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# The Expanding American Waist-Line: Critical Approaches to Obesity and the Lived Experience of Body Weight

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UNIVERSITY OF MIAMI

THE EXPANDING AMERICAN WAISTLINE: CRITICAL APPROACHES TO  
OBESITY AND THE LIVED EXPERIENCE OF BODY WEIGHT

By

Brittany M. Harder

A THESIS

Submitted to the Faculty  
of the University of Miami  
in partial fulfillment of the requirements for  
the degree of Master of Arts

Coral Gables, Florida

August 2013

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Throughout this thesis, I argue that the dominant approaches in obesity research do not adequately address obesity. Researchers that take a bio-medical, individualistic approach to treating obesity assume universal standards for bodies and body weight, which do not represent the actual experiences that people have. I argue that the meanings of body weight must be explored in the context that body weight is experienced and that recognizing multiple meanings of body weight is critical in understanding obesity.

I interview 15 women who are considered “overweight,” “obese,” or “morbidly obese” by medical standards. I use a phenomenological approach complemented with grounded theory methodology in order to provide in-depth meanings of body weight. Throughout this project, I address the following research questions: 1) How do those who have been labeled or identified (by others and/or self) as “overweight” and “obese” experience this label? How do they experience their bodies? 2) In what ways does being considered obese fit into the lives of the participants? How do their bodies fit into their lives? How do their lives fit into their bodies? 3) What struggles do the participants face? How do the participants deal with these struggles? 4) How do participants define themselves? How do participants think of obesity defining who they are?

Through my findings, I reveal consequences to the way researchers and health professionals have studied obesity and how they conflict with many underlying assumptions of body weight. For example, participants expressed multiple meanings of body weight, and these meanings differed among participants. Therefore, I conclude that a universal meaning or approach to body weight is insufficient in our efforts to understanding obesity. I also found that most participants do not accept their weight label as “overweight,” “obese,” and “morbidly obese,” which has major implications considering the American Medical Association’s (AMA 2013) recent decision to label obesity as a “disease.” Additionally, my findings are at odds with many pre-assumptions of overweight and obese people. For example, most participants reported consciously thinking about their weight, which for some included dieting for most of their lives. Furthermore, my findings reveal major challenges and constraints participants shared regarding physical and social environments. Lastly, findings from this project support previous literature that report lingering effects of weight-based stigma throughout the life-course, which also have major implications for policy efforts.

## **DEDICATION**

I dedicate this thesis to all of my participants and to those who have ever been treated differently because of their weight.

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Caitlin, thank you for keeping me together. You have seen the worst of me and you are still right by my side. I think by now you know as much about obesity as I do. Thank you for never giving up on me or on us. I owe you the world!



## TABLE OF CONTENTS

	Page
LIST OF FIGURES .....	vii
LIST OF TABLES.....	viii
Chapter	
1 INTRODUCTION .....	1
Introductory Remarks .....	1
Approaches in Obesity Research .....	4
Critical Approaches to Obesity .....	12
Previous Critical Approaches .....	13
The Aim and Purpose of a Critical Approach .....	15
Chapter Summary .....	16
2 THEORETICAL FRAMEWORK .....	19
A Society Separate from Individuals .....	19
Society as Active.....	21
Intentionality .....	22
Symbolic Violence.....	23
Embodiment .....	24
Phenomenology & the “Life-World” .....	26
Chapter Summary .....	29
3 METHODS AND DATA ANALYSIS.....	31
Research Approach.....	31
Research Design.....	32
Sampling and Recruiting.....	34
Location .....	37
Participants .....	39
Analysis .....	42
Chapter Summary .....	45
4 FINDINGS .....	48
Findings .....	48
Response to Labels .....	53
Meanings of Body Weight.....	55
Perceived Restrictions .....	59
Overt Bullying and Discrimination .....	61
Meanings of Food .....	62
Appetite Control .....	64

Pregnancy and Childcare .....	66
Chapter Summary .....	69
5 CONCLUSIONS .....	71
Future Research and Limitations .....	76
Qualitative Research and Body Weight .....	78
Chapter Summary .....	80
REFERENCES .....	82
APPENDICES .....	90

## LIST OF FIGURES

1 Examples of Initial Codes .....	50
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## LIST OF TABLES

1 Participant biographies.....	40
2 Themes and theme descriptions.....	51

## CHAPTER ONE: INTRODUCTION

### Introductory Remarks

The “expanding American waist-line” refers to the dramatic increase in obesity rates and the overwhelming response defining obesity as a major health problem (Boero 2007). The Centers for Disease Control and Prevention has estimated that 35.7% of adults and 17% of children are currently obese in the United States (CDC 2012). These rates are by far the highest the nation has experienced.<sup>1</sup> Recently, the American Medical Association (AMA 2013) has publically identified obesity as a “disease,” a new label that is predicted to effect the way obesity is diagnosed and treated in the United States. Prior to AMA’s recent announcement, obesity had been labeled a health “epidemic” according to the Surgeon General’s Call to Action to Prevent and Reduce Overweight and Obesity in 2001. Traditionally, the label “epidemic” has been used in public health referring to an outbreak or an increase of disease. However, health professionals concluded that “epidemic” was an appropriate label for obesity because of its growing prevalence in America and its threat to health (Kumanyika and Brownson 2007).

