve whether or not I lose weight. If I lose a little bit of weight, I'm going to feel extra benefit, like for every five pounds at this point I am going to feel an extra training effect just from pushing this weight around. I think there'll be slow improvements, but I am 55 and it's hard work. I mean, as I said to my [relative], like the first six hours of working out a week is just to maintain at this age. You don't get to go ahead very easily. - Amelia, Int 2, Woman – 50s*

During participant observation, participants emphasized the importance of comfort in places of activity. In addition to larger bodies, the presence of other disabled or middle-aged bodies was mentioned as a comforting factor. Amelia, for example, joined a fitness facility after a major injury. While initially she exercised alone due to repercussions from her injury, she subsequently joined and valued a more communal atmosphere. I accompanied Amelia to this small, private facility, where she was known by every other person in the facility, apart from a new member.

*On joining the fitness facility following an injury: And I owed – like I was a different client than the gym clients and so I think I cut myself a lot of slack on self-judging because I was there with the athletic therapist and then when I went – like I would see him once a week and then I would go two or three other days and do his program even though he wasn't there, I was still doing his program, I am just there doing my therapy. So I didn't really pay a lot of attention to the rest although I did try to go when nobody was there. So I was always checking with the staff, "when is it really quiet?" and then I would plan my day to go when I would expect nobody else to be there because one of the things with the head injury was I couldn't adapt to changes very easily. So if I knew my program was such and such, it was really hard for me to change the order of it or...*

*Well this is where they were very accepting of me at my weight. So I have always felt that I was respected for being there and that in their minds my physical body was absolutely no deterrent to any goal that I might have. I was the*

*person walking in the door and they were the people with the skills. So there is this great acceptance and it is a small gym. Maybe we didn't see so much today but the clientele there are typically middle aged active – middle aged to young seniors, active folks. So it is a community that I – like it does feel like a community place. It's like my Cheers, where everybody knows my name right? - Amelia, Int 2, Woman – 50s*

Christine felt accepted at her current larger chain-gym, and she was warmly welcomed by the fitness class instructor. However, despite signs proclaiming acceptance of all bodies throughout the gym she believed it would benefit from more inclusivity regarding disabled accessibility:

*Okay, what I don't like about it is that there is – today was the first day I saw a person with a cane and they have a wheelchair, like a wheelchair shower. So I am pretty sure the wheelchairs go there but I have never seen that and I haven't seen them for older people and at the [other facility] there is more, like there is a wide variety because...there is physically challenged people that they are whatever, their worker brings them at the [other facility]. I would like to see this place have more – but you know, you can't have everything... - Christine, Int 3, Woman – 50s*

The extreme winter conditions had a major effect on participants' functioning, mobility, and ability to socialize and engage in activities. This became especially evident in interviews conducted in the winter, in which participants often referenced the current weather conditions:

*Re: Challenges to weight maintenance: The winter has just because in the summer I was biking to work every day. So that was probably, like, 400 calories burned. So I don't have that as much. I was playing Ultimate [ph.] in the summer, which was a ton. Whereas now I just, kind of, go for about an hour walk each day. Still probably more than a lot of people but not ... nothing compared to what I was used to. - Todd, Int 4 Man – 30s*

*Because I'm not eating right, I've gained weight, and I can't get-, I can't get to the gym. And the solution is to move out of this nine months of winter. I know I can't walk on ice. I'm getting-, I have a prescription for a walker. And I'm young. I shouldn't need a walker. But I've got a prescription for a walker so I can get around in this stuff. - Christine, Int 4, Woman – 50s*

*... I haven't done anything all winter. It's been a terrible winter.  
...You don't want to do anything. You don't want to go anywhere.  
...I just want to sleep early in bed and watch TV. - Daisy, Int 4, Woman –*

**50s**

Maintaining function and mobility, particularly in light of the possibly inhibiting effects of injuries, aging, and climate, was thus a primary concern for these participants. This was evident even in the amount of fitness activities in which I participated, alongside study participants, while conducting the study. These activities included 3 fitness classes and a personal fitness regime incorporating resistance and cardiovascular training. Hindrances to participants' activity over time, through the sustained injuries or across seasons, produced descriptions of major impacts on their health and wellbeing.

### ***6.3 Compulsion, Addiction, and Validation***

Participants continued to emphasize feelings of compulsion and need for validation with respect to multiple aspects of their lives in repeated interviews. Some participants discussed their lack of control with respect to food, sometimes stimulated by the mere presence of food, and sometimes associated with particular emotional states. Between the first and second set of interviews, Rachel had what she described as an “epiphany” with respect to her relationship with food:

*The body part and the fitness part has never been a problem. The eating part is. And I think that I've come to an -- I'm starting to understand how it is that I will feel stressed out or sad or lonely and I will eat.*

*So I think I've become more mindful of how I eat. Yeah. Like specifically how I feel lonely and I want to dive into a bag of potato chips. Like just what that's like...And so whereas before would just dive into a bag of potato chips and you know come out just all covered in crumbs and --. That's not going to transcribe very well. But come out all covered with crumbs and full of shame and self-hatred. And now I'm able -- I will still on occasion dive into a bag of potato*

*chips. But I'm like what was that. What just happened? Why was I feeling -- what was that? So that has been really -- it's a really big deal. And I realize that to a certain extent there is an oblivion from my feelings that I'm seeking from eating a great deal of food. – Rachel, Int 2 Woman – 40s*

*I just like to eat so much. I really do. It's like it calls me. I'll make something and I'll have supper and I'll put it in the fridge so I don't nibble on it. And it's just calling me and calling me because it's my favourite. And it doesn't matter how full I am, I still eat it...And some things I know really give me a sore stomach, but I'll eat it anyway because it's so good. And suffer after. And that is so stupid. - Daisy, Int 2 Woman – 50s*

Participants also engaged in seemingly compulsive behaviour in other areas:

*You know, I was thinking about this recently that...I hate labels, but probably I have some OCD. And it's almost like it gets shifted from being obsessive or compulsive about eating to being OCD about tracking and that's unstable. Like it can shift back and forth so easily. So by not putting the OCD onto that, I mean, maybe I'm a little obsessive about going to Yoga classes, but I don't know. It feels a little different. - Amelia, Int 2 Woman – 50s*

*Like, you know, like I said, I used to be quite content to just play video games on the couch for a weekend. Now it's...if it's warm outside, like I really feel like I should be outside biking or hiking or walking or doing something outside. So yeah, very different than the...I remember I used to like get off work at like five o'clock, go to my [relative] and just play like [computer game] until like Monday at seven in the morning when I had to go to work. Just would stop and just run out to go get fast food for lunch, so yeah, it's almost kind of pulled an opposite. - Todd, Int 2 Man – 30s*

The need for validation regarding appropriate lifestyle choices or weight loss was evident in a number of repeated interviews:

*... I remember every time I used to lose a pound or even a half a pound I'd just be like oh yeah, like I can do this, I can beat this, and it was almost like a drug and like I can totally see how people get addicted to losing weight and get these crazy eating disorders. But with maintenance, you're just same weight, same weight. Like, you feel like you're striving for mediocrity almost, so. - Todd, Int 2 Man – 30s*

*Then I've actually posted something about a week ago saying that I think that what I need is for people to-, whenever I post that I've completed a diary for the day or that I've done an exercise that they say yeah good job. That seems to*

*work for me and I was its pathetic, but it's like that's what I need, so it turns out that's what I do. – Rachel, Int 3 Woman – 40s*

This was also reflected in participants need to no longer be recognized as obese or as failing to be 'healthy':

*And like I'm not obese, you know. I'm overweight but I would defy anyone to look at me and say "you're obese", that they would look at me and say you're overweight and I'm a comparer and when I go out in the world I'm like I'm looking pretty good compared to women in my age group. I've got nothing to be ashamed of for this appearance. I had that argument discussion with myself quite often. I spend way too much time on it, I'm sure... Yeah, I still think that the labels are inappropriate and mass supplied and used and manipulated for advertising to a spectacular degree. I guess I feel like I've slipped outside of judgment... Yeah, that I've gotten myself outside of the range of judgment. That doesn't sound like it's health either. - Amelia, Int 2 Woman – 50s*

*I feel really good about the way that I can present myself in terms of my health journey, although it's bit of a hackneyed word but in terms of my health journey of my health, my ongoing health. The ongoing engagement with that getting healthy process, with my client, like I feel really confident in how I present myself and how I like okay this me, this is how I am and this is what I do, and so that feels really good, I feel like I have more integrity. Don't think that I felt like I had less integrity before in terms of how I presented health issues with my clients, but I feel like I have more integrity, like I feel I have more-, a deeper well to draw on. - Rachel, Int 2 Woman – 40s*

The relevance of science in backing up participants' lifestyle choices was similarly evident. Authority was granted to studies or credentialed authorities used to justify particular lifestyle choices:

*Re: Online fitness community: They were just-, they had really good results and most of them the ones that I'm following or that I'm sort of heeding are part members of the community. They are regular folks; they are not dieticians or anything. Who have had great results and so who are they these people who are eat, train and progress? In this-, so there's different groups right? I'm not like a real forum person like I don't contribute a lot I sort of look I'm not really-, that feels too naked for me. People like [online pseudonyms] are people who've done really well and who seem to have some science to back themselves up. They do quote studies and stuff. - Rachel, Int 3 Woman – 40s*

Re: Non-professional aspect of non-favored facility: *Yes. Specifically they had receptionists who may have been high school students. I don't know exactly. They always seemed to have one person in an office who looked like they may have been the professional fitness person but they were never, ever in the gyms and the gyms were very isolated rooms. There were four different types of gyms, different equipment and each one was completely isolated but they had one closed circuit camera and you would see that was playing through a loop in the reception area. That was all of the interaction that anyone would get.*

In contrast to her preferred fitness situation: *I throw money at the professionals. I hired a new trainer, I still do boot camps where I'm supervised by quality professionals and by doing the type of Yoga that I'm...the Ashtanga series that I'm learning, it's from a very experienced instructor who guides each person on their own time and with individual instruction rather than being in a class and expected to keep up.* -**Amelia, Ints 3 & 2 Woman – 50s**

Todd found the infrequent validation troubling in his current weight maintenance stage. He posted before/after pictures on a social media site to gain some positive reinforcement, but he seemed resentful of a seeming shift toward body acceptance:

*Like, you'll see--if you remember when for a while there was a lot of people complaining about Abercrombie and Fitch. That guy made a comment saying that he didn't want overweight people wearing his clothes, and three-quarters of my Facebook people, maybe I have a lot of fat friends, I don't know. Three quarters of my feed was oh let's boycott Abercrombie, let's boycott Abercrombie. And it's like this happened at the same time that like a big factory collapsed in Africa and it's like you boycott a guy who's like no fat chicks, but you're okay with a guy who's building factories to such poor standards that they collapse and kill hundreds of people so that you can have 20 pairs of socks for a dollar. It's funny how different things people jump on bandwagons when it comes to stuff like that.* - **Todd, Int 3 Man – 30s**

Both male participants seemed to experience similar misgivings, but no women related these concerns. The males who responded to the study tended to be weight-losers wishing to discuss their success, and this was less frequently evident in women. Thus, it is difficult to disentangle the differing influences of weight loss trajectories and gender on these effects.

Many participants weighed themselves frequently, if not daily. However, this had a differential impact on body acceptance. Some participants found their acceptance levels and mood increased with less weighing. Amelia continued to weigh herself daily, looking for slight and slow trends. Over the course of the interviews, however, she but had ceased other forms of food monitoring. She, too, felt this had a positive effect on self-acceptance. Some found less frequent weighing actually improved their weight loss outcomes:

*I read something on the internet and then I started really watching and I haven't weighed on the scale. I just weighed on the scale once in two months and I was down the ten pounds. So it is just not stressing out about it. – Christine, Int 3, Woman – 50s*

*Now when I'm more active and more routinely active, that I feel that less those values of like poor self image are not as low and I think that in all probably since I've stopped weighing myself, they're more realistic. Not weighing myself has really helped me to not like even though I might feel great, I might feel good in my body and every part of it is working in my all that day, and pain free and all. I could step on a scale and that would all be erased so that feels good, it feels really good to me. - Rachel, Int 2, Woman – 40s*

Overall, participants seemed to be inclined to quantify progress and engage in exacting self-monitoring to achieve their aims. For participants actively striving for weight loss or fitness goals, therefore, there was an inclination toward self-monitoring of food, activity, and weight. In Phase 1 interviews, many HAES-inclined participants were striving to overcome these inclinations. By the end of interviews, participants achieved a mix of results in halting these activities, and feelings produced were largely ambiguous. For example, Amelia ceased some (but not all) of her monitoring activities and felt this improved her overall self-acceptance and mood. Todd felt himself becoming more “complacent” over time, and this promoted guilt and anxiety.

Participants often longed for external validation and recognition of their efforts. For some individuals, this seemed to be in direct response to previous stigma. Participants sought communities, including social media communities, which would recognize their accomplishments and progress. Rachel, for example, showed the researcher postings on her online community, exposed the researcher to the posts of other users, and showed the researcher how the site interface worked and how it linked to a variety of other social media sites, such as Facebook, or to mobile devices. On this site, Rachel meticulously posted her food and nutrient intake and sought positive reinforcement.

For Amelia, this pursuit of recognition often manifested in the desire for recognition from a ‘qualified’ source, an individual she viewed as being possessed of sufficient expertise to judge her fitness levels based on post-secondary education. The fitness facility to which I accompanied her was chosen in part due to its sufficiently qualified staff. Indeed, the overall focus on self-monitoring seemed to reflect participants’ reliance on scientific authority. For example, Todd and his partner, referenced sources citing the need to daily weigh one’s self.

Compulsive inclinations were also apparent in how some individuals discussed their relationship to food. These participants emphasized a lack of control, addiction, or the use of food as a coping technique. As participants fluctuated with respect to self-acceptance, their diligence and attitude regarding various forms of monitoring changed. Some participants grew weary with monitoring food intake over time and were less stringent, at least temporarily. Other participants would cease marking their physical activity progress and only look for long-term trends in fitness and weight. Yet other

participants completely ceased weighing themselves and felt this actually improved their health outcomes. Transitioning to a less stringent approach to food or physical activity often took time, however, or provoked feelings of guilt. In summary, participants often described compulsive food behaviours that could rebound into stringently monitored dieting behaviours. This preoccupation was echoed in other areas of life including physical activity, as was a focus on external acknowledgment of accomplishment.

#### ***6.4 Social Effects of Weight-related Changes***

The need for validation tied to compulsivity and self-monitoring, was related to another overarching theme, that of the effect of weight, food, and fitness on social relationships. The building of community was highly important to participants. This particularly translated to fitness and eating situations. Participants recounted ending relationships amongst those they felt were not accepting of their size. However, participants also expected a certain degree of dedication or support amongst their peers for any altered lifestyle goals. This seemed related to some participants' need for bonafides from lifestyle advisors:

*And that's kind of a big deal. And it took me -- it's taken me now years of coming and going with this process of tracking my food and tracking my exercise and being part of an online community that is supportive, full of people who are eating and working out with varying levels of success. And witnessing their failures and witnessing their successes, that I've started to understand what goes on for me. - Rachel, Int 2, Woman – 40s*

Rachel also discussed how being surrounded by size-accepting people who were well-informed regarding the possibilities of fatness and health helped her cope with the surrounding stigmatizing society:

*I have like the unbelievable, wonderful blessing of working in a workplace where people are supportive and are smart and would never ... you know, it just wouldn't even enter their mind to shame somebody because they're big and it's a really loving, wonderful place to work. And then that anchors me when I go out to the big scary world and there's ... you know, you have a relationship with like every ... you know, there's like the way you interact with everyone, right? And people make judgments based on how everybody looks as soon as they see, I'm assuming me. And so yeah, I feel anchored in good relationships when I go out to the world despite having had like grown up with weight challenges and, you know, thinking I was a fat kid before I was even fat and then really being a fat kid and then being a fat adult and the kind of shaming that came with that and then sort of getting past that, I think, you know. - Rachel, Int 3, Woman – 40s*

Christine praised her new fitness facility for providing a welcoming environment for her family, while emphasizing the need for external exercise motivation:

*So it was only once since July that I have been there and with seeing the snow and everything if I didn't have...see what I need, what I...what overweight people need and it goes for my friends that are overweight too, even from TOPS, if you have an appointment or have something that you have to do, then you just – it's just getting going.*

*Oh just the instructor and just because she is – you have to be able to interact with, like generally we go – the other one is on [Place], it's not that far from here. [Daughter], that instructor is just different. Like this one is just jolly and she doesn't care and she will stop and say, for a modified, because she knows that I need modified, and she will just do it with the other ones. This lady, that is why I asked her where she was because the schedule has changed, because it is just – I would rather take any kind of a class from her... Yeah, and you have to feel welcome. I mean at the [other facility], we went there for a while and there was really nobody. It was a different clientele or a different – I don't know. This place, well there are a lot of people but it feels small and like you belong there as a family. Like she knows you. - Christine, Int 3, Woman – 50s*

Todd felt most content amongst those interested in working as strenuously as he did:

*Re: Missing a sports team post-injury: Yeah, I miss it quite a bit. Like, every now and then I'll meet up with the team afterwards when they go out for beers and stuff like that. I do miss them.*

*I didn't have very much fun doing the volleyball, but the floor hockey was fun...The floor hockey was all younger guys, so it was a little bit more serious and a little bit more competitive and a little bit faster. I felt like the volleyball, it was just like 50-year old women playing and it was volleyball so it's just like, you just*

*stand there and like one in six balls will maybe come in your area. It was a lot quieter I find. Like, I didn't do it and feel like I had a workout. I didn't even think I...I don't think I need to shower after this. I just walked out. - Todd, Int 3, Man – 30s*

The influence of various weight trajectories on social relationships was felt in complex ways. Participants described how gaining weight could result in the loss of social relationships, while losing weight (however temporarily) could promote (often transitory) friendships. When conveying initial interest in losing weight, participants often found others expressed willingness to help. However, this stated willingness did not necessarily translate into action. Furthermore, participants were often in the process of multiple caregiving roles and were laden by commitments to others. This was evident throughout interviews and participant observation, when participants were often interrupted by urgent phone calls from friends and relatives requiring instrumental or emotional support. Often, participants detailed their elaborate pre and post-interview caring activities including visiting sick friends and family members, helping family plan social events, or assisting ill relatives in housing situations. Such relationships were not always reciprocal, did not ameliorate stigma, and could contribute to weight gain:

*People are weird. You know, they say, oh yeah, I'll walk with you and I'll help you. And nobody ever does. They are all talk. I'll support you. I'll be there. And they don't. - Daisy, Int 2 Woman – 50s*

*And I'm not going to tell anybody because then...what I find is when I drop weight, people, even from our church, they'll come up, "Oh, you look so good, you've done so good." And they'll be all on you and then you'll have a down and you might gain ten pounds and then they all disappear. All these friends you think you had. So I haven't told anybody.*

*Oh, I...I've been used so much and it's just...finally my kids have said, "Mom, stop it already. They don't need you. Hang up on them." I mean from just other people calling and...I'm like I'm a giver and I'm a doer and those are wrong traits to have to try to...because you want to help other people more than you want to help yourself and that's not good.-Christine, Int 2 Woman – 50s*

Christine spent the year I interviewed her negotiating bureaucratic strictures to receiving disability payments and professional healthcare support for an ill child. In later interviews, Christine discussed how these non-reciprocal caregiving roles could precipitate weight gain:

*Well I think it adds to my weight because I don't get to eat properly then. And you're not home. And you don't get to exercise, like you're always on the run. And I've been on the run since the last time I saw you. I've been to the gym once, and that was-, and because of my [partner] today, he says, "Oh I don't want to do all that running around," because our car is sort of banged up and it's going to the body shop. And so I said, "Well you just drop me off at the library and I will get the bus home." And it all takes a toll, and over the year I gained 10 pounds this year, and I should have lost. - Christine, Int 4 Woman – 50s*

Stigma had major impacts on the lives of participants:

*Well, you know, you never tell somebody who's skinny that they look too skinny, or stuff like that. So why people think they can tell you, you look too fat and not to eat things amazes me. I would never have the gall to say that to somebody. Yeah, people do. You know, like should you be eating that? You're eating all of that? - Daisy, Int 2 Woman – 50s*

*Yeah, for sure. I rode my bike for the first time in a couple of years on the weekend. And I was -- I live in the north end and I have to go through some pretty dodgy areas. And for my own personal safety there is some stoplights that I wish had been green that I had to stop at. And there were kids, and especially teenage boys I find can be especially cruel, at least that's how I remember them. And I was like -- I was worried they were going to make a comment. Oh look at the fat girl on a bike. Fat lady on the bike I guess they would say now because I'm older. And I found myself tensing up. So I'm worried that that would happen because I think that would hurt. It would hurt. I make -- I do -- no I don't make an apology. But I sort of present it as when I talk to my clients about weight, I say like someone like me for instance, if I was pregnant this is how many -- I would want to gain less weight than someone who weighed say 40 or 50 pounds less than I do. I'm certainly more matter of fact about it. And I think that was a step that I needed to take. I needed to sort of -- it needed to be on the table that it was very obvious that I was this size. But I no longer feel a great deal of shame because I can't be ashamed if I'm going to put it on the table. I just have to present it as this is how it is. - Rachel, Int 2 Woman – 40s*

*Well, my [partner]left me. There was one big one. And that was one of the three reasons was I thought you were going to lose the weight after the baby. Well, I did lose all the weight after the baby, but then I gained it from stress, the weight that I gained after. But he wasn't happy with my appearance. And I felt shunned and people might say oh you're making that up. But I did feel that because I had "let myself go", these are air quotes that you're hearing, they didn't want to associate with me. It was a visible marker of my unworthiness or it was just a really lonely time. - Amelia, Int 2 Woman – 50s*

Remnants of stigma remained an integral part of participants' lives, even post-weight loss. For example, Amelia had previously related participating in an outdoor group fitness activity in which she experienced severe discrimination. During later interviews, she now felt sufficiently confident and fit to undertake such activities again; thus far, however, she did so alone:

*Well interesting that I did it by myself. So I was not externally judged or didn't feel externally judged that I could be in my own time and place and make my own decisions about what I wanted or needed at any given time, be it rest or movement or food or whatever. I was just in my own rhythms. That's an interesting thing for me to take that out into such an active thing as travel and camping and such because I have mostly been in my own rhythms in my house before. So I am considering going back into group hiking. - Amelia, Int 3 Woman – 50*

By the end of the interviews, Amelia was able to command sufficient confidence to challenge inequitable relationships defined by a negative conceptualization of her appearance:

*And in the last I've started to stand my ground about how much energy I'm willing to give relationships, like, that there's reciprocity and respect and all these things, all part of the global healing within me. And though I haven't cut any of those off completely I'm sitting back and going, like, I'm only going so far on this but I'm not going to be your ... your homely side kick. So, you know, go with you to go meet guys. - Amelia, Int 4 Woman – 50*

Social situations involving food and eating out were exceedingly difficult for participants to navigate:

*'Cause there's so much...and anywhere you go everybody's giving you food. So if I could get to stay home and not have company, because when you have company then you have to feed them different...well, the don't eat like...my family has to eat what I cook, unless they bring it home. But I don't know. It's just that foods...and you walk...if you go to the Fringe Festival they have the...they have this taco place. - **Christine, Int 2 Woman – 50s***

*And everywhere I turn there's food. And working in [hospital unit] there's food constantly. And I just don't have the willpower to not eat it...People bring us food in [hospital unit workplace] like you wouldn't believe, Filipino food, sandwiches, like you know after meetings they have the sandwiches and the dip and the [inaudible 0:04:19] and that, anyone in the hospital if it's left over they bring it to [hospital unit]...You know, we have family of a patient bring in tons of chicken and fries and everything. And there's constant food in there. It's amazing. - **Daisy, Int 2 Woman – 50s***

In his first interview, Todd related being a “killjoy” regarding social eating situations. Later interviews showed his attempts to “not be that guy”, although he commented on specific food choices when I and his partner were eating in public venues:

*Not really. Although I'm sure there's people who, before we go, like oh we're not going to be able to eat 'cause [Todd]'s coming [inaudible 00:44:00] or something, so I'm sure there's...behind there's some stuff going on. I think most people are pretty supportive of it. The last time we went to [other province], we had to make two stops because I had to go to Subway and my [companion] wanted to go to A&W, so we dropped them all off and get a sub, bring it back to A&W and there's stuff on the A&W menu that you can probably get that's probably just as good as a sub, but it's just the principle. - **Todd, Int 3 Man – 30s***

His partner, whom he met following his weight loss, discussed having to alter food-related behaviour after their marriage. Todd's eating habits also affected relations with his in-laws:

*Well, I have a Mennonite background so pretty much all social gatherings revolve around food and I wouldn't say that I overdo things, but certainly I've noticed I usually enjoy doing baking and cooking and stuff and I don't do it as much anymore because [Todd] just doesn't want to have baking especially at home, right, so then it's...so then I do it a lot less because then he doesn't like it when it's there and he'll still eat it and I don't want to have that temptation there for him, so that's probably changed a bit for me in the sense that I don't do that part, stuff anymore.*

*I know that there's some info out there about, like, he weighs himself every morning and I know that that's sort of micromanaging his weight, but I've never been one to do that all the time. So when I see him weigh himself and get frustrated, it's frustrating for me and I'm like well why do you bother. You know that you had chips and wings and Pizza Hut, which add a whole bunch of salt and a whole bunch of water, so it's not going to really matter. So sometimes I'm like well why are you even gain it and lose it and it's no big deal, but at the same time I know that it is a big deal and it is important, like, for some people to check every day.* – **Partner of Todd, Int 3**

*'Cause [partner]'s mom will just always have stuff. Come on, have some more, have some more, have some more. Like oh here I know you like bread, so I made you like six loaves of bread. Which bread, which goes bad in like five days unless you eat it and I hate to waste food.* - **Todd, Int 3 Man – 30s**

Attitudes toward others' habits were affected by weight trajectories in sometimes critical or resentful ways:

*And then just anything, it doesn't...I mean, you know it's...I was on the bus today and there was a heavysset lady right in front of me and she was just munching on her pretzels. Well, I used to munch on pretzels but I know what to eat, like what to eat but sometimes you just give in and just...and then when you give in you really, like I ate whole box of...I was crying one day because I hurt so bad and I just stopped at the Dollar Store and that's the cheapest food to get, right? And they had Munch and Crunch, you know that popcorn?* -**Christine, Int 2 Woman – 50s**

*I don't think you're ever prepared for-, and I said and I watched this girl at work as I had this other [bariatric surgery] done and she always has candy with her and always nibbling whatever. She's still lost a lot of weight but just annoys me like why can you eat like that and lose all that weight. I can't do that but when I look at what I eat, I eat a lot more than that.* -**Daisy, Int 3 Woman – 50s**

A combination of very complex feelings regarding internalization and ambivalence of messages concerning willpower, others' behaviours, and resentment of forces he felt were complicit in his own weight trajectory was evident in Todd's responses when I accompanied he and his partner to a high-end chain restaurant:

*It hasn't really changed that much I don't think. Like, I do find that...Like, as far as my perception, I still blame restaurants for a lot of the issues that overweight people have, like my brother who's fairly overweight and he eats at McDonalds all the time and I'm just like, you know, yeah it's all about self-control, but disciplined willpower, but if this food wasn't do damn cheap and so accessible, and it's so good, we wouldn't have a lot of problems like that. - Todd, Int 3 Man – 30s*

Concrete patterns concerning the effects of weight alterations and attitudes on social relationships were difficult to discern. Social relationships were thought to contribute to participants' obesity and relationships could be dissolved based on weight alterations or subsequent changes in lifestyles. Ultimately, participants' descriptions suggest that many of their social relationships were not 'weight-neutral', in that their bodies' fluctuations were reflected in their social lives' mutability.

### **6.5 Acceptance and Mood**

Over the course of the research, participants' levels of acceptance of their own bodies, societal attitudes toward obesity, and their moods fluctuated. For example, Amelia found that as her fitness improved, her personal acceptance levels increased. Concomitantly, her mood obviously appeared to improve. However, she acknowledged the easing of her anger regarding obesity stigma was in part because she felt such stigma was no longer focused on her. As her fitness improved and with shifts in weight, she felt she could focus more on health than weight. However, her anger at prior mistreatment remained evident. Likewise, Christine chose to focus on health not weight, in part, because she felt weight-based focuses precipitated weight gain:

*I think that getting into the ... this size where I don't feel publicly criticized allows me to focus on health rather than weight. – Amelia, Int 4, Woman – 50s*

*Oh now it's not so focused on losing weight. Now it's just on being healthy and being happy and doing what I can...Probably because worrying about it is the worst thing because then you just eat. – Christine, Int 4, Woman – 50s*

Some participants found acceptance increased as various tracking behaviours decreased. At Interview 2, Todd was worried that his gradual “complacency” regarding food and his weight would lead to weight gain. In subsequent interviews, he returned to strict monitoring practices. He acknowledged that the extent to which he valued weight loss may be unhealthy but felt his results compensated for these concerns. Furthermore, as time wore on, and he no longer received the on-going successes of weight loss, he resented what he perceived to be a societal shift to weight acceptance.