Throughout the past decade, government and health organizations have created policies and programs aimed toward deflating obesity rates.<sup>2</sup> However, some sociologists, nurses, and social theorists have questioned the results of the research that guides policy

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<sup>1</sup> In 2011, new methods were implemented throughout the fielding of the Behavioral Risk Factor Surveillance System (BRFSS) to include data received from cell phone users rather solely from the use of landlines. Therefore, it is noted that the results from the 2011 BRFSS, including the most recent obesity rates, should not be compared to previous rates because of these methodological changes (CDC 2012). However, despite changes in data gathering over the past two years, obesity rates have remained high and national health organizations such as the CDC continue to keep track of the percentage of Americans that are overweight, obese, and morbidly or extremely obese.

<sup>2</sup> For a review of recent interventions and public policy regarding obesity rates see Gearhardt et al. (2012); Wadden, Brownell, and Foster (2002).

interventions and programs (e.g. Monaghan, Holland, and Prtichard 2010). Within this new and emerging area, the epistemology, methodologies, and research agendas among many obesity researchers are questioned and critiqued. Specifically, those taking a critical approach to obesity (e.g. Colls and Evans 2010) have debated the theoretical underpinnings of such a large body of work and have discussed the implications of policy interventions based on current obesity research. Those taking a critical approach to obesity apply concepts from the sociology of knowledge and the social construction of health and illness to the study of obesity (e.g. Evans and Colls 2009). Taking a constructionist approach to health does not necessarily mean working against those in medical and health professionals. Rather, those who study the social construction of illness can provide information that is grounded in the everyday lives of those experiencing a particular condition or situation. Additionally, social constructionists provide an understanding of the social factors, lay knowledge, and day-to-day experiences that can contribute to health knowledge and policy (Brown 1995).

Inspired by critical approaches to obesity and by drawing from the works in social psychology, social constructionism, contemporary theory, and the sociology of the body, I approach body weight in a unique way that expands the work in obesity research. I align with previous critical approaches to obesity by questioning how health knowledge is created and maintained in the area of obesity research. I question how a positivist, behavioral, and individualistic approach to obesity has survived and maintained dominance in understanding body weight. Throughout this project, I address the following research questions: 1) How do those who have been labeled or identified (by others and/or self) as “overweight” and “obese” experience this label? How do they

experience their bodies? 2) In what ways does being considered obese fit into the lives of the participants? How do their bodies fit into their lives? How do their lives fit into their bodies? 3) What struggles do the participants face? How do the participants deal with these struggles? 4) How do participants define themselves? How do participants think of obesity defining who they are?

By using a phenomenological approach, I listened to and recorded the stories of those who are considered to be overweight, obese, and morbidly obese by medical standards. I interviewed 15 women ages 24-76 of various backgrounds in the states of Florida and New Jersey that meet the medical standards of “overweight,” “obese,” and “morbidly obese.” I used grounded theory in my analysis to understand the meanings given to body weight, the meanings given to labels associated with body weight, and the overall experiences of those labeled abnormal based on their current weight status. Throughout this project, I contribute to the existing obesity research by providing more thorough understandings of what it means to be “obese” and “overweight” by medical standards. Additionally, I provide understandings of how those considered “obese” and “overweight” experience particular social situations. My contribution to previous critical approaches to obesity includes the strong theoretical basis that is absent in existing critical approaches. Additionally, most existing critical approaches to obesity have focused on obesity in Western-European countries and Australia. To my knowledge, this project is one of the first studies of its kind pursued in the United States. The results of this project provide an avenue to listen to others’ stories and experiences of their lived bodies, opening up possibilities to understand body weight in a unique way.

### Approaches in Obesity Research

Researchers from many disciplines have taken interest in the study of obesity and there is a number of ways that researchers have approached the phenomenon. Therefore, competing approaches and definitions of obesity exist. Kumanyika and Brownson (2007) argue that the definition of obesity varies by the knowledge, experience, or background one may have. They explain that those in medical and health professions define obesity as “a condition that not only can be objectively measured but may also immediately bring to mind a heightened awareness of increased risk for associated adverse health outcomes” (Kumanyika and Brownson 2007: 25). Although Kumanyika and Brownson (2007) discuss an objective measure of obesity, they say that for others, obesity is a much more subjective concept that leaves defining it a difficult task.

Kumanyika and Brownson (2007) provide an alternative definition of obesity as “something that is loosely based on a visual impression or a preconceived mental attitude about the phenotypic expression or cosmetic appearance of a body size that is considered large” (Kumanyika and Brownson 2007: 25). Many researchers (e.g. Monaghan et al. 2010) reject the use of “obesity” and prefer using the concept of “fatness.” Throughout this project, I use the term “body weight,” understanding that those labeled as “overweight” and “obese” by others may not self-identify as so. Likewise, I recognize that some may label themselves as “overweight” or “obese,” but are not labeled so by others. In this context, I view body weight as a phenomenon that is subjective, arbitrary,



relative, and flexible. I am interested in the meanings that the participants give to body weight and therefore, I do not provide my own definition of body weight or obesity.