Participants who were disappointed by their non-engagement in perceived health-promoting behaviours often experienced low mood and acceptance. Daisy enjoyed exercise but was often hampered in re-engaging in activity by injuries, winter weather, lack of support, and non-sustained motivation:

*That's why I'm ... Yeah. And I think I'd feel so much better if I just got moving. But I kind of just want to sleep and sleep and sleep. – Daisy, Int 4, Woman – 50s*

Regardless of weight fluctuations, the involvement in activity or ‘healthy’ food consumption appeared to improve mood and health. Rachel experienced improvements in mood, self-perceived health, and acceptance as her activity level and engagement with health increased. This was despite her being (intentionally) unaware of her current weight status, which she presumed to be relatively high compared to previous periods:

*I don't think I've ever really thought that a person my size was unhealthy. Like I think I always resisted that notion because I always knew that I had*

*capacity to do stuff that other, you know, smaller people couldn't possibly do and I know that I can still do that, right? So I can outswim most people, I can out lift most people and I ... you know. So there's all sorts of things that I can do that other people can't do and it's important to me to be better at stuff than other people, I know that. But I ... So I never really thought that being this size was unhealthy. I mean, I thought that it ... I mean quantifiably, yes. Like its ramifications are unhealthy and its possibilities are unhealthy but that the state in and of itself, I always knew that all of the components were good. My blood pressure was good, my blood sugar was good, you know. It was just the weight part. So ... And I always resisted people's definitions that ... who just looked at me and then all of a sudden labelled this as unhealthy without even knowing, you know, that my ... you know, that my resting pulse is 60 and my blood pressure's 90 on 60 and my blood sugar's totally solid, right? So yeah. So ...* – **Rachel, Int 4, Woman – 40s**

In summary, participants' moods and levels of self-acceptance tended to co-vary. Participants were inclined towards higher mood and acceptance when they felt they were acting in accordance with their goals. If their goals were primarily weight-based, this may require very strict lifestyle accommodations. For those seeking health, more permissibility respecting food and physical activity may be allowed. Participants who failed to behave in accord with their self-imposed standards tended toward self-negativity. Like participants' overall experiences of obesity, their goals and lifestyles were highly subject to change and contingency.

## **CHAPTER SEVEN:**

### **DISCUSSION**

#### ***7.1 Introduction***

In this critical ethnographic examination of obese persons' health perceptions and lived experiences, three major themes emerged: the importance of function to health and quality-of-life; compulsion, addiction, and the need for validation; and social impacts of various weight trajectories and perspectives. Participants, in defining health and articulating health goals, often cited the need to be able to engage in their activities of (often preferably energetic) daily life. Participants described their relationships to food and health-related behaviours that often emphasized the compulsive, addictive, or excessively monitored nature of these activities. Some participants described shifting from one extreme of compulsive, emotionally-induced eating to a vigilantly monitored exercise and dietary regime. Often, this coincided with the need to attain some external recognition of the appropriateness or value of their efforts. Also discussed were the myriad ways that weight trajectories and differing weight perspectives altered their social relationships including experiences of stigma, attitudinal changes, and alterations in levels of social engagement. These themes will be explored through the theoretical frames of Foucauldian biopower and healthism, agency, and stigma. This will foster a greater understanding of the contextual, social, and discursive factors that influence obese persons' experiences, attitudes, and identities and facilitate the development of recommendations for more inclusive and affirming public health and healthcare programming.

### **7.1.1 Obesity as Moral Deviance**

Obesity is a highly visible state that is considered attributable to personal behaviour (Puhl and Heuer, 2010). This construction of obesity causation is known to exacerbate obesity bias (Puhl and Heuer, 2010), and obese persons are considered a burden to themselves, others, and nation states (Halse, 2009). Obese individuals are thus both visibly non-normative and transgress moral and social norms. According to Goffman's (1963) understanding of stigmatized subjectivities, they would be considered both discredited and deviant spoiled identities.

Crawford (1980) termed the moralism attached to health pursuits as healthism. A health-focus was once viewed as a more holistic phenomenon than the previous more disease-centric approach of public health. Healthism has subsequently colonized multiple dimensions of individuals' lives and imprinted upon them the need to act in accordance with health-enhancing behaviours. As health is not a finite measure, individuals must be ever vigilant in perfecting their degree of health (Crawford, 1980). Healthism had affected participants in my study. For example, in one interview, Rachel discussed never being satisfied regardless of the amount of weight she lost. She always wanted to be less and less, even though this was something she felt was at odds with her feminist beliefs.

The moral imperative of health exists within a particular historical and relational context that has shaped societal understandings of the body and health. Foucault (1975) discusses the transition from sovereign power to disciplinary power in the 18<sup>th</sup> to 19<sup>th</sup> centuries. Sovereigns shifted from punishing individuals' physical bodies to imprisoning criminals and punishing souls. Within prisons, individuals in prison and other educational and economic institutions were subjected to meticulous observation and recording. Power

was exerted by the enforcement of discipline over every aspect of an individual's life and body, and this discipline became willingly internalized by individuals (Foucault, 1975).

Disciplinary power eventually shifted to regulatory power (Foucault, 1978). Sovereigns no longer wielded power over life and death by the outright killing of delinquents. Rather, sovereigns exerted power to “foster life or to disallow it” (Foucault, 1978:138). Power was demonstrated, and control enacted, by increased regulation; administration; and categorization of life, institutions, and populations. This was achieved through the increasing use of classification and statistics (Foucault, 1978). An era of biopower began, characterized by a diverse array of techniques and institutions mobilized to aid in the subjugation and control of bodies and populations and the hierarchization and segmentation of societies (Foucault, 1978:140). Myriad institutions and strategies, termed biopedagogies, now operate in diffusing biopower-related messaging including mass media, public health, schools, cyberspace, popular culture, and families (Wright and Harwood, 2009). One method through which this valorization of particular bodies may operate is “the imperative of health: at once the duty of each and the objective of all” (Foucault, 1991:98-99, 103). These mechanisms instill an internalized health imperative that produces, through citizens' self-monitoring and technologies of the self, the creation of malleable, improvable, and politically and economically useful “docile bodies” (Foucault, 1975; 1978; 1988; 1991).

Individuals are increasingly measured, categorized, and hierarchized based on their weight, size, shape, and body mass index (BMI). The constant reference to these values in popular media and cyberspace (Gard and Wright, 2005; Miah and Rich, 2008; Holmes, 2009; Rich, 2011), ensures individuals are able to internalize these values and

adopt self-disciplinary, self-monitoring, and self-surveillance regimes. Foucault terms these regimes “technologies of the self” (1988; 1997:177-178, 223-251). Through these regimes, individuals strive to become idealized docile bodies (Foucault, 1975).

The willingness of an individual to maintain or achieve an ideal weight determines their moral worth as, what Halse (2009) terms, bio-citizens. Bio-citizenship expands on Foucault’s biopower (1978) and on Rose and Novas’s (2005) concept of biological citizenship. Biological citizenship emerges when an individual’s social, electronic, and political affiliations and alliances are constituted based on their various bodily considerations such as illnesses and genetics. Bio-citizenship arises when the body is merged with the political, cultural, economic, and social roles and functions of a citizen of the state (Halse 2009). Within the current public health environment, in which obesity discourse is predominant, a virtuous bio-citizen is one who prioritizes, and is conscientious in achieving and maintaining, a normal BMI (Halse, 2009).

Through exposure to biopedagogies, individuals may internalize oft-stigmatizing and individualizing depictions of obesity (MacNeill, 1999; Burrows and Wright, 2004; Lawrence, 2004; Gard and Wright, 2005; Miah and Rich, 2008; Burrows, 2009; Fullagar, 2009; Jennings, 2009; McPhail 2009, 2010; Puhl and Heuer, 2010; Warin, 2011). This can instill a publically acknowledged and normalized hierarchization of bodies. Amongst my participants, these factors were evident in a number of ways. For example, the self-monitoring of food, physical activity, the use of measurement technologies, and the guilt and anxiety over food and exercise choices experienced by participants are all examples of internalization of biopedagogical messages. Some participants even discussed the sources of such messages, which was often the workplace or the internet.

### **7.1.2 Encounters with Healthcare**

As Halse (2009) discusses, individuals now are credited with being a worthy citizen based on their capacity to maintain a normative body size. ‘Failure’ in this respect renders them poor bio-citizens. Obese persons’ shape and size are used to infer poor health, regardless of the non-certain linkage between health and obesity (Bacon and Aphramor, 2011). They are therefore denounced as poor bio-citizens whose weight presumably negatively impacts others and their nation states. This was evident in how participants discussed the frequently media-reported statistics on the presumed strain obesity lent to healthcare systems and their worry for future generations.

An obese, and consequently deviant individual, will be urged to acknowledge that their size indicates they are unhealthy, lazy, and gluttonous through both clinical encounters and public health campaigns. This conspicuousness of disease may be heightened in a biomedical encounter. A clinical examination may take the form of ‘the “confession” described by Foucault (1978). In such a confession, an individual seeks salvation by admitting to an authority figure their deviance respecting a particular power/knowledge relation, and discursive, transgression. A suitably disciplined subject will then undergo conversion and atonement and adopt a more appropriate subject position within a particular discursive and disciplinary framework.

As Jutel (2006) recounts, in clinical encounters, truths regarding lifestyle are not necessarily expected from obese patients in questioning; rather, truth is revealed through anthropometric assessment. Indeed, one common stereotype attached to obesity is that of dishonesty (Puhl et al., 1998; Puhl and Heuer, 2011). Thus, a fat body, regardless of the experience of the obese individual, serves as an always evident, potentially non-

volitional, confession of pathology (Murray 2009a) and its presumed underlying gluttony and slovenliness. Obese individuals are urged “to confess” their ill-health and deviance through both clinical encounters and public health campaigns (Foucault, 1978; Murray, 2009a; Rail and LaFrance, 2009). Then, they must strive to achieve redemption by normalizing their bodies (via weight loss) according to health and ascetic standards (Murray, 2009a; Rail and LaFrance, 2009). Certainly, there is some evidence of more nuanced perspectives (e.g. Sharma and Kushner, 2009; Garrel 2012a, b; Havrankova 2012a, b; Heintze et al., 2012; Ladouceur, 2012), in which clinicians recognize obesity stigma and seek to avoid it or question the benefit of encouraging often futile weight loss; however, weight bias among healthcare providers appears pervasive (Schwartz et al., 2003; Edelstein et al., 2009; Puhl et al., 2009; Swift et al., 2013).

Participants described frequent encounters with healthcare providers that were disrespectful, reductionist, or cast them as dishonest. Such instances often preceded the development of doubt regarding standard biomedical obesity discourse. In contrast, some participants related more empowering experiences with providers, such as Clarissa, who ensured providers adhered to her rules of care. Emphasizing the intersubjectivity of stigma (Yang et al. 2007), many participants were themselves healthcare providers and witnessed discrimination or positive interactions between providers and obese patients. Warin and Gunson (2013) further articulate the relational nature of obesity stigma, as reliant on what particular subjects know and can decode respecting a particular field. For healthcare provider participants in the present study, their status, knowledge, and subjectivity as obese persons would affect their interactions with other obese persons and/or healthcare personnel, particularly within a medical context. Similar to the

dilemmas faced by Throsby and Evans (2013), researchers who were ambivalent in their role as weight equality advocates in any and all circumstances, some participants were conflicted over whether to intervene on obese patients' behalf or how to proceed in a sensitive manner as providers.

## **7.2 Ambivalence**

Participants' perspectives on their own embodiment, others' bodies, and abstract concepts such as health were characterized by a high degree of ambivalence particularly with respect to their own bodies. For example, Katrina, who had come to accept her size after years of intense perceived stigma and weight cycling, was primarily interested in discussing her experiences with persistent discrimination; regardless, she emphasized her stamina and recent weight loss due to intense walking. Indeed, participants sometimes emphasized their engagement in physical activity, even when being contrite with respect to their eating habits.

Rachel was highly ambivalent with respect to the impact of weight on her identity and health. As a child, she had experienced an eating disorder while training as a ballerina. In adulthood, her weight, and attitude toward it, fluctuated greatly. Having been wounded by stigma as a child, she was affronted by weight-related discrimination and advised "editing out" biased individuals from one's life. Having been exposed to the HAES movement, she accepted some of its tenets but still was concerned that her weight would impede her ability to function well in her vocation in women's health as she aged. She was also very preoccupied with the image she presented to her healthcare clients when advocating for a healthy lifestyle. She was hoping for weight loss but positioned it

as a pleasant side effect of more holistic health aims. Importantly, however, the catalyst for her renewed health aims was weight loss connected to injury rehabilitation training. While she often maintained that it was entirely possible to be healthy at a larger size, she also was critical of very heavy clients.

Even Rachel's lifestyle habits varied across a size-intolerant to fat-accepting spectrum. She was concerned about lapsing into eating disorder behaviours and ceased weighing herself during the course of data collection. She stringently monitored her intake, was guilty regarding missed gym appointments, and felt concerned over her use of food as a numbing agent. However, in addition to the great deal of care taken in her meal planning was a clear sense of pleasure and delight in preparing and consuming food. Rachel was thus impossible to unequivocally categorize as accepting or non-accepting of her size. Indeed, her perspectives on health and weight altered quite substantially from interview to interview.

The fraught relationship with public and private embodiment and body satisfaction exists even among fat study and critical obesity scholars (Heyes, 2006, 2009; Murray, 2008a, b-2010; Throsby and Gimlin, 2010; Longhurst, 2012; Lupton, 2012; Throsby and Evans, 2013). For example, Murray (2008 a, b-2010), a prominent fat studies scholar, has analysed in depth her embodied critique of fat activism and acceptance, 'coming out as fat', and her own and others' reactions to her decision to undergo weight loss surgery. Intriguingly, despite her openness regarding her ambivalence toward her fat appearance, it is health complications that she uses to justify the surgery. Again, this suggests the disciplinary ethos dominant in obesity discourse, which positions surgery as the 'easy way out' and only justifiable in extreme cases

(Drew, 2011). In Murray's case, it also aids in minimizing potential critiques of her seeming assimilation of a thin ideal. Similarly, Heyes (2006, 2009), Longhurst (2012), Throsby and Gimlin (2010) explore the seeming irreconcilability of their own scholarly and politicized critique of bodily ideals and personal body dissatisfaction and engagement in weight loss endeavours. Honeycutt (1999) who studied female fat acceptors, weight losers, and those seeking size acceptance independently, also identifies a large degree of ambivalence amongst this latter group, although they were supposedly size-acceptors.

In the present study, multiple factors were involved in creating participants' fluid weight perspectives and degrees of acceptance. Participants' fluctuations in self-acceptance and various weight-related perspectives may be a form of "agency play" (Battaglia, 1997) or "playing with reality" (Jackson, 1998). Battaglia (1997) describes this play as involving the use of agency as discourse, its strategic concealment, and its foregrounding when actors ambiguate subject positions to elevate their positioning in particular contexts. This form of strategic negotiation occurs in other embodied contexts, such as persons with anorexia in their resistance to, and engagement with, treatment services and pro-anorexia websites (Lavis, 2011).

In my study, for example, Katrina's discussion of stress eating and stigma suggests a concealment of agency, by highlighting the social costs she has endured due to her size and her method of eating as coping. When she discusses her recent triumphs, however, with respect to education and occupation, she is foregrounding her resilience, in spite of the discrimination and hardships she highlighted earlier. Daisy similarly invoked an inability to control her eating; however, she would then shift to castigating those who

would stigmatize her, or downplay her own agentic resources when recounting the factors precipitating her food addiction. Rachel occasionally demonstrated outright contradiction. She never strayed far from the idea that she had been healthy at a larger size, but she would also justify her weight loss desires by emphasizing the health benefits she would accrue from being smaller. She would also emphasize her own healthy lifestyle, in contrast to larger clients.

Jackson (1998) discusses the human need to imagine oneself as able to exercise control in one's life. Pictured as a game, this may operate along a spectrum from observance of the game's rules to their outright rejection. During threatening periods, mastery play allows for the mental reconceptualization of an individual's "*experience of the situation*" (Jackson, 1998: 30). This may be essential for understanding some participants' experiences with weight loss. For example, Melissa and Matilda previously attempted to be conscientious weight losers. However, their efforts ultimately resulted in mental turmoil and physical deterioration as they slipped into unhealthy weight preoccupation and disordered eating. Their capacity to exert absolute control over their bodies was called into question, as it was for chronic weight cyclers, such as Katrina. Ultimately, these participants maintained their perceived mastery by rewriting the game's rules and choosing to privilege a variety of alternate health outcomes over weight loss aims.

In joining in this "play" (Battaglia, 1997; Jackson, 1998), what is at stake for participants is their legitimacy as responsible bio-citizens (Halse, 2009). As such, they may seek to position themselves as healthy citizens who merely fall outside of societal approved sizes, but not standards of health. If they have not recently been active, they

may instead depict themselves as responsible citizens who are currently invested in fulfilling their contrite bio-citizenship roles by correcting any lapses in healthful behaviours (Halse, 2009). If they do not engage in socially-condoned health behaviours, they may resort to presenting a justifiable reason for failing to fulfil these roles based on pre-existing circulating discourses, such as recovery from previous abuse or overwhelming stress. If they opt for less stringent adherence to the standard weight loss/maintenance “game” (Jackson, 1998), they may reimagine themselves as revolutionaries in designing a new game (Wann, 2009). This game’s objective may shift from weight to health and self-acceptance. In the case of Clarissa’s mastery play, even the imperative of health remains intact. Only the definition of what constitutes health (the game’s objective) has been reconstrued based on HAES discourse. This allows fit and active Clarissa to advance herself as a worthy contender, regardless of her size.

Murray (2008a) discusses an alternative understanding of ambivalence that was also evident among the present study’s participants. Murray (2008a) critiques the fat liberation movement’s proposal that fat persons can merely alter their views of their bodies and achieve fat acceptance. Murray (2008a) argues that this is extraordinarily difficult given discursive influences on embodied subjective experiences. A fat person’s experiences of evoking disgust and being stigmatized have likely instilled, at the least, an ambiguous relation to one’s fat body (Murray, 2008a). Thus, in addition to strategic negotiations of agency and accounts, participants likely shifted affectively with respect to body acceptance. For example, Katrina was most adamant about reducing weight stigma, but she also longed for bariatric surgery to become more accessible, blamed herself for not overcoming gestational diabetes, and acknowledged that even when she viewed her

appearance positively, others may have continued to objectify her as disgusting. Rachel may have always viewed her body as relatively healthy and resented healthist, fat-phobic discourse, but she seemed to feel sincerely pleased with achieving a more normalized shape. This positivity seemed to derive both from personal embodiment and from her body's increased currency in the present discursive environment. Importantly, one aspect of the relationship between size acceptance and weight loss that is especially difficult to disentangle is active participants' pleasure in activity and its results, although during participant observation, participants often seemed proud, inviting, and cheerful when engaging in physical activity and demonstrating techniques to the researcher.

In summary, participants' reported views on their bodies were dependent on attempts to leverage their histories and circumstances in order to present the best possible picture of their size, health, and lifestyles in a healthist-saturated discursive environment (Crawford, 1980; Wright and Harwood, 2009). Their views were also inalienably tied to their embodied subjectivities and experiences. They had lived most of their lives in bodies considered abject, stigmatized, and contemptible. Therefore, even while espousing HAES beliefs or anger over discrimination, they may not have been able to “*simply chang[e] [their] mind[s] about [their] bod[ies]*” (Murray, 2008a:109 - emphasis Murray's) and may have remained in an ever-contingent, ever-fluctuating state of body (dis)satisfaction.

### **7.2.1 Weight Loss and Ambivalence**

For many of the participants, engaging publically in attempts to lose weight (or recounting these attempts to a researcher) may be a form of contrition and stigma

management. They are seeking to normalize their bodies and partake in the imperative of health (Foucault, 1991). However, the degree to which the desire for weight loss permeated their sense of self and health and bodily understandings, often suggested a far more deeply-rooted degree of ambivalence. Rachel, for example, seemed to vacillate between being a particularly well-informed proponent of HAES and a conflicted dieter, depending on her current weight loss stage. When weight loss seemed to be a possibility for her and she was in a weight loss cycle, she was more likely to view weight loss as a possibly beneficial and feasible option. When her weight was more stagnant, she more fully immersed herself in the role of HAES adherent, including actively seeking out health research supporting this perspective.

Likewise Amelia, when bearing the brunt of stigma, was more willing to adopt a sceptical approach toward popular obesity discourse. When she felt she was less of a target for direct stigma, she remained sceptical but less overtly angry, defensive, and politicized. Highlighting the manner in which participants tended to emphasize their taxing social roles as health-impacting, she felt her lack of engagement in actual fat activism was a form of self-care in not overexerting herself. This understanding of self-care, as sanction for engaging in desired activities and non-participation in further obligations, was common among those exposed to HAES discourse. It suggested a broader definition of health that was particularly resonant among those who described holding themselves to an occasionally debilitating high standard. Among members of a commercial weight loss group, Heyes (2006, 2009) also recognized the potentially affirming aspects of dieting, as a form of Foucault's "care of the self" (Foucault, 1988). Regarding "care of the self", Foucault (1988) discusses the ethical obligation in the

ancient world to undertake a regime of self-knowledge and improvement via self-monitoring, meditation, reflection, and particular procedures and behaviours. The beneficiaries of such practices were thought to extend beyond the individual to the world in general, thus imbuing “care of the self” with moral weight.

Heyes’ (2006, 2009) participants relied on the cultural approval of dieting to justify their “care of the self”. Thus, while ultimately serving to create docile bodies, weight loss dieting also allows for a temporary escape in which it is socially valorized for women to be preoccupied exclusively with better knowing themselves and their lifestyles in minute detail, including calorie counting, physical activity monitoring, and infinitesimal weight changes; enhancing their presumed appearances, health, and habits; and experiencing attendant feelings of pleasure, power, and accomplishment, all within an ostensibly enabling and supportive environment (Heyes, 2006, 2009). In contrast, some female participants in the present study relied on the authorization of HAES or therapy discourse to more selectively choose their engagements and obligations.

The least conflicted believers in HAES were often individuals who had experienced disordered eating or pathological weight preoccupation and had stabilized at higher weights. Even for participants, such as Christine, who avoided a weight-focus so as not to exacerbate weight gain, a shift in focus to health seemed to precipitate greater positivity toward health and motivation. Todd was particularly vulnerable in this regard; he was a first-time weight loser who attached little importance to health at the present time. Weight for him remained an appearance-dominated indicator of his success and willpower and was integral to his self-esteem and identity.

### ***7.3 Hope and Obesity***

Continual attempts at weight loss, despite previously unrewarding experiences are also described by Heyes (2006, 2009). In part, Heyes (2006, 2009) attributes this to attachment to the potentially enabling “care of the self”-relevant factors that may accrue from weight loss dieting in a social, commercial weight loss group. This helps to explain the seeming paradox of the unstinting take-up of weight loss dieting among individuals, despite widespread knowledge of their inefficacy and high rates of recidivism (Heyes, 2006, 2009). It also seems likely that the action of weight loss dieting, even without accompanying sustained results, may be a form of stigma management. Obese individuals that engage in weight loss dieting, even if they are convinced of its futility, are still demonstrating that they have interpellated their appropriate subject position within obesity discourse. Their larger bodies may still mark them as inhabiting discredited identities; however, they are engaging in the imperative of health (Foucault, 1991).

A possible cause of weight cycling has been discussed by Polivy and Herman (2002, 2008) as what they term a “false hope syndrome”. While conceding a dearth of empirical evidence, they argue that repeated failed attempts at self-change involves a process of explanation that allows future endeavours to seem worthwhile. In the case of dieting, this involves the dieter blaming the failure of the diet on something that can be altered in future attempts, such as the specific mechanisms of the diet or insufficient effort, and positively remembering the diet’s early success (Polivy and Herman, 2002, 2008). This was evident in many conversations with participants who described in detail why, despite frequent past weight cycling, this dieting attempt would be different. Polivy

and Herman (2002, 2008) see this as allowing for a degree of self-protection and for investment in future dieting attempts. The urge to continue pursuing weight loss is attributed by Polivy and Herman (2002, 2008) to a lack of deterrents to continual attempts, frequent early successes during dieting, numerous presumed incentives to weight loss, and a less distinct memory of the weight regain period.

Some participants did exhibit a willingness to continue to re-engage in dieting attempts, despite repeated weight regain cycles. However, participants' experiences with weight cycling are more complex than the hypothetical "false hope syndrome" proposed by Polivy and Herman (2002, 2008). For example, participants were well aware of the dangers of unrealistic expectations and the vagaries of the weight loss industry. They did tend to set moderate, long-term goals, and many had no preference to fall within a 'normal' BMI range. Weight losers did not abandon attempts due to insufficient losses. Indeed, many participants persisted in healthy behaviours without regard to weight loss, for the sake of other health goals or enjoyment. Therefore, it is not merely false expectations that contribute to unattainability. Thus, the solutions posited by Polivy and Herman (2002, 2008) that dieters can mitigate negative effects of the "false hope syndrome" by more cautiously approaching the process are unlikely to be relevant. Some of the negative feelings that Polivy and Herman (2002, 2008) associate with weight cycling such as perceived deprivation, hostility, and feelings of non-healthiness may be produced by dieting itself, and their reliance on insufficient willpower among dieters is contested by recent research on biological stimuli of weight regain (MacLean et al., 2011; Sumithran et al., 2011; Hussain and Bloom, 2013). Furthermore, in the present study,

while hope could be re-ignited with respect to weight loss possibilities, this was occasionally preceded by unplanned weight losses, not intentional weight loss dieting.

What resonates most from Polivy and Herman's (2002, 2008) "false hope syndrome" with respect to participants in the present study was a recognition of the suffering involved in weight cycling, and an acknowledgment that weight loss would not necessarily cure all of the participants' ills. Many participants felt that weight loss would ensure greater functioning, lowered stigma, and future health. Some participants however, such as Amelia, who was on the cusp of achieving a degree of desired weight loss, found this loss did not ease all previous difficulties. Indeed, even body image and self-esteem issues may not be eradicated with weight loss, and all of weight loss, dieting, and weight regain are associated with negative psychological consequences (Polivy and Herman, 2002, 2008; Mustillo et al., 2012; Gilmartin, 2013).

Rather than viewing weight cycling, devoid of context, as a sign that "a better approach to getting dieters to behave more sensibly" is needed (Polivy and Herman, 2008:114), it is possible to reconsider participants' renewed weight loss actions from an agency, or mastery, play perspective (Battaglia, 1997; Jackson, 1998). Participants are inundated with references to their diseased and 'disgusting' state. Re-engaging in dieting behaviour may be a response to outside triggers, including attempts to re-assert a perceived lack of control over one's body or health or to present an image of responsible citizenship (Monaghan, 2008; Halse, 2009; Murray, 2009). It is not a sign of nonsensical psychology for frequently stigmatized persons to seek the only relief they believe is available to them, despite previous failures. For obese individuals who truly had depleted their faith in weight loss as a possibility, there are few options for maintaining a positive,

empowered identity. Some participants, however, did locate alternate possibilities. These included exploring one's potential educationally (Katrina) or adopting a HAES perspective (Melissa and Clarissa). These strategies helped maintain some degree of perceived agency or mastery and did not relinquish all sense of advantage. In contrast, for those participants who lost weight without especial intention, this may have precipitated Murray's (2008a) sense of embodied ambivalence and a desire to re-shape oneself to fit into an inflexible world.

#### ***7.4 Negotiating Stigma via Accounts***

The attribution of obesity to personal behaviour tends to exacerbate obesity stigma (Puhl and Heuer, 2010; Sikorski et al., 2011). One manner in which obese individuals may try and cope with this stigma is in how they explain the origin of their size. Monaghan (2008) and Monaghan and Hardey (2009, 2011) investigated how big men (Monaghan and Hardey's term) in the U.K. managed stigma through the reasons they gave for their weight-related issues. In doing so, they built on prior sociological theories of talk, known as accounts, used to explain socially-censured behaviour (Scott and Lyman, 1968; Orbuch, 1997).

Monaghan's (2008) and Monaghan and Hardey's (2009, 2011) participants could broadly be categorized as those who accepted the pejorative status of obesity or those who denied or challenged the pejorative status of obesity. Those who accepted the pejorative status of obesity may manage their discredited identity by offering excuses that mitigate individual responsibility for their size. Monaghan (2008) and Monaghan and Hardey (2009, 2011) discussed possible excuse accounts of obesity and those they

encountered in discussing obesity with their participants. Such excuses may include appeals to obesity as a genetic condition; the result of aging or a diminished metabolism; or the secondary result of another medical condition, including a psychological issue or food addiction, which was a common account in the present study.

Indeed, participants in the present study often referenced accounts that would be considered excuse accounts according to Monaghan's (2008) and Monaghan and Hardey's (2009, 2011) typology. Importantly, Scott and Lyman (1968) use the term excuse accounts to refer to protective and strategic negotiations. While common parlance may suggest a degree of disingenuousness attached to the word 'excuses', the researcher uses this term only to refer to participants' attempts to explain to the researcher (and themselves) the causes of their current, or past, obesity.