In general, the most commonly used measure of body weight is Body Mass Index, often referred to as BMI, defined as an individual's weight in kilograms divided by the individual's height in meters squared. A BMI of 25 - 29.9kg/m<sup>2</sup> is defined as "overweight" or "pre-obese" and a BMI equal to or greater than 30kg/m<sup>2</sup> is defined as "obese." More specifically, "obese" has three classifications: obese class I (BMI of 30-34.99kg/m<sup>2</sup>), obese class II (BMI of 35-39.9kg/m<sup>2</sup>), and obese class III, often referred to as "morbidly obese" or "extremely obese" is a BMI equal or greater than 40kg/m (WHO 2013)<sup>3</sup>. Although limitations of using body weight indices have been addressed, measures of weight (relative to height) have been used for over a century and continue to be considered useful in defining body weight categories in health research (Keys, Fidanza, Karvonen, Kimura, and Taylor 1972). Many researchers have focused on health risks associated with obesity, including cardiovascular disease, Type II diabetes mellities (e.g. Young et al. 2001; 2002), osteoporosis (e.g. Sadler and Huff 2007), sleep apnea, hypertension, gall bladder disease, dyslipidemia, infertility, pregnancy complications, cataracts, stroke, glucose intolerance, respiratory problems, psychological distress, and certain types of cancer (Kopelman 2007; Stein and Graham 2004).

Most research on obesity aligns with what medical sociologists refer to as the "medical model" or as Gabe, Bury, and Eltson (2004) refer to it as "the dominant approach to disease in Western medicine based on a pathological anatomy of the body"

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<sup>3</sup> A BMI of 18.5-24.9kg/m<sup>2</sup> is considered to be "normal". A BMI below 18.5kg/m<sup>2</sup> is classified as "underweight" (WHO 2013).

(Gabe et al. 2004: 125). Gabe et al. (2004) also explain that within the medical model, the ability of the physician to diagnosis a patient is seen as highly important and even favorable. The patient is expected to “recognize” signs and consult their healthcare provider, who then provides a diagnosis based on a comparison to the body at some “natural state” (Gabe et al. 2004:126). A medical model is that disease is individualistic, something that happens to an individual rather than a group of people. Within this approach, the individual (or patient) feels an increased amount of pressure to take control of his or her health by complying with physician orders and wanting to get better (Parsons 1951). In general, those using a medical model favor an internal locus of control because it suggests that the individual has control over his or her health and does not attribute illness to something higher or existential. Instead, the person faults him or herself for not taking responsibility.

Many obesity researchers have adopted such individualistic approaches. For example, Young et al. (2001) and Conroy et al. (2010) examined different “motivators” for weight-loss behaviors among a group of women. Participants talked about changing their eating habits and increasing their amount of physical activity. Results suggest that weight loss, physical activity, and eating are individual behaviors that are dependent upon certain individual motivators, and laziness is a major barrier to motivation. Within these individualist approaches, the “internal locus of control”, or the individual responsibility for health, diet, and exercise, is illuminated. Warin, Turner, Moore, and Davies (2008) found that participants’ experiences with food and body weight were “at odds with the individualistic approach of current health promotion messages” (Warin et al. 2008: 107). Therefore, although an individualistic approach to health and obesity is frequently taken

in obesity research, many times this approach is found irrelevant to the participants' actual experiences.

Although most of the research on obesity is based on an individualistic approach, other approaches such as holistic, etiological models (e.g. Eyler et al. 2003) do exist. For example, a holistic model (e.g. Davies 2008) includes the biological, psychological, and social (biopsychosocial) factors that, in a complex way, interact with one another, and altogether factor into obesity. Davies (2008) encourages primary health care nurses to use a holistic approach in treating patients who are overweight. Researchers using holistic models like the one introduced by Davies (2008) define obesity as a chronic disease and illness that must be treated in a sensitive manner by health care professionals. With a holistic model, Davies (2008) attempts to gain a deeper understanding and awareness of the patient's weight in order to offer realistic advice and weight-loss goals. Through a holistic approach, the author's purpose is to help overweight patients lose weight through providing free, healthy lunches and encouraging patients to join what she calls, "slimming clubs" (Davies 2008: 20).

In the realm of obesity research and the medical treatment of obesity, holistic models such as the one proposed by Davies (2008) are seen as liberal and progressive because the intention is to adopt a wider awareness of the possible underlying factors that contribute to the patient's weight while understanding the complexity of such an approach. Additionally, while the intention of adopting a holistic approach may be good, researchers using this approach still glorify a "normal" body size with a focus on weight-loss. Although social factors are included in most holistic models, the social factors are limited to aspects such as socioeconomic status and stigma in social settings. However,

McKinlay (1996) argues that government policies, organizational practices, and provider behaviors may explain as much as, if not more than, previous explanations have offered regarding reported health rates. He concludes that such social system influences have the possibility through policy to improve the health of a population.

Others studying obesity have focused on how certain social factors contribute to health inequalities based on class, race, and gender differences. Zhang and Wang (2004) claim that minorities are more “vulnerable” to obesity. Further, Chaufan, Fox, and Hong (2011) have called obesity an “unequal opportunity disease.” Chaufan et al. (2011) argue that the perception of obesity has shifted from an individual problem to a social problem and should be studied using a fundamental social cause approach. A fundamental cause approach as posited by Link and Phelan (2010) provides explanations for the persistency of the relationship between socio-economic status (SES) and health by noting that those with higher income and education levels are more likely to have access to living healthy lifestyles, having social support, working in clean and safe places, and better healthcare providers. While it depends on how researchers measure socioeconomic status in studies that explore this, prevalent findings suggest lower SES is, in some way, associated with higher obesity rates among women (Sobal and Stunkard 1989). In Sobal and Stunkard’s (1989) review of the literature on the relationship between SES and obesity, authors concluded that in developed societies, the prevalence of obesity increases due to rising wealth and available food. However, in these same developed societies, there is consistently an inverse relationship between SES and obesity among women for which the authors provide some possible explanations. Although their review is now two

decades old and there has been no similar (cross-national) up-to-date review, more recent studies of obesity in the U.S. have reported similar findings.