#### **7.4.1 Excuse Accounts**

Participants in the present study occasionally implicitly deployed genetic 'excuse' accounts by mentioning familial or ethnic predispositions to larger body size. These were also present in Warin and colleagues (2011) study among larger mothers who frequently made recourse to the notion of their size being 'natural' due to hereditariness, large bones, or their status as mothers. Among participants in this study, aging was more frequently referenced as a greater overall functioning worry. Thus, unlike the men in Monaghan's (2008) study, participants in my study were more likely to be concerned about the effect of their size on mobility and health as they age, rather than attribute their size to aging. Food addiction, in contrast, was frequently mentioned by participants with striking directness and magnitude, unlike its rare invocation in Monaghan's (2008) study.

This differs from the view presented by Murray (2008b, 2010) who is skeptical that many fat people would necessarily view themselves as food addicts. Indeed, many of my participants did label themselves as food addicts.

Some participants, such as Daisy (who stated that desirable food “calls [her]”), seemed to view food addiction as a factor that should mitigate weight-based stigma; other participants viewed it more as a personal characteristic for which they were accountable. Todd, while occasionally directing blame toward the fast food industry, believed that individuals were responsible for their own health (and implicitly body sizes), although he also believed himself to be addicted to fast food. Some participants related addictions to various components of their life. Todd discussed his fast food consumption and his video game usage in terms of addiction and also the obsessive-compulsive nature of his weight control management. Some participants stated they were addicted to praise or went through phases of “collecting awards”. A number of participants related an inability to sleep because of a preoccupation with calculating caloric deficits. Amelia shifted in the use of food “as a drug” to the use of exercise in a similar capacity. Harmony went from addictive eating, to alcoholism, and finally resorted to smoking. She spoke of trying to turn off “her angry brain” via such methods. Some of these conversations were couched in neutral tones, but many individuals seemed to be self-loathing in regard to their addictive natures. As most of my participants were women and this is a highly feminized discourse, these references to addictive eating and eating as a coping mechanism may not be particularly surprising (McPhail, 2010).

Other excuses identified by Monaghan (2008) focused more on lifestyle issues that contributed to obesity, such as an injury or a social role that prevented involvement

in regular physical activity; a lack of knowledge concerning effective weight maintenance; low levels of willpower; comfort eating; crash dieting; family problems; or smoking cessation. Injuries were a persistent account disclosed by my participants, but they operated in complex ways during individuals' weight trajectories. Injuries may have precipitated some individuals' periods of inactivity and possibly subsequent weight gain. However, injuries also motivated participants to adopt healthier lifestyles and often occurred during periods of already high activity.

Social roles, occasionally explicitly gendered roles, also featured prominently in accounts. The stress of new motherhood was a major contributor to Pauline's weight gain, and familial caregiver role issues were felt to intercede majorly in the potential to eat properly and exercise in the lives of Christine and Daisy. The function of caregiver roles in contributing to such behaviours is similar to the effects of motherhood and smoking rates identified by Graham in the U.K. (1994). Having a greater degree of childcare burden, including ill children, increased the likelihood of mother's heavy smoking (Graham, 1994). Likewise, Christine found caring and worrying for her ill adult children resulted in limited time for cooking and exercising, and often led to the consumption of cheap and filling comfort food. Emotional eating, similarly to food addiction, was frequently mentioned by participants. Often, the context leading to resorting to these habits was described in detail. For example, Katrina described eating to cope with weight stigma, and exam, financial, or relationship anxiety caused stress-eating in Hannah, Christine, and Harry.

Monaghan also provides (2008) some excuses that adopt a broader perspective and reference the obesogenic environment or socioeconomic status. Some participants

found the high price of fitness facilities prohibitive. A number of participants were currently, or had previously, experienced economic difficulties. However, most accounts of socioeconomically-induced obesity were proposed hypothetically. That is, participants referenced 'common sense' or frequently proposed contributors to obesity, such as the high price of produce, without describing any personal experience of these hardships. This may suggest the increasing pervasiveness of the environmental account of obesity (Lawrence, 2004) and is suggestive that my participants, while occupying a variety of socioeconomic statuses, were rarely so impoverished as to be dangerously food insecure. Importantly, 'excuse' accounts may serve other functions than merely defending participants' non-normative sizes. Orbuch (1997) reviews some other possible usages of accounts including providing control, understanding, closure, and hope in certain contexts and situations. Particularly pertinent to the present study is the use of accounts to provide self-insight and explanation. For example, Rachel viewed her awareness of her reliance on emotional eating as a major transformational experience. It was also something she rarely disclosed. For participants, the sharing of embodied weight histories may have been less an attempt to justify themselves to an outsider than to explore their own histories. This seemed to be reflected in the study's high response rate and participants' eagerness to discuss sensitive bodily issues. Similarly, Throsby (2007) discusses her obese participants' desire to both mediate some moral blame for their size and gain some comprehension of their bodily history. Warin and colleagues' (2011) sample of large mothers similarly distanced themselves from the abject 'Other' (obese persons) by relying on accounts of their sizes' 'naturalness' and thus, the blamelessness of their embodiment.

#### **7.4.2 Justification Accounts**

Justifications differ from ‘excuse’ accounts in that they may be used by those more critical of standard obesity discourse (Monaghan, 2008). These justifications may criticize the validity of BMI tables in accurately measuring health; make appeals to healthy status, despite higher weights; or counter with the potential self-fulfilment of pleasurable eating experiences, relationships enhanced or sustained through enjoyment of food, or sexual attractiveness or masculinity resultant from embodying a larger size. Participants in my study deployed a number of justifications similar to those mentioned by Monaghan (2008). Participants in this study were often similarly dismissive of the body mass index (BMI), a particularly potent instrument of biopower (Foucault, 1975). Potential participants often disclosed their BMI without prompting and knew how much weight they were required to lose to fit into the ‘normal’ weight category. Thus, participants were exposed to a discursive instrument that is disseminated via multiple sources including the mass media, fitness centres, healthcare providers, and public health messaging. Those who fell outside its normative strictures were interpellated to seek a normative, non-deviant size, so as to reduce the presumed health risks associated with obesity and associated burdens on the State. Participants had a great deal of familiarity with the instrument, and some had to use it in the workplace, even while being critical of its utility. Given the compulsive nature of many participants, some ostensibly rejected its value but remained haunted by its disciplinary admonishment.

Other participants invoked a denial of injury (Scott and Lyman, 1968). That is, they referred to their good health, despite their size (Monaghan, 2008). For some respondents, this helped cast doubt on standard messages of the health consequences of

obesity. For others, however, such as Hannah and Megan, this offered only a temporary respite from a future they felt would be characterized by weight-produced ill health. Fear of the future, particularly in respect to effects on functioning tempered even more critical participants, such as Matilda and Rachel. These participants' fear of the effects of added weight on their joints was a resonant example of the ambivalence individuals felt regarding their aging bodies and their health.

Another prominent justification among participants was that their previous history of dieting had irreversible impacts on their metabolism. This justification was deployed by those who had experienced disordered eating and would have encountered HAES discourse in treatment. While this account did allow for participants to 'justify' their size in a stigmatizing context, it did not move beyond the dominant reliance on an 'energy balance' model of causation. It still positioned individuals as necessarily defending their body size and doing so by asserting their past accordance with (and victimization by) behaviours dictated by healthism (Crawford, 1980).

### **7.4.3 Repudiation Accounts**

Individuals who reject the discredited nature of obesity may engage in repudiation and potentially affiliate themselves with fat activism. This allegiance is often preceded by chronic weight loss struggles and acts of contrition (Monaghan, 2008; Dickins et al., 2011). Repudiation may involve incorporating aspects of excuses or justifications in producing weight-related accounts. These accounts may mitigate personal responsibility for their size, emphasize natural body diversity, or de-emphasize the actual importance of

weight in regard to health or quality-of-life. Rarely did participants demonstrate repudiation. These participants had initially dieted for weight loss purposes, experienced damaging weight-related disorders, and were attempting to find a healthier approach to food and physical activity. Interestingly, one participant found herself struggling to allow herself occasional reprieves from constantly representing the fat acceptance movement, often via her own healthy status. This is especially demonstrative of the omnipresent importance of health and external validation for participants. No participants chose to present a form of fat activism that did not highlight the possibility of health in the presence of fatness.

#### **7.4.4 Contrition Accounts**

Individuals who accept obesity as a pejorative status may engage in various degrees of contrition such as weight loss dieting, resignation, or indifference (Monaghan, 2008). In the dominant obesity discourse, obese persons are expected to assume the subject positions of irresponsible, deviant citizens who have brought upon themselves their ‘problematic’ size. At the very least, they should be willing to take accountability for what is viewed as a collective burden (Halse, 2009; Murray 2009a). Participants who were striving to lose weight or maintain weight loss were involving themselves in acts of contrition. A further understanding of contrition may relate to Foucault’s notion of confession and atonement (1978). Indeed, some of Monaghan’s (2008) participants explicitly relied on metaphors of confession and religion with respect to disclosing food-related ‘transgressions’. Salvation was sought through weight loss dieting. Consistent with this idea of confession is that indulgences should generate guilt.

Many of participants engaged in acts of contrition. Todd, for example, stated that he calculated the caloric expenditure necessary to negate the intake of various indulgences. Ultimately, he found such indulgences were never worth the guilt he experienced in eating such foods. Feelings of depression, shame, and anxiety were often spoken of among participants regarding weight gains or food consumption. This may have also been a form affective contrition among participants who considered themselves at fault for their size. Thus, some of the excuse accounts that were laden with tones of self-loathing may be considered contrite.

Condemnation of condemners (Scott and Lyman, 1968; Monaghan, 2008) was often deployed by participants in recounting experiences of stigma. Frequently this would combine a denial of injury account, as participants described discriminatory behaviour by healthcare providers. Participants often felt they were disrespected by practitioners who reduced their health status solely to their weight and refused to accord relevance to their own embodied experience. Some resentment was also directed toward individuals who participants perceived as less conscientious regarding their own diet and physical activity habits but who could 'pass' as healthy given their thinner body size. For participants who may have developed doubt over the pejorative status of obesity through experience of stigma or weight cycling, these excuses may have been a way of dissociating themselves from more submissive contrition.

#### **7.4.5 Accounts and Weight loss Surgery**

Participants' use of accounts can be further compared to individuals undergoing bariatric surgery (Throsby, 2007). Throsby's (2007) bariatric surgery patients from the

UK described some explanations for their pre-surgery weights similar to those referenced by my participants. These accounts included genetics; eating habits instilled by family early in childhood; and instances in which life interceded in weight management efforts such as injuries, employment, familial obligations, and gendered accounts of female comfort eating or males' reported over indulgence in social situations (Throsby, 2007).

Weight loss surgery patients must further explain their decision to undergo surgery knowing surgery is viewed as a dodge for more difficult acts of contrition, i.e. dieting and exercise. Participants in Drew's (2011) study justified their decision for undergoing surgery by discounting its potential risk by accentuating newer, safer techniques; highlighting that its expense was alleviated through insurance, and underlining the disciplinary techniques required post-surgery in the form of dietary and lifestyle modifications. As weight loss surgery is presented as an 'easy' option, and even as a cure to obesity, this stresses the degree to which a healthist discourse dominates the thinking of obesity, and the extent to which etiology eclipses a merely therapeutic approach. Even in the presence of a technology that is often presented as a failsafe solution, individuals must seek validation for its utilization by referencing their willingness to deprive and exert themselves to 'correct' their deviant bodies. Indeed, Daisy recounted her experience with bariatric surgery with regret and shame, in that she did not undergo appropriate emotional and behavioural 'work'. This work, she felt, may have produced less transient results, although she does acknowledge the limited counselling she was provided and the life-threatening complications she endured.

#### **7.4.6 Accounts Summary**

Monaghan (2008) emphasizes that the use of any accounts are socially situated and contingent. While one account may suit a particular context, a different account may be more useful in managing stigma in a different situation (Monaghan, 2008). Participants, in various instances, would deploy altering accounts and even vary in their willingness to accept or deny the pejorative nature of fatness. This was particularly apparent when they experienced various shifts in weight and fitness over the course of data collection. All of these variations in accounts may have reflected differing and altering reactions to a weight stigma-pervasive environment.

#### ***7.5 Participants' Moral Experience***

To better understand stigma as a determinant of ill health, Yang and colleagues (2007) and Kleinman and Hall-Clifford (2009) emphasize the need to examine the effect of stigma on the moral experience of persons. As Kleinman and Hall and Clifford (2009) state, an individual's moral experience is contingent on their moral standing within a particular, local social setting that can be arrived at through ethnographic exploration. Such standing will be affected by an individual's capacity to adhere to norms and obligations. At present, maintaining a 'normal' body weight is considered an essential moral component of a citizen's duties (Halse, 2009). Thus, all of my participants were currently, or had in the past been, in violation of their role as citizens. This would have produced a loss in moral status. Such a loss of status may have had an impact on their moral experience, the aspects of their lives to which they (and potentially others) attached the greatest value.

In my study, the effects of particular constructions of obesity had very obvious effects on what mattered most for particular participants. This perspective on stigma emphasizes the inter-relationships of 3 identified themes: function and mobility; compulsive, addition, and validation; and effects on social lives. For many participants, what mattered most was largely related to their social lives, indirectly reflecting the intersubjective nature of stigma (Yang et al., 2007). Directly related to this concern, often, was participants' capacity to function in a manner conducive to partaking in social activities. Frequently, participants discussed the desire to interact with their families and how this was impeded by poor health that they often attributed to size. This focus on functionality incorporated other intersubjective, socially-relevant concerns such as low energy and desire for isolation.

For example, both Rachel and Christine viewed obesity as a risk to their future. For Rachel, this seems to be the manifestation of a stigmatizing view of obesity, as she was currently in quite good health, highly active, and much invested in healthy eating. Despite these considerations, Rachel was very worried that her size would negatively impact on her capacity to continue her vocation, certainly her "moral experience".

Christine, in contrast, had experienced more negative health conditions than Rachel, such as diabetes mellitus. Christine's primary concern was regarding her children's futures and her own socioeconomic challenges. Neither her son, nor her daughter, was in particularly good health. Christine was worried that her, and their, poor health would impede on their life chances (Kleinman and Hall-Clifford 2009). Christine believed that her weight was affected by her role as a caregiver with limited support. She felt weight stigma, in part, hindered her ability to make reciprocal, supportive

relationships that would facilitate her ability to care for her children and make arrangements for their future. Thus, like participants in Yang and Kleinman's (2008) study on chronic illness sufferers in China, her weight caused "a loss of face", and she was unable to generate sufficient social capital to address her needs. Furthermore, she felt that the often stigmatizing and non-holistic treatment she received from healthcare providers severely impeded her ability to address her own and her children's wellbeing. Likewise, Katrina felt that the stigma she had experienced in life impacted her career and education opportunities and her capacity to advance professionally.