Globally, except in the poorest countries, women have a higher life expectancy than men, yet, women have higher rates of morbidity than their men counterparts. Higher morbidity rates over a longer life span suggest that although women are living longer, they are living with more and higher rates of disease (Rierker et al. eds. Bird et al. 2010: 53). The authors note that those studying gender differences in morbidity and mortality rates rarely agree on explanations. However, several possibilities have been suggested. In examining weight-loss behaviors among low-income African American, Caucasian, and Latina women, Breitkopf and Berenson (2004) found that African Americans had high rates of obesity and the highest rate of morbid obesity when compared to Caucasian and Latina women. African American women also dieted and exercised less frequently than the other two groups, and over 50% of the African American participants had not engaged in any additional weight loss behaviors, including purging, taking weight loss pills, laxatives, or water pills. Similar findings are suggested by Gaillard et. al (2007), who report that African American women are more likely to be obese compared to their white counterparts. African American women are more likely to have diabetes mellities than other groups, which is sometimes seen as a product of high rates of overweight and obesity among this group (Young et al. 2002).

In a particular noteworthy study, Read and Emerson (2005) found that Blacks born in minority white (e.g. Africa, South America) and racially mixed (e.g. West Indies) regions have better self-rated health than U.S.-born Blacks. However, the researchers note that Black immigrants from majority white (e.g. Europe) nations do not significantly

differ from U.S.-born Blacks in any of their health status measures. Additionally, the authors report that Black immigrants who have lived in the U.S. for more than five years have worse self-assessed health compared to that of immigrants with less than five years of U.S. residency (Read and Emerson 2005: 191). Related findings are presented by Read and Emerson (2005) concerning the intersections of race and health outcomes in the United States. Regarding obesity, Antecol and Bedard (2006) found that female Hispanic immigrants came to the U.S. with lower BMIs than U.S. born Hispanics yet over time, the immigrants' BMIs become similar to those born in the U.S. Therefore, in addition to continuing the research in obesity inequalities, researchers might address why the length of residency in the United States matters for health and weight status.

Boero (2007) argues that obesity is perceived as an individual, moral issue, placing blame on those who are considered large. Therefore, those who are considered "overweight" and "obese" experience size-based discrimination in many forms. Obesity as a stigmatized condition has been documented in the sociological literature as early as 1968, when Werner J. Cahnman pointed out the social aspects of obesity (Cahnman 1968). Cahnman (1968) noted that he was amazed by the lack of attention sociologists paid to obesity. He led the discussion of social deviance and stigma by discussing the moral responsibility that has been tied to overweight and obesity. Through his discussion, he provided a path for sociologists and others to explore the social aspects of obesity. Since then, obesity has been tied to social-psychological concepts such as identity, deviance, self-concept, and perceived discrimination. Most of the sociological and social-psychological research on obesity has its origins in the work of Erving Goffman and his discussion of stigma.

Goffman (1963) notes that society establishes how people are categorized and which attributes are ordinary for members of these categories. Further, we usually do not become aware of these demands until an active question arises as to whether or not these ordinary attributes will be fulfilled (Goffman 1963). It is then that we may notice a stranger possessing an attribute that is different from the attributes we have already assigned to this normal category. Therefore, we see the stranger as not only different, but also less desirable, or handicapped. Goffman says, “The stranger is then reduced in our minds from a whole and usual person to a tainted, discounted one (1963: 2).” Using Goffman’s concept of stigma, an obese or overweight person might be seen as less desirable and a tainted, discounted person.

Schafer and Ferraro (2011) note the lack of attention to social processes involved in identity formation in obesity and body weight research. Those experiencing weight-based or size discrimination interpret their body weight status in various ways including through their interaction with others (Schafer and Ferraro 2011). The researchers found that those who perceived discrimination based on their body weight were more likely to report feeling “overweight” and “very overweight” than those who did not perceive such discrimination. Similarly, in their exploration of self-concept and self-esteem among young girls who transitioned from an obese to normal weight during adolescence, Mustillo, Hendrix, and Schafer’s (2012) found powerful lingering effects of stigma that threatened self-concept even after the girls were considered to have a “normal” body weight.

Further, Lewis et al. (2011) conducted phone interviews with 141 individuals in Australia about their body weight. In their analysis, they drew from the works of Link

and Phelan (2001; 2006) by searching for phenomena that seemed to align with Link and Phelan's categorization of types of discrimination and their concept of stigma. Lewis et al. (2011) categorized their participants' experiences as direct stigma, environmental stigma, and indirect stigma. Most participants who experienced environmental stigma felt unable to challenge this type of stigma, specifically, because this would involve challenging the norms of society and would entail lobbying businesses or large industries (Lewis et al. 2011:1353). Although Lewis et al. (2011) do not expand on the reasons why participants stated they were unable to challenge environmental stigma, I argue the following possible explanation. Stigma, particularly environmental stigma (e.g. fitting in a bus seat, finding stores to shop for clothes) appears as if society or an entire system is discriminating against a group of people, in this case, larger-sized people. Retaliating or fighting back is often perceived to be overwhelming since the oppressed group believes it to be a whole system that they are facing, rather than another group of individuals. Throughout this thesis, there will be a further discussion on confronting discrimination and stigma.