Other participants referenced forms of moral experience suggestive of Yang and Kleinman's (2008) notion of "saving face" among individuals with AIDS or schizophrenia in China. Many participants discussed their need for social validation respecting their health or fitness. This suggests that participants were striving to obviate some of the impact that their size produced on denouncing their moral character in a healthist, biopower-informed moral context (Foucault, 1975; Crawford, 1980; Kleinman and Hall-Clifford, 2009). For participants, this appeared to manifest in the need for 'qualified' individuals to authenticate their hard work in fitness-related endeavours and/or the building of fitness-centric supportive communities. Amelia, for example, discussed the lessening of some of her body-related angst, now that she felt her fitness superseded the previous size-directed stigma she had encountered. Rachel relied to a great degree on the approval and recognition of her online fitness community.

For some participants, these validation efforts seemed to be a broader attempt to redress overarching feelings of loneliness and isolation. These activities also afforded them the opportunity to perform acts of contrition as stigma management; engage socially

without the tempting presence of certain foods; and participate in compulsive weight management actions with the (perhaps unknowing) collusion of others. The need for constant external approval hints at the status anxiety discussed by de Botton (2004), and the overwhelming need to be viewed as a meritorious ‘winner’ in current society. From this perspective, characteristic in neo-liberal discourse, obesity is a personal failure that generates an overwhelming sense of shame and social angst.

Todd was more concerned with appearance than health and had lost the continual ego boosts to which he was accustomed during weight loss. His fear of weight regain related to his need to never encounter the scorn he felt he may endure as a ‘failed’ weight loser. He continued to seek out opportunities for generating self-esteem, particularly in social contexts. To this end, he posted before/after pictures to a social networking site. Interestingly, he appeared resentful of what he viewed as a lessening in societal stigma directed at larger persons following his own weight loss. Having responded to society’s interpellation to rectify his own abject deviant body, he resented that a more accepting ethos seemed to detract from his accomplishment. Todd’s recent feelings of ambivalence towards his larger family members is similar to the feelings of superiority among former smokers compared to current smokers described by (Vangeli and West, 2012), as part of the transitional stage of developing a non-smoker identity. This ambivalence also suggests a fear of moral contamination and a distancing from stigmatized others (Yang and Kleinman, 2008). This moral contamination issue may also have been present in the widespread experience of stigma in healthcare situations reported by participants. Todd’s attitude toward size acceptance, healthcare providers’ stigmatizing approaches, some participants’ deep-seated self-loathing, and Rachel’s interactions with obese clients

emphasize Yang and colleagues' (2007) notion of stigma occurring in a shared social space. The need to address stigma and illness requires the interactions of multiple persons, all of whom inhabit various power relations with respect to each other, and who inter-relate in complex ways. Rachel may recount her own stigmatizing experiences, but at work she must negotiate with her own patients a respectful manner of addressing weight. Todd must reconcile himself to a seeming perceived shift toward size acceptance among his peers, even as he seeks ongoing valorization for his act of contrition. All participants must cope with the ongoing presence of food in their lives, its importance to social occasions and bonding, and their frequent experiences of censure and surveillance when eating in public. For Daisy, such constant observation (and frequent commenting) even led to her switching workplaces; yet, she remained critical of others' eating, exercise habits, and weight. Again, this demonstrates the supreme ubiquity of obesity discourse and the insidiousness of its messages concerning consumption and size.

### **7.5.1 Gender, Fatness, and Stigma**

Participants' accounts of their experiences concerning obesity were occasionally highly gendered. For example, female participants, such as Christine and Daisy, often discussed in detail how their caregiver roles contributed to their size, a possible 'excuse' account described by Monaghan (2008). They also prioritized functional fitness for the sake of being active with their children and grandchildren. Indeed, for many female participants, this gendered responsibility for others may constitute their moral experience (Yang et al., 2007; Kleinman and Hall-Clifford, 2009). Scholars have noted that the focus on caregiving and preventing obesity in others, which was a definite concern among

female participants, is an added source of fat-based gender discrimination (McPhail, 2009; Warin et al., 2012).

Participants also discussed emotional eating, which is a highly gendered category (Throsby, 2007; McPhail, 2010). Historically, female obesity has been attributed to female (over)emotional dysfunction. Intriguingly, this was not exclusive to female participants, but Harry likewise referenced stress eating in explaining his previous size. More research with men is needed to discern whether this is a previously unrecognized or emergent discourse among men.

Male participants' descriptions of stigma also varied considerably when compared to those of female participants. The only males who contacted the researcher were those who had experienced weight loss success or were seeking information regarding obesity. Male participants acknowledged the presence of obesity stigma, which was also acknowledged or displayed by the male participants in the ethnography of large men by Monaghan (2008), but tended to downplay the suffering it evinced or their own experience of it. For example, Harry considered stigma as a motivating force in his weight loss struggles, and Todd grew critical of fat acceptance following his own weight loss success. Women, in contrast, often spoke of the devastating effects of stigma in their interpersonal, activity-based, and professional lives. This greater impact of weight-based stigma on the lives of women has been noted for years by feminist theorists and social scientists (e.g. Bordo, 1993; George and Rail, 2005; Rice, 2007; Puhl et al., 2008; Farrell, 2011; Warin et al., 2012).

The methods of coping with stigma also appeared gendered. Women recounted issues in physical activity, professional advancement, and social engagements due to size,

which they sought to overcome by achieving acceptance or inclusion. Male participants were more inclined toward relying on their own triumphant narratives and demonstrating masculinity to a heightened extent. They did so, for example, by emphasizing to a high degree their athleticism and their need for maintained potency and virility with age. This may suggest a protective reaction to the discursive feminization of male excess fat (Monaghan, 2008; McPhail, 2009). Sport may also serve as a socially appropriate way by which men can discuss seeking bodily maintenance and modification (Norman, 2011).

Only 2 male participants were included in the study. This makes it difficult to substantiate these intriguing gender differences. Furthermore, the 2 male participants were unique in other ways in the sample. They were some of the only weight loss maintainers included, and they were at the extremes of the sample's age range. This complicates trying to discern concrete gender patterns. The hints of differences between male and female participants in this study, however, suggest highly necessary and compelling areas for future research in more evenly gender-distributed samples.

### ***7.6 Consequences of Stigma***

The effects of stigma on participants' lives had far reaching effects on their relationships, their life chances, and their self-esteem. Importantly, however, Yang and colleagues (2007) emphasize further physical health consequences of stigma. That is, stigma directly affects individuals' health through psychobiological, moral-somatic, sociosomatic, and moral-emotional pathways. The manner through which these health effects are manifested may not even be acknowledged by the sufferer but may greatly

impact their quality-of-life. Participants described a number of health and wellbeing effects that may be traced back to experiences of stigma.

### **7.6.1 Functioning and Mobility**

One pervasive theme was the de-motivating and isolating effect that low mobility and functioning could have on individuals. Many individuals were also coping with disabling injuries. Any further impingement in this area had devastating impacts on other profoundly important aspects of participants' lives. The value of functioning and mobility was mentioned as essential to engagement with family, particularly children; active aging; and mood stability. Stigma, even apart from its relationship with function and mobility, could induce self-loathing and feelings of depression. This appeared to generate a self-perpetuating cycle. Individuals may have felt uncomfortable engaging in physical activity, this may have lowered their mood and functioning capacity, and this exacerbated their lack of motivation. Some participants described reacting to these emotions via emotional eating, isolation, or inactivity. This is reminiscent of Muennig and colleagues' study (2008) that found body dissatisfaction had a more potent effect on reported days of ill health than actual BMI. In the environment characterized by extreme weather in which this study took place, long, cold, and icy winters could exacerbate these factors. Finding an appropriate accepting environment in which to address their therapeutic needs was another essential component in coping with stigma as an obese person who valued mobility and functioning.

### **7.6.2 Weight Cycling and Eating Disorders**

Most participants had a long history of weight modification attempts. Many had undergone multiple weight loss/gain cycles, and these cycles illuminated another mechanism through which stigma, in part, affected participants' health. Participants often at some point in their lives, and often motivated by others' harsh treatment, attempted to normalize their non-normative bodies through weight loss. For example, Daisy's attempt to lose weight through bariatric surgery resulted in immediate life-threatening complications, persistent painful side effects, and possibly only transient weight loss.

Participants often described emotional, compulsive, or addictive eating styles, but their weight loss efforts were frequently similarly intense. Many participants described themselves as compulsive, obsessive, competitive, or high-level achievers in multiple areas of life. Todd and Amelia both described their weight-related behaviours as "OCD". Participants' food behaviours, in terms of monitoring, restricting, or consuming, evinced compulsive tendencies. Todd preferred more strenuous sporting leagues compared to more casual sporting events. Joanne described her athletic history as being characterized by a high level of competition, which she was trying to avoid. Clarissa was attempting to hold herself to less stringent standards, including in her artistic pursuits.

When approaching weight loss, often these participants utilized highly effective but all-consuming methods of achieving a caloric deficit. Participants described hours of exercise, sleep deprivation caused by caloric calculations, and severe calorie restriction. Even for participants who viewed themselves as 'recovered' from these extreme behaviours, a high reliance on self-monitoring and/or need for external validation was evident. Some participants weighed themselves as often as daily; recorded every item

they ate, and its constituent calories and macronutrients; and tracked their physical activity and estimated caloric expenditure.

For some, previous weight loss attempts resulted in disordered eating sufficiently extreme to warrant medical intervention. This placed an enormous strain on participants' mental health, social relationships, and physical wellbeing. Many participants also felt these early weight loss attempts had a sustained impact on their metabolism and predisposed them to weight retention. Indeed, evidence suggests that weight discrimination is associated with the likelihood of developing obesity, as is dieting at a young age (Ikeda et al., 2004; Sutin and Terracciano, 2013). Weight-based teasing as a child is also associated with disturbed eating, eating disorders, and higher BMI in young adult American women (Quick et al., 2013).

Some participants, such as Todd, Joanne, and Harmony, described the impact that weighing themselves had on their self-esteem. Losses produced euphoria, and gains caused despair. Christine even felt that weighing herself resulted in weight gain. Over time, some participants, such as Amelia, Rachel, and Clarissa found that weight stability, and/or better fitness and health seemed to be more likely with a less-weight-centric approach. This may in part have been due to a lessening in anxiety produced by the excess worry associated with minor weight changes. This is again suggestive of the role that stress may have on mediating effects of weight stigma and body dissatisfaction on health (Muennig et al., 2008; Puhl and Heuer, 2010). As is evident with Todd, who was caught in a constant struggle to maintain a weight loss, a lower weight does not guarantee higher self-esteem. Mustillo and colleagues (2012) found that formerly obese adolescent

girls continued to display the lower self-esteem characteristic of their chronically obese peers.

Thus, weight fluctuations may be influenced by the experience of stigma directly or through various coping mechanisms. Other effects on health may be produced through similar mechanisms. Participants discussed how being active and feeling capable of activity improved their diabetes and mental health symptomology. While being large affected some participants' sleep, so too did obsessive dieting behaviours. Better mental health and coping skills also helped participants with emotional eating coping styles, which might have produced better overall health. Participants often linked feeling better with a capacity for functioning. For those with injuries, such functioning was linked to rehabilitative exercising; thus, being and feeling capable of movement was imperative to mental, physical, and weight-related health.

### **7.6.3 Social Effects**

Katrina, who felt that her size had unfairly disqualified her from progressing professionally, demonstrated another complex mechanism through which stigma may impact health. This mechanism is detailed by Ernsberger (2009) in his examination of the links between mortality, socioeconomic status, and obesity. He found that the relationship between mortality and obesity is most potent in socioeconomic circumstances in which obesity stigma will be at its most heightened. This suggests that obese persons may experience a diminishment in socioeconomic status, and suffer relevant consequences in stress, poverty, and poorer health (Ernsberger, 2009). Like Katrina, who only recently felt

capable of pursuing post-secondary education, individuals may find their life chances and health curtailed prematurely due to early exposure to stigma.

Social eating patterns were made complicated by participants' various weight-related concerns. Todd and his new partner had to modify their food preparation and consumption patterns to accommodate Todd's desire to maintain lost weight. Christine and Daisy also cited the difficulties in trying to eat in a weight loss-inducing manner during social occasions or at the workplace. Individuals cited feeling censured and surveilled while eating in public or trying to fit into tight places. Privately, individuals may cite the various 'alternate' healthy food conceptualizations that defined their dietary choices: i.e. organic, homemade, local, or HAES; however, in public these meticulous and well-informed notions of health could be reduced to one specific 'unhealthy' food choice. This may explain the extreme care some participants took in monitoring their diet and seeking validation from others in trusted health-related communities.

Differing weight trajectories could also sunder relationships. Participants often referenced romantic relationships that ended, or were negatively impacted, by weight gain.

Similarly, a number of participants cited the potential of losing current partners or wanting to re-enter dating life as a reason to lose weight. Participants further discussed how weight changes could result in the loss of friendships, possibly a form of moral contamination (Yang and Kleinman, 2008). Others found that weight loss and improved appearance altered friendship dynamics previously reliant on inequity. Some participants found that their non-reciprocal caregiving roles impacted their weight by hindering their capacity to care for themselves. They viewed their ability to put limits on these non-reciprocal relationships as a major indicator of personal growth.

Importantly, participants' attitudes toward others changed with shifting weight statuses. Certain participants remained, regardless of their own weight, stoutly critical of others' dietary choices or size. Others found themselves shifting more toward this attitude with weight loss, a finding similar to Honeycutt's (1999) among her "Fat Buster" participants. As some individuals gained in self-acceptance, their willingness to tolerate others' discrimination decreased. Several participants were highly resentful of others' judgments, yet continued to associate with individuals whose comments clearly had an enormously negative impact on their self-image.

Ultimately, no clear-cut picture of obesity's impact on social relationships was evident. The one discernible finding was that stigma could have severe effects on individuals' health and quality-of-life, as could isolation. Participants' descriptions of loss of friendships and their unwillingness to disclose weight loss attempts due to lack of support, or anticipation of future friendship cessations or weight regain, are similar to other findings in the literature. There is qualitative evidence that weight loss efforts, weight regain, and concomitant lifestyle changes, changing dynamics, and emotions, may also result in the dissolutions of friendships (Nichter, 2001; Stinson, 2001; Thomas et al., 2008). As these same individuals also discussed the inevitably temporary nature of diet-induced weight loss (Thomas et al., 2008), this further problematizes the presumed health benefits of weight loss. This may also offer a frequently disregarded mechanism through which weight stigma may affect health.

Terms like "infectious", "spread from person to person", and "social contagion" have been deployed when describing obesity in epidemiological studies using social network analysis or investigations into whether obesity is clustered socially (Christakis

and Fowler, 2007; Hruschka et al., 2011). Such studies speculate on possible physiological or body-tolerance alterations induced by being around larger persons, often with the implication that obese persons are necessarily inactive and overeaters. This frame seems to be particularly detrimental to the potentially health-enhancing and stress-reducing benefits of social support networks for individuals. As developing obesity is extremely feared (Schwartz et al., 2006; Hruschka et al., 2011), it may be very isolating for obese individuals to having their friendship presented as a risk for developing obesity (LeBesco, 2011).

Many participants had lived lives characterized by stigma, and many had experienced frequent alterations in their relationships, based on fluid bodily states. Participants in the present study were often further isolated by the extreme weather, chronic disability, pain, and low mood. The importance participants placed on social health, and the low levels of support and high rates of loneliness cited by some participants may help explain the persistent need of some individuals to seek out validation and form new communities centred on notions of health and acceptance.

### ***7.7 Strengths and Limitations***

This study is characterized by a variety of strengths and weaknesses. There is little in-depth understanding concerning the long-term effects of chronic obesity, weight cycling, or maintained weight loss, particularly from a qualitative perspective. A more thorough conceptualization of obese individuals' health, wellbeing, and lifestyle priorities may allow policy-makers, healthcare providers, and public health promoters to provide

salutogenic, inclusive, and affirming prevention and intervention programs and messaging that could benefit the health of all Canadians throughout the entire life-course.

A general strength of the study is the novelty of its approach in obesity studies. While repeated interviews and ethnography are long-established approaches in other disciplines, their application to studying obese persons' perceptions and experiences may contribute to theory and methodological innovations. This is especially true given the present study's rare focus on weight trajectories and the chronicity of obesity. Furthermore, even among critical obesity researchers, there have been little empirical, qualitative examinations of obese persons' lived experiences (Warin and Gunson, 2013). In part this may be due to how the tacit understandings of obesity as a stigmatized, morally-laden condition can complicate in-depth involvement in a sensitive and necessarily embodied research area (Warin and Gunson, 2013). As such, the researcher chose to overtly use the term 'obese' in research materials and allow participants to choose their own engagement with the label.

This study was open to all genders, unlike several previous studies with narrower gender-inclusion criteria. The study experienced a high level of recruitment, requiring unanticipated interviews and eventual turning-away of potential participants. An important consideration with respect to the sample, however, is its relative ethnic homogeneity and the preponderance of women, particularly those in middle-age. More data are needed on the embodied experiences of obese persons of color. The sample analyzed for this study was predominantly white, with only a fifth of participants of ethnic minority status.

Additionally, as one method of recruitment involved a hospital electronic mailing-list, numerous workers affiliated with the healthcare system participate in the study, and this may have had an impact on the range of lived experiences and health perceptions available for exploration.

### **7.7.1 Critical Ethnography and Researcher Reflexivity**

Broadly, critical theory involves aiding humans to resist the limitations impinged on them based on their gender, ethnicity, religion, nationality, country of origin, sexual orientation, class, and race (Creswell, 2007; LeCompte and Schensul, 2010). Critical researchers examine the historical and political forces that resulted in particular power structures within a culture and are particularly motivated to explore which groups have gained access to knowledge and power within a culture (LeCompte and Schensul, 2010). By illuminating power relations, it is thought by critical researchers that more equitable relations can be created (LeCompte and Schensul, 2010). Ethnography is a valuable tool in studying marginalized populations, as well as the ‘taken for granted’, mundane, and everyday aspects of life that may need to be clarified to truly understand the everyday lives, lived experiences, and emic perspectives of a group (Rabinow and Marcus, 2008). This study thus benefited from critical theorists’ enduring concern with oppressed persons, and ethnographers’ capacity to illuminate how their everyday lives may reflect their relationship with oppression. Through participant-observation, in-depth, semi-structured interviews, and long-term engagement with participants, the researcher was able to develop a thorough, emic insight into the life and health perspectives of participants.

The researcher's positioning as a PhD student in a Community Health Sciences department may be a further strength of the study. The researcher is in a position to bring forward a more problematized, emic understanding of obesity to a health professional, practitioner, and policy-maker audience. However, it also highlights how frequently reflexive the researcher had to be throughout data collection to limit her own biases or social desirability bias from compromising trustworthy processes and findings. The researcher had to be reflexive with respect to her own power in research relations when conducting the research, and strove to treat participants as those with expertise (Creswell, 2007; Oakley, 2010). The researcher's positioning as a student in a Faculty of Medicine occasionally appeared to facilitate discussions about a sensitive issue by moving the issue into a clinical arena. However, as a student in a medical faculty with a medium-size body, the researcher occasionally inadvertently gave the impression of wanting to know more for the sake of 'correcting' participants' size. This, too, was mired in complexity and inconsistency, as some participants rejected such a premise, whereas others hoped this study would produce a weight loss solution.

When participants addressed questions concerning obesity directly to the researcher or appeared to be seeking particular information, she answered based on her knowledge; however, she did not use interviews as an opportunity to 'educate' participants. Rather, she deferred to their experiential insights.

A further power relation requiring consideration is that the researcher was a thinner woman at the time of the interviews, and this may have initially impeded the development of rapport. With participants who queried her stance on obesity, she was open regarding this study's critical lens. She was similarly open about her own prior

history as a significantly larger woman with participants who made direct inquiries. This happened only rarely, however, and she did not want to overbear her participants' expertise in obesity by emphasizing her own experiential knowledge of obesity. The long-term engagement with participants and semi-structured interviews facilitated the development of rapport that hopefully helped mitigate some of these tensions.

The participant observation component of the study also helped develop rapport over time, particularly the researcher's actual participation alongside her participants in fitness regimes and activities. Some findings from this study would be less rich without this observation. For example, the researcher was able to witness the anxiety produced in eating situations, the visibility of public eating at a workplace, the reaction of others to participants exercising, and the passion and thought that participants invested in cooking and menu-planning. This enhanced the validity of the study, added nuanced understandings to participants' descriptions, and allowed the researcher to follow up on potential shortcomings of accounts.

While rapport was enhanced during these sessions, tensions (often in the form of burn-out or exhaustion) could emerge, given the long periods of individual sessions and sensitive questions addressed. As food was occasionally consumed during these sessions, by both the researcher and participants, this could add a further layer of anxiety over what constituted 'appropriate' eating in an obesity study. This could be further accentuated by participants hoping to present themselves as particular discursive subjects (i.e. weight loss success story, fat activist), and the researcher attempting to be neutral with respect to dietary choices. Participants' own internalization of guilt, stress, obsession, and self-loathing over consumption and bodies could also occasionally be taken up by the

researcher. While these instances may have made data collection somewhat less comfortable, this also helped reinforce the researcher's understanding of participants' often emotionally-charged everyday experiences.

### **7.7.2 Qualitative Study with Repeated In-Depth Interviews**

Longitudinal qualitative research, such as repeated in-depth interviews can be a potent method for understanding change over time in particular settings and among particular groups (Saldaña, 2003). These studies may involve the accumulation of large amounts of data that require frequent re-analysis (Saldaña, 2003). These data must be assessed over time, across the sample, within, and between, participants (Saldaña, 2003; Smith, 2003; Thomson and Holland, 2003). In order to maintain focus on particular research interests during analysis and to systematically address how change will be analyzed, based on what scales, and which comparisons, studies conducted by a single researcher may need to use a small sample. This study was only able to reasonably include 15 participants. However, Yates (2003) contends that an over-emphasis on technical issues of comparison and data-treatment within such small studies potentially dilutes the inherent strength of the study based on making reflexive, continual, interpretive comparisons, as well as considering the whole range of data.

In analyzing longitudinal qualitative data, it may be difficult to isolate change introduced into other aspects of a longitudinal qualitative research process, including evolution in research design, the researcher, and the relationship between researcher and subject (Gordon and Lahelma, 2003; Saldaña, 2003; Thomson and Holland, 2003). However, previous ethnography with participants can also result in a shared frame of

reference, enhance rapport, and produce a source for rich data (Gordon and Lahelma, 2003).

The long-term engagement with participants allowed for a less static view of participants' lives, health, and the experience of obesity to emerge. Rather than presenting a 'snap-shot' view of obesity, wherein a participant either embodied an oft-vilified fat body or that of the triumphant weight loser, these repeated interviews intervened in these simplistic narratives by demonstrating the fluidity of participants' bodies and attitudes over time. Over the course of a year, participants' bodies and lifestyles changed, participants adamantly hoping for weight loss embraced self-acceptance and vice-versa, and participants striving for weight maintenance altered in their dedication to stringent self-monitoring. Even had the study included as diverse a sample as possible, these circumstances of change over time would be impossible to detect in single interviews. It also allowed the researcher to explore what impacted on changes in attitudes and bodies, to incorporate emerging themes into future interviews, to further establish rapport, and to organically embed member-checking and validity insurance into data collection. Again, the long-term engagement required of participants and the researcher could occasionally be overwhelming and mute enthusiasm. Overall, however, participants were eager to share, and the researcher to learn from, their knowledge of the lived experience of obesity.

### ***7.8 Conclusions***

Participants' perspectives on obesity, health, and quality-of-life were fluid, evolving, and contingent on multiple factors including their weight histories, current

weight status, and discursive and social contexts. A wide spectrum of ‘obesities’ was in evidence from participants adamantly hoping for, and believing in, sustained weight loss; individuals consumed by self-loathing over their failing to achieve permanent weight loss; participants resigned to the impossibility of weight loss; and proponents of fat acceptance and HAES. Participant shifts within this continuum occurred frequently, often precipitated by weight changes. Weight-related aspects of individuals’ lives could be all-consuming and risked colonizing entire identities.

Participants had been exposed to healthist and biopower-related discourses. They were well aware of their deviance regarding multiple conflated health, appearance, and moral norms and the expectation that they confess and atone for their deviance via weight loss (Goffman, 1963; Foucault, 1978, 1991; Bordo, 1993; Lupton, 1995). Even for participants who had largely internalized these values, anger at stigmatization was often evident. To cope with stigma and better understand their own embodied experience, participants often relied on accounts from popular obesity discourse, such as food addiction, the impact of stress, or health in spite of obesity.

Stigma influenced individuals’ health via the interrelated aspects of their lives they viewed as most important. Stigma and functional ability may negatively impact on one another. Additionally, stigma and alterations in weight trajectories and perceptions could result in the dissolution of important relationships or provoke depression and isolation. To counter stigma and achieve highly prioritized social validation, participants’ weight loss-related behaviours could take the form of highly monitored, compulsive activities. For some participants, this echoed their previous coping mechanisms of

emotional eating or food addiction and seems to represent a complete inversion of past behaviour.

Ultimately, participants' cared deeply about their health and their standing and roles in local social worlds (Yang et al., 2007). Their body sizes, and their attitudes with respect to their bodies, had a profound impact on multiple aspects of life and wellbeing. Bodies and associated perspectives were in constant flux (Longhurst, 2001). Ambivalence and complexity were key aspects to most participants' body and health understanding, and social and discursive contexts mattered a great deal in determining participants' perspectives. Weight loss was not a panacea for participants, nor was it a finite experience. It represented an on-going struggle that affected identity, functioning, wellbeing, and perhaps most profoundly, social relationships. Regardless of personal histories and current health and circumstances, the promise of a smaller, less maligned body often held an illusory hope for participants. This hope inspired major social, lifestyle, and rational re-alignments with every fluctuation in shape and size.

This study adds to the knowledge base of public health and critical obesity literature in a number of areas. The study privileged understanding obesity as a contingent, multidimensional chronic condition, whose effects on life and subjectivity persist regardless of bodily fluidity. In doing so, the study identified new themes relevant to obese persons' lives and wellbeing including the implications of social effects; compulsivity, addiction, and validation; and functionality on larger persons' wellness. The study additionally did not focus exclusively on women but incorporated men, who are understudied in this area. The study also included individuals with a wide range of views on obesity, health, and weight loss and at all stages of obese weight trajectories

including post-weight loss. This study also introduced a more nuanced approach to understanding the effects of stigma on larger persons' lives by focusing on its impacts on what participants identified as the most salient aspects in their lives and how this may change over time. Most importantly, this study is one of few to incorporate participant observation, repeated interviews, and long-term engagement to truly learn from participants how their health perceptions, bodies, and lives may change over time and across different weight trajectories, rather than assuming that a 'snapshot' view of the lived, embodied experience of obesity is sufficient.

### **7.8.1 Recommendations**

Participants discussed what they would most value in healthcare and public health programming. Related recommendations could be inferred from the study's findings. Given participants' focus on functional fitness, it may be beneficial to prioritize activities that will facilitate function and mobility for larger persons. Participants often highlighted their need for mental health services. Simon and colleagues (2006) found in nationally representative American data that obesity was associated with having 25% greater risk of mood and anxiety disorders. For some individuals, social service contacts may be needed to cope with socioeconomic issues. This may be essential to moderate the risks associated with increasing downward mobility related to obesity, stigma, and subsequent mortality identified by Ernsberger (2009). Weight was often one issue among myriad affecting participants' quality-of-life.

Individuals were highly invested in physical activity but could find relevant facilities uncomfortable or non-inclusive. It would be helpful to collaborate with larger

persons on designing healthcare and physical fitness centres that are inclusive, affordable, accessible, and safe spaces for them to seek care and physical engagement. The liberating effects of physical activity spaces and classes specifically for larger persons have been explored (Ellison, 2007, 2009; Schuster and Tealer, 2009) and could form a basis for future fitness interventions.

Similarly, participants benefitted substantially from trusting relationships with healthcare providers and prided themselves on their biomedical knowledge. However, negative experiences with healthcare providers could be very disheartening for participants. It would be beneficial to develop weight bias awareness training among healthcare personnel to facilitate trusting relationships between patients and providers. Weight discrimination is known to be high among clinicians (Schwartz et al., 2003; Edelstein et al., 2009; Puhl et al., 2009). However, more nuanced perspectives have also been identified. Heintze and colleagues (2012) found clinicians do not wish to over-emphasize weight, worry about over-extending existing services, and emphasize the importance of respectful physician-provider relationships. Davis and colleagues (2006) found patients hoped for greater focus on their weight than their providers offered. This suggests that more openness could ease tensions between providers and patients and facilitate improved healthcare provision for obese persons.

A focus on health, rather than weight, was often found to be more motivating and less self-esteem damaging for individuals, regardless of weight-related goals. Most participants were interested in, and actively pursuing, healthy living aims (although priorities varied). For some participants, a focus on weight led to problematically compulsive weight-control practices. Weight loss was often transitory; it may have

unintended effects on social life and mental health; and it was sometimes insufficient for improving wellbeing. The adoption of a Health-at-Every-Size approach (Aphramor and Bacon, 2011; Bacon, 2010) was advocated by some participants and would seem to coincide well with participants' interest in functional fitness and healthy diet, without triggering excessive monitoring activity or disappointment.