### Critical Approaches to Obesity

Critical approaches to obesity have developed in response to the increasing concern and attention given to obesity as a public health epidemic. Those taking a critical approach to obesity challenge contested medical knowledge and how it conveys a link between body mass, fatness, and poor health that are conveyed as absolute fact or truths (Colls and Evans 2010: 100). These "truths" are presented through the media, health care training, and policy efforts and have an array of audiences that have depended upon these truths. Colls and Evans (2010) define three major areas in critical approaches:



questioning obesity “truths,” embodiment, and alternative policy that promotes a Health at Every Size (HAES) approach to body acceptance. The first major area, questioning obesity “truths” is aligned with Rail, Murray, and Holmes’ (2010) challenge of contested medical knowledge and “facts” as a responsibility of social research in health. Colls and Evans (2010) provide the most commonly presented obesity “truths,” for example, that BMI is a measure of fatness. They argue that research combating obesity “truths” has been conducted but has not gain much public attention. The second major area, embodiment, rejects the notion of reducing the body to a number or data point. Colls and Evans argue that the “living, feeling, and fleshy obese body” is absent in obesity research (2010: 102). They suggest that the obese body should be acknowledged and its experiences be taken seriously by including the experiences and of fat bodies into obesity research. The third major area, alternative policy, began with groups of people in the U.S. and the U.K. involved in size acceptance movements and fat activism (2010:103). Colls and Evans provide examples of alternative policy including organizations that fight for the rights of fat persons and online resources that help to identify “fat-friendly” healthcare providers and bigger sized clothing outlets (2010:103). Those taking a critical approach to obesity provide explorations into the taken-for-granted scientific knowledge on obesity, engage with the lived body and its experiences, and fight for the rights of fat persons through alternative policies.

### Previous Critical Approaches

Researchers with a critical approach to the study of obesity have recognized the absence of lived experiences in health-promotion policies and practices, critiquing that an individualistic and behavioral approach fails to account for participants’ local and

relational worlds (e.g. Warin, Turner, Moore, and Davies 2008). Similar to the argument presented by Warin et al. (2008), critical approaches to obesity with a strong theoretical basis provide an opportunity to position the experiences of body weight, and the local and relational worlds these experiences come from, *somewhere*. However, placing lived experiences at the center of the “obesity crisis” should not be the aim for alternative approaches. Those taking an alternative approach have the opportunity to create an entirely new way of studying experiences of body weight. The new way of studying body weight will not be achieved if those taking this approach attempt to channel an alternative approach through the approach(es) under critique (bio-medical, individualistic, behaviorist, energy in-energy out, obesity “epidemic”).

Researchers using critical approaches to obesity have, so far, created a path for an alternative way of studying body weight by critiquing the current studies of obesity. However, in order to offer an entirely new way of studying body weight, a strong theoretical basis is needed. A strong theoretical basis includes a discussion of dualism and why an entire epistemological shift is needed to study body weight, including the fundamental concept in phenomenology known as intentionality. Other important components that would contribute to a strong theoretical discussion of studying the body also include praxis and embodiment. The aim for a critical approach should not be limited to allowing instances of size-discrimination to become more apparent and provocative in traditional approaches to studying obesity. By describing the theoretical basis used in traditional approaches and the reasons why studying body weight requires an entire new way of thinking, a critical approach to obesity can serve as much more than simply a critique to traditional and positivist approaches to studying the body.

Elevating or centering experiences of body weight within the context (or world) that it comes from may allow others to understand, at the very least, why programs and practices (using a behavioral approach) have not yet been successful in attempting to deflate obesity rates in the United States. However, beyond a minimal understanding of failed practices, elevating the lived experiences of body weight encourages the question of how a positivist and behavioral approach to obesity has survived and maintained dominance in the study of obesity despite the many unsuccessful programs and critiques of a medical-model approach. After recognizing why a positivist paradigm creates the illusion that size matters based on scientific measures and truths, one recognizes this perspective as just one narrative among many other possible narratives.

#### The Aim and Purpose of a Critical Approach

Those taking a critical approach to studying obesity should recognize: 1) it is not the “epidemic” or “society” that is being confronted, but it is simply other individuals. 2) it is not the “epidemic” or “society” that size-discriminates, but rather, it is other individuals. 3) the “epidemic” and “society” provide only one narrative out of a pile of possible narratives. 4) the “epidemic” and “society” appear as “reality” for only those who have given them the ontological status of something greater, powerful, stable, and most importantly, *active*.

A critical approach should not be limited to critiquing the “epidemic” or how “society” views body weight or beauty. A critical approach should involve a strong theoretical basis and a description of an entire new narrative, rather than just critiquing an old narrative. Additionally, rather than merely being concerned with bringing the

experiences of lived body weight to the center of the obesity epidemic, those taking a critical approach could create an entirely new area of study where those lived experiences take the stage of what we know about lived body weight instead of “the obesity epidemic”. If those taking a critical approach continue to write in the face of “the epidemic”, the opportunity to create something more will be lost in the margins of obesity research. Those concerned with the ways in which others study obesity are able to not only critique but also create and describe an alternative and possible narrative where body weight is viewed differently, if at all.

### Chapter Summary

Obesity rates in the United States have rapidly increased over the past two decades, which has led to an obsession with America’s “fat problem.” From the moment we wake up, most Americans face the pressures of body image from the media, manufacturing companies, the food industry, the health sector, family and friends, and even strangers. A “normal” body is glorified while anybody that falls outside of normal is shamed. Those who are labeled as “overweight” and “obese” often encounter a great deal of discrimination based on their weight. The “hype” over obesity as a major public health problem that lies in individual responsibility has contributed to the assumptions, judgments, and stereotypes that many people who are labeled overweight often deal with.

Governmental programs and policy interventions aimed towards deflating obesity rates depend on academic research for the “facts”. Therefore, obesity research has gained attention and momentum across a variety of disciplines. Health professionals, particularly public health scholars and epidemiologists, are currently at the forefront of research

aimed toward lowering obesity rates and treatment of health risks associated with excess weight. Social scientists such as psychologists and social psychologists have contributed to obesity research by exploring how body weight affects the individual, behavioral patterns, self-emotions, and the self-concept. Rather recently, sociologists have questioned the epistemology and methodologies used in obesity research and since, have debated the theoretical bases of such a large body of work.

Specifically, those with a critical approach to obesity question how health knowledge is created and how an individual, objective, and realist approach has maintained dominance in obesity research. Researchers who use a critical approach have integrated work in embodiment research into the study of obesity. Some researchers taking a critical approach have also suggested alternative policy interventions that move away from weight-loss as the primary goal. Alternative policy suggestions include a “health at every size approach,” or (HAES) that focuses on being healthy regardless of body weight. Although critical approaches to obesity have provided new avenues to the study of obesity, many critical approaches are often dismissed as merely a critique. Following the work of critical approaches to obesity, I provide the theoretical framework that is missing from previous critical approaches. Additionally, I provide more thorough understandings of what it means to be “overweight” and “obese” in America.

Using a phenomenological approach complemented with a grounded theory methodology, I interviewed 15 women, ages 24-76 yrs. old from a variety of backgrounds, who are considered “overweight,” “obese,” or “morbidly obese” by medical standards. Throughout this project, I addressed the following research questions:

- 1) How do those who have been labeled or identified (by others and/or self) as

“overweight” and “obese” experience this label? How do they experience their bodies? 2) In what ways does being considered obese fit into the lives of the participants? How do their bodies fit into their lives? How do their lives fit into their bodies? 3) What struggles do the participants face? How do the participants deal with these struggles? 4) How do participants define themselves? How do participants think of obesity defining who they are? The results of this project provide opportunities to understand body weight from the context(s) it is experienced and to study body weight in an entirely new way.

## CHAPTER TWO: THEORETICAL FRAMEWORK

Those taking a critical approach to the study of obesity have recognized the absence of lived experiences in health-promotion policies and practices, arguing that an individualistic and behavioral approach fails to account for participants' local and relational worlds (e.g. Warin, Turner, Moore, and Davies 2008). However, the philosophical and theoretical basis that allows one access into a participant's world has not yet been described in critical approaches to obesity. In Rail et al. (2010)'s critical account of knowledge produced by dominant health sciences, authors argue for a conversation of the construction of health sciences and research. In terms of epistemology, authors argue that health research has been built on a single, positivist paradigm. A positivist paradigm assumes that reality is objective, which is to say that it exists, "out there", absolutely independent of the human observer and of the observer's intentions and observations. The authors argue that those in health research constantly point to the "facts" rather than the "truths". They note that qualitative research may be useful in helping to reflect on the everyday life-worlds of participants because it can provide a reflection of the production of scientific knowledge and a discovery of everyday truths (Rail et al. 2010).

### A Society Separate from Individuals

Through dualism (mind and body separate, fact and opinion separate), the use of a rigorous and neutral methodology is seen possible. Unbiased measures can be created which is thought to lead the researcher to pristine and uncontaminated knowledge. If the "proper strategies are adopted," the belief is that the social world may be studied in a

neutral and unbiased manner (Murphy 2012: 56). Murphy (2012) explains that through this perspective, researchers are careful to follow certain steps of the research method and if done so correctly, the researcher is able to reach an unbiased, empirical reality. While studying body weight, researchers taking a dualistic or realist approach have presented size and BMI as neutral standards through the use of math, science, and technology, that allow us to seek medical truths (e.g. Stein and Colditz 2004; Abeson and Kennedy 2004). Since these measures are viewed as unbiased and neutral, standards are created on the basis of these measures and so, these standards are also seen as neutral and unbiased.

Murphy (1994) argues that through dualism and the belief in universals comes an effective means of controlling behavior, where control is seen as rational and necessary (1994:70). Such control has dangerous consequences for body image and weight. For example, a researcher or a doctor believes he or she is simply reporting objective facts when studying or treating a body. The researcher or doctor in this case believes that these facts are unbiased and neutral because of the unbiased and neutral methodology that has allowed for the body to be measured in a seemingly objective way. So it does not seem as if the doctor or researcher is determining what is considered to be a “normal” body or an “obese” one; but rather, an illusion is created that makes it seem as if these standards already exist despite human action.

Similarly, through dualism, it can seem as if society establishes what a “normal” or “usual” body type is since “unusual bodies” are often constrained by their physical environments. For example, Lewis et al. (2011) describe this type of discrimination as “environmental stigma,” referring to the size of seats on an airplane, the width of a doorway, and the size of a car are made for normal bodies. However, it’s not really an



abstract society that is doing anything to anyone. Murphy (1994) explains that by using structural terms to describe society, all human elements are removed and society appears as “neutral.” Through this, the illusion is created that makes it seem as if society (as separate from persons) is doing something if and only if society is seen as having the ontological status of a larger, a-historical, autonomous, and powerful entity. Society, in this regard, is not disrupted or moved by human contingency. A society with the ontological status of an a-historical entity gives the appearance that it is autonomous, stable, and will operate in a space regardless of human action. It is within this control that provides the basis for order: in the form of institutions or an all-encompassing term such as “the system” or “society”.

How does society gain such a powerful ontological state? And how is it then, that a powerful society is the direct actor in producing social control? The society that takes on the ontological form of autonomy, on a separate level from persons, is possible only through the idea that 1) something like “the social” is divorced from human action; 2) a necessary and urgent need for something larger to keep individuals under control; 3) The belief that something as abstract as an institution or a “social” would provide the order that individuals were in desperate need of.

### Society as Active

In Anne Game’s (1991) *Undoing the Social*, she argues that power, also called “the social,” stands over and against subjects (1991: 34). The power (or social) is distinct from the subject. She asks, “How can this all too solid thing-power, the social- be changed (Game 1991:34)? When the social or society is viewed as something that is

large, autonomous, and a-historical, it also appears that the social is capable of acting. For example, society *provides* order and stability, meaning that the social can now “do” or “act”. If society can provide order, what else can it “do”? Although society remains uncontaminated by people (human contingency), people do not remain uncontaminated by society, and therefore, the social and persons are understood as unequal. Game’s (1991) plea for “undoing the social” can be simplified: power-the social- or “society” and the “subject” have an unequal and unidirectional relationship where the social controls the subject. For example, in Lewis et al (2011), participants found environmental stigma the most difficult type of stigma to confront, since they discussed being overwhelmed by facing society. Those who experience size-based discrimination perceive retaliating or fighting back as overwhelming; since they believe it to be a whole system that they are facing, rather than confronting other individuals.

### Intentionality

In opposition and rejection of dualism, intentionality is the epistemology that allows us to study the lived experiences of others. Intentionality means that everything known and understood by a person comes from their intimate connection to the social or life world. Dualism rejects this notion of the body always being connected or tied to the world; in fact, dualism assumes that the body and the mind are separate entities. Dualism is passé in intentionality. Consciousness can never be turned off or separated from what is happening because consciousness is intimately connected to everything that is experienced and known. Intentionality rejects the notion of the mind being a “tabula rosa” or blank slate, which is required in a dualistic approach to studying social life (Murphy 2012: 34-35).

Intentionality is the fundamental epistemological shift away from dualism that allows us to study the lived experiences and life worlds of others. In positing an alternative way to study body weight, intentionality is what allows us to take an alternative approach as social researchers, so we cannot ignore it. Through dualism, a standard of a “perfect” body can be portrayed since the measurements that make up that standard are viewed as neutral and unbiased. People that give this standard the ontological status of a universal, either devote their whole lives to doing all sorts of things to meet that standard of the ideal body or, feel bad that their body does not meet that standard and probably never will (Murphy 1994). The latter is related to people participating in their own oppression based on their bodies, which is a dangerous implication of symbolic violence.

### Symbolic Violence

Symbolic violence, originated from the works of Pierre Bourdieu, is a type of violence that lies in naming and categorizing others and the implications regarding power and domination (Postone, LiPuma, and Calhoun 1993:10). What makes symbolic violence symbolic, is how this type of violence operates under a mask of neutrality. In other words, opposite of “overt” or “covert” violence, Murphy (1994) explains that within symbolic violence, the “exercise of force is concealed” (1994:74). A discussion of symbolic violence is absent in previous critical approaches to obesity, which limits these approaches to a discussion of the dangers and the ethics of labeling people as fat. However, those that take a critical approach should realize that what is happening as a result of dualism and the illusion of BMI as a neutral, unbiased measure creates symbolic violence. Symbolic violence is a much more dangerous implication than previously

suggested by regarding it as simply a labeling problem. With the ontological status of powerful, autonomous, and active, society appears to be capable of acting without human consent, action, or interruption involved. In other words, society appears capable of doing whatever society wants to do at any time, regardless of humans. Through this perspective, the obesity “epidemic” (mainly in the last two decades) has maintained a similar ontological status as the social. In other words, the “epidemic” has maintained the status of something that continues to occur despite human action. The obesity epidemic has been seen to persecute those who are considered “obese” and those who are at a high risk for “obesity”. So, it appears that society or better yet, the obesity epidemic is discriminating based on size without anyone (any human) actually being a part of the discrimination. Symbolic violence is the most dangerous type of violence, perhaps, because if a person or a group of people wants to confront the discrimination, it appears as if those people are facing “society” or the “epidemic,” instead of confronting actual people. This is how symbolic violence is much worse than simply being labeled “fat” or “obese”. Also, one may see his or herself as deserving of being discriminated against, if he or she also views BMI or weight as objective, neutral measures. In this case, the individual sees BMI and weight as legitimate measures and can rationalize the reasons why he or she faces weight-based discrimination.

### Embodiment

Studying the experiences of a lived body describes something completely different from studying the experiences of a biological body. Using Gabe et al.’s (2004) definition of embodiment, embodiment refers to “the lived body; our body being-in-the world, as the site of meaning, experience and expression” (Gabe et al. 2004:73). It is the

experience of the whole body in the world, referring to the entire being of the person as experienced by the person. The term “embodiment” describes the process that the object-body is actively experienced, produced, sustained, and/or transformed as a subject-body (Waskul and Vannini 2006: 3).

Although over the past two decades, embodiment has gained much attention in social contemporary theory, many of these writers argue that the body has always been at the heart of sociology. Drawing from many themes in social psychology, embodiment “must be understood as a form of reflexivity” (Waskul and Vannini 2006:5). When we look at the bodies of others, we interpret what we observe and others interpret what we may be seeing. It is not a reflection of what others see, but it is an imagined reflection (Waskul and Vannini 2006) or an imagined judgment and our feelings once we imagine another’s judgment (Charmaz and Rosenfeld 2006: 36). Although we can never know the exact judgment others make of us, the imagined judgment can evoke very strong emotions (Charmaz and Rosenfeld 2006). Monaghan (2006) explain that people make these judgments based on “comparative images and normative standards”, where some bodies are more “acceptable” or “appropriate” and according to Western biomedical definitions, fatness equals “bad” or “sick.”

Charmaz and Rosenfeld (2006) provide an example of how this process of reflexivity unfolds. In an interview with a participant, Charmaz explains that the woman felt others were judging her and her weight as the incapability to control her appetite, although she shared that since being in a wheelchair, she barely ate anything at all (Charmaz and Rosenfeld 2006: 39). Using Charmaz and Rosenfeld’s (2006) terms, this process relies on language and meaning, which makes it a social and subjective process.

Monaghan (2006) explains that bodies are embodied and active bodies constantly engage with other bodies, which constitutes shared meanings of bodies” (Monaghan 2006: 126).

### Phenomenology & the “Life-World”

The beginning stages of ‘doing’ phenomenology involves getting to know the context of the phenomenon and ensuring that the phenomenon being studied stays close to its context (Spiegelberg 1960). The investigator’s responsibility in qualitative research is to “combine advocacy with accuracy; that is, telling the truth about how particular sets of people live their lives,” (Erickson 2010: 112) which in phenomenology, is to tell the story within the context it comes from or the context in which it is experienced. In other words, the phenomenologist recognizes individual experience and attempts to explore another’s world as it is seen and understood by the individual. Exploring another’s world, however, does not assume that the researcher is capable of getting a “birds-eye view” or an objective look into a person’s world. Phenomenologists reject the ability to see the world as objective, because phenomenologists believe that the researcher’s mind is always active, and is incapable of becoming passive. Phenomenologists believe that perception is reality, meaning that how the individual experiences something is in fact, understood as what is real.

Phenomenologists use the concept, “life-world,” to describe a world that is a lived-one, an embodied, subjective, and inter-connected world. In the life-world, a person engages with others and finds others who are similar to them (Schutz and Luckmann 1973:3-5). Now, dualism is passé, and the mind and the body are understood as one. The mind and the body are connected to others in an active world. An active world means that

nothing is divorced from human action or contingency. Every human action is connected with others because even when an individual is physically alone, they are never alone in the life-world. The life-world is made-up of people who interact and act together. There is nothing that takes the ontological status of something larger or autonomous because everything in the life-world happens through human action.

Further, the life-world is one's fundamental and paramount reality (Schutz and Luckmann 1973: 3). It is not a private world but one that is inter-subjective and shared. The life-world is one where "we are engaged in lived experiences and these experiences become meaningful. Once they are meaningful, past lived experiences are grasped reflectively" (Schutz and Luckmann 1973: 16). Therefore, one's life-world is understood as reality to phenomenologists. Body weight is the particular phenomenon in this project; therefore, body weight is studied in its context of the lived body in the participant's life-world. The focus of this project is on the lived experience of body weight in the world and the stories told by persons who are identified (by self and/or others) as obese or overweight.

To explain specifically how a phenomenological approach is used, I apply the following steps of the "phenomenological method" (Spiegelberg 1960:653-701) to studying the lived experience of body weight. Spiegelberg (1960) notes most phenomenologists have agreed on at least the first three steps in the phenomenological method, with a small group using the remaining four steps (Spiegelberg 1960: 659). The initial step of the phenomenological method is discovering particular phenomena, which requires an understanding of the context in which we are studying the phenomena. It also consists of phenomenological analyzing or exploring phenomena with the relations to and

connections with adjacent phenomena (Spiegelberg 1960:670). For example, in this project, body weight could be related to fatness, health, food, etc. These related phenomena are as important as body weight if they are experienced by the participants as inter-connected. This initial stage of the phenomenological method also warns that phenomenological description of phenomena is crucial. As Spiegelberg (1960) explains, those using a phenomenological approach are often ‘frustrated and perplexed’ when trying to find the proper description that reflects accuracy, a responsibility of social researchers. Using proper and accurate descriptions are important for phenomenologists because the “phenomenological description should serve as a reliable guide to the listener’s own actual or potential experience of the phenomena” (Spiegelberg 1960:673).

After the phenomena have been discovered, the next step is to explore the phenomena’s general essences. The term “general” does not refer to universals or a singular truth that can or should be applied to social life. In other words, there is no generalization here. Rather, this stage involves looking at the particulars. It is more of a reflection of what can be observed and connecting those particulars to the general phenomenon being studied (Spiegelberg 1960: 676). For example, the particulars in this study could be recollections of a past diet or how the participant was engaged in a certain activity growing up. It is the particulars that are what lived experience of body weight is made-up of. Whatever the particulars may be, it is the “pervading essence which is reflected in all of them (Spiegelberg 1960: 679)” that is the phenomenon of the lived body weight.

The third step is apprehending essential relationships. Apprehending essential relationships includes the discovery of not only the components of the phenomena being



studied, but, using