The labelling of particular foods or practices as explicitly morally 'good' or 'bad' or eating styles as necessarily pathological may have unintended consequences. It may be more salutogenic to consider language that focuses more on factual recitation of nutritional information. Moralistic food terminology risks individualizing complex issues and producing damaging degrees of guilt, stigma, anxiety, and self-loathing for what were largely innocuous and common activities. As Puhl and Heuer (2010) review, shame-based public health approaches to obesity do not succeed in producing thinner individuals, but rather promote poor health outcomes including disordered eating, inactivity, and psychological issues.

It may also be more affirming to consider less stringent and narrow 'normal weight' categories. For some individuals, a truly drastic weight loss may be necessary to no longer be considered (and stigmatized as) obese. Narrow weight categories may allow individuals only unrealistic aims and motivate potentially damaging, rather than health-conducive, practices, which may go largely unnoticed or even be valorized when adopted by larger persons. They also may not accurately reflect related mortality and morbidity risk (Bacon and Aphramor, 2011; McAuley and Blair, 2011). For example, Green and Buckroyd (2008) recount the disordered eating practiced by successful members of

weight loss groups, and evidence suggests school obesity prevention programs may be associated with disordered eating in students (e.g. Evans, 2008; Isono et al., 2009).

## 8.0 References

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## **Appendix A: Initial Interview Guide for Obese Participants**

Thank you for agreeing to be interviewed. This is a University of Manitoba research project designed to better understand obese individuals' perceptions of health and obesity and the lived experience of weight loss, gain, or maintenance over time. Your responses will help us better understand how to best promote health and wellbeing for all individuals in a positive manner. I am going to ask you some questions and encourage you to tell us about your experiences and your thoughts on weight and health in order to learn more about Canadians' priorities in health and quality-of-life. This interview should take approximately 60-90 minutes.

Your participation in this project is voluntary, you may quit at any time, and all efforts will be made to keep your responses confidential.

1. Can you tell me about why you were interested in participating in the study?
2. Can you tell me about your weight history?
3. How do you feel about or how would you describe your health?
4. Is how you feel about your health affected by your weight and changes in your weight?
  - a. What are the biggest factors to you in describing your health?
  - b. Do you do any specific activities to promote your health?
  - c. Where do these activities take place?
5. Where do you get health information?
6. How important is your health to your quality-of-life?
  - a. Is how you feel about your health affected by your weight and changes in your weight?
  - b. What are the biggest factors to you in regard to quality-of-life?

- c. Do you do any activities specifically to promote your quality-of-life?
  - d. Where do these activities take place?
7. Have you ever felt discriminated against because of your size or weight?
- a. Can you describe the experience for me?
  - b. Are there any places or situations in which this occurs particularly frequently?
  - c. How do you react in response to these experiences?
8. What do you think would be the most helpful approach for public health in promoting health for obese people?
- a. What do you think would be the most helpful approach for public health in promoting health for everyone?
9. What do you think the most helpful approach for public health in promoting quality-of-life for obese people?
- a. What do you think would be the most helpful approach for public health in promoting health for everyone?
10. I have no more questions. Is there anything else you would like to ask or add?

Thank you for your time and participation.

## **Appendix B: Second Interview Guide for Obese Participants**

Thank you for agreeing to be interviewed again. This is a University of Manitoba research project designed to better understand obese individuals' perceptions of health and obesity and the lived experience of weight loss, gain, or maintenance over time. Your responses will help researchers better understand how to best promote health and wellbeing for all individuals in a positive manner. I am going to ask you some questions and encourage you to tell me about your experiences and your thoughts on weight and health in order to learn more about Canadians' priorities in health and quality-of-life. This interview should take approximately 60 minutes.

Your participation in this project is still voluntary, you may still quit at any time, and all efforts will be made to keep your responses confidential.

Questions for all:

1. How are you feeling about your health now?
2. How are you feeling about your size/weight now?
3. Are you currently trying to lose weight/maintain weight loss/accept your weight?

Trying to lose weight:

4. How are you trying to lose weight?
5. Have you tried to lose weight before?
  - a. If yes, how is this time the same/different from before?
  - b. If no, how is trying to lose weight the same as, or different than, you expected?

6. How have others reacted to your weight loss attempts?
7. How do you think your health will be different after weight loss?
8. How do you think your life will be different after weight loss?
9. Do you have any worries about your weight loss goals?
  - a. If yes, can you tell me about that?
  - b. If yes, how do you address those worries?
  - c. If no, why not?

I have no more questions. Is there anything else you would like to ask or add?

Thank you for your time and participation.

Trying to Maintain Weight:

10. How are you trying to maintain weight?
11. Have you tried to maintain weight loss before?
  - a. If yes, how is this time the same/different from before?
  - b. If no, how is trying to maintain weight loss the same as, or different than, you expected?
12. How have others reacted to your weight loss and weight maintenance attempts?
13. How has your health been different after weight loss?
14. How has your life been different after weight loss?

15. Do you have any worries about your weight maintenance goals?

a. If yes, how do you address those worries?

b. If no, why not?

I have no more questions. Is there anything else you would like to ask or add?

Thank you for your time and participation.

Trying to Accept Weight:

16. How are you trying to accept your weight?

17. Have you tried to accept your weight before?

a. If yes, how is this time the same/different from before?

b. If no, how is trying to accept your weight the same as, or different than, you expected?

c. If no, why are you now trying to accept your weight?

18. How have others reacted to your weight acceptance attempts?

19. How has your health been different since trying to accept weight?

20. How has your life been different since trying to accept weight?

21. Do you have any worries about your weight acceptance goals?

a. If yes, how do you address those worries?

b. If no, why not?

I have no more questions. Is there anything else you would like to ask or add?

Thank you for your time and participation.

### **Appendix C: Third Interview Guide for Obese Participants**

Thank you for agreeing to be interviewed again. This is a University of Manitoba research project designed to better understand obese individuals' perceptions of health and obesity and the lived experience of weight loss, gain, or maintenance over time. Your responses will help researchers better understand how to best promote health and wellbeing for all individuals in a positive manner. For this interview, as previously discussed, you will first take me to a place, activity, or situation that has meaning to you as an obese (or formerly obese) person. I will observe and participate in this situation as appropriate. I will take notes, but no identifying or personal information from any other individuals will be requested or disclosed. Then, I am going to ask you some questions about that experience and encourage you to tell me about your experiences and your thoughts on weight and health in order to learn more about Canadians' priorities in health and quality-of-life. This interview should take approximately 60 minutes.

Your participation in this project is still voluntary, you may still quit at any time, and all efforts will be made to keep your responses confidential.

1. How are you feeling about your health now?
2. How are you feeling about your size/weight now?
3. Are you currently trying to lose weight/maintain weight loss/accept your weight?
4. Why did you want me to see this place?
5. What is special about it?
6. What is special about the people here?
7. How does it make you feel?

8. How does it compare to other places?
  - a. How do the people compare to people elsewhere?
  - b. How does the experience compare to experiences elsewhere?
9. How has your perception of the experience changed over time?
  - a. How has your perception of the people changed over time?
  - b. How has your perception of the place changed over time?
10. How has your perception of the experience changed at different weights?
  - a. How has your perception of the people changed at different weights?
  - b. How has your perception of the place changed at different weights?

I have no more questions. Is there anything else you would like to ask or add?

Thank you for your time and participation.

## **Appendix D: Third Interview Guide for Obese Participants**

Thank you for agreeing to be interviewed again. This is a University of Manitoba research project designed to better understand obese individuals' perceptions of health and obesity and the lived experience of weight loss, gain, or maintenance over time. Your responses will help researchers better understand how to best promote health and wellbeing for all individuals in a positive manner. I am going to ask you some questions and encourage you to tell me about your experiences and your thoughts on weight and health in order to learn more about Canadians' priorities in health and quality-of-life. This interview should take approximately 60 minutes.

Your participation in this project is still voluntary, you may still quit at any time, and all efforts will be made to keep your responses confidential.

Questions for all:

1. How are you feeling about your health now?
2. How are you feeling about your size/weight now?
3. Are you currently trying to lose weight/maintain weight loss/accept your weight?
4. What helped you in the most in trying to lose, maintain, or accept your weight?
5. What hindered you in trying to lose, maintain, or accept your weight?
6. What would you have changed regarding you weight journey?
  - a. Why?
7. How have your views changed on weight loss?

- a. What do you think caused these changes?
8. How have your views changed on health?
- a. What do you think caused these changes?
9. How have your views changed on people's attitudes towards weight?
- a. What do you think caused these changes?
11. How have your health goals changed over time?
- a. How have your health goals changed with weight losses and gains?
12. How have your health behaviours changed over time?
- a. How have your health behaviours changed with weight losses and gains?
13. How have your relationships changed with different weight changes?

I have no more questions. Is there anything else you would like to ask or add?

Thank you for your time and participation.

## Appendix E

### PARTICIPANT INFORMATION AND CONSENT FORM

**Title of Study:** “Obese individuals’ perceptions of health and obesity and the lived experience of weight loss, gain, or maintenance over time”.

**Principal Investigator:** Andrea Bombak, [REDACTED]

**Co-Investigators:** Dr. Sharon Bruce, [REDACTED]

You are being asked to participate in a research study. Please take your time to review this consent form and discuss any questions you may have with the study staff. You may take your time to make your decision about participating in this study and you may discuss it with your friends, family or (if applicable) your doctor before you make your decision. This consent form may contain words that you do not understand. Please ask the study staff to explain any words or information that you do not clearly understand.

#### **Purpose of Study**

This research study is being conducted to study the health perceptions and experiences of obese people, and clinicians’ thoughts on treating, and promoting the health of, obese individuals. A total of 15 self-identified obese people and 10 clinicians will participate in this part of the study. Some of the 15 obese people will be asked to return for further

interviews over a 1 year period. Ultimately, this study will provide researchers with information on obese people's experiences and feelings on health and may help in developing public health programs and policies that better serve obese people and reflect their priorities.

### **Study procedures**

If you take part in this study and are an obese, **or formerly obese**, individual, the primary researcher will sit down with you to talk about your experiences as an obese person, how you feel about your health, what things are important for your wellness and quality of life, your possible experiences of discrimination, and what you recommend as public health strategies for obese and all Canadians. If you take part in this study as a clinician, the primary researcher will sit down with you and talk about your clinical experiences with obese patients and your thoughts on improving the health of obese patients. The interview will take place at the University of Manitoba Bannatyne campus or a location of your choice, and will last about an hour. The interview will be recorded and later placed on a computer. This recording will be destroyed 5 years after the completion of the study. **Participants will be asked about sites relevant to their experience as obese individuals (i.e. where they engage in health-related behaviors, where they feel accepted, where they feel stigmatized, etc.). For example, participants may discuss pursuing a healthy lifestyle by attending an exercise class at a leisure centre or may report feeling stigmatized when making food purchases at a grocery store. The researcher will then accompany participants to these sites and collect detailed field notes concerning the physical context, events, and participants' and others'**

**behavior at these sites. Participants will have the opportunity to more fully explain their feelings and experiences when they are physically situated in the setting.**

You can stop participating at any time in the study. However, if you decide to stop participating in the study, we encourage you to talk to the primary investigator first. Group results from all participants will be all that is reported in research papers or presentations. For example, the researcher will discuss overall public health recommendations from all participants in related presentations and papers. No individual interviews will be given or reported to anyone. Your personal identity will not be revealed in any paper or presentation.

### **Risks and Discomforts**

The risks to you for participating in this study are minimal. Talking about possibly negative experiences as an obese person may be upsetting.

### **Benefits**

There may or may not be a direct benefit to you from participating in this study. As an obese **or formerly obese** participant, it may be helpful to discuss past negative experiences or sharing ideas on how to improve the lives and health of others. As a clinician, it may be helpful for your practice to discuss how best to treat and promote the health of obese individuals. We hope the information learned from this study will benefit obese people's lives by exploring: (1) health and wellness issues of importance to obese individuals; and (2) ways of improving obesity-related health care and public health

programming.

### **Costs and Payment for Participation**

There is no cost to you for participating in this study. Non-clinician participants will receive a \$25.00 gift certificate to a major department or grocery store upon completion of each interview to acknowledge their time and effort.

### **Confidentiality**

Information gathered in this research study may be published or presented in public forums, however, your name or other identifying information will not be used or revealed. Your name will not appear on any study-related documents. At the start of the study, you will be assigned a study number. Only that number will appear on study-related materials. Data from all procedures described above will be entered into a computer on a network only the researchers identified above can access. When these data are entered into the computer, only your study number will be entered. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. Your personal information may be disclosed if required by law. The University of Manitoba Health Research Ethics Board may review records related to the study for quality assurance purposes.

All records will be kept in a locked secure area. Only the research investigators identified above will have access to these records. If any of your research records are copied to any

of the above investigators, your name and all identifying information will be removed. No information revealing any personal information, such as your name, address or telephone number will leave the University of Manitoba.

### **Voluntary Participation/Withdrawal from the Study**

Your decision to take part in this study is voluntary. You may refuse to participate or you may withdraw from the study at any time. Your decision not to participate or to withdraw from the study will not affect your health care or any current or future relationship with the University of Manitoba. If the investigator feels that it is in your best interest to withdraw you from the study, you will be removed from the study without your consent.

You will be told about any new information that may affect your health, welfare, or willingness to stay in this study.

### **Questions**

You are free to ask any questions. If any questions come up during the study or after the study, please contact the primary investigator: Andrea Bombak at [REDACTED].

For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at [REDACTED].

Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.

### **Statement of Consent**

I have read this consent form. I have had the opportunity to discuss this research study with Andrea Bombak. I have had my questions answered by them in language I understand. The risks and benefits have been explained to me. I believe that I have not been unduly influenced by any study team member to participate in the research study by any statements or implied statements. Any relationship (such as employer, supervisor or family member) I may have with the study team has not affected my decision to participate. I understand that I will be given a copy of this consent form after signing it. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I authorize the inspection of any of my records that relate to this study by The University of Manitoba Research Ethics Board for quality assurance purposes.

By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

- I agree to be contacted for future follow-up in relation to this study,

Yes \_\_\_\_\_ No \_\_\_\_\_

Participant signature \_\_\_\_\_

Date

\_\_\_\_\_

(day/month/year)

Participant printed name: \_\_\_\_\_

Relationship (if any) to study team members: \_\_\_\_\_

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has knowingly given their consent

Printed Name: \_\_\_\_\_ Date

\_\_\_\_\_

(day/month/year)

Signature: \_\_\_\_\_

Role in the study: \_\_\_\_\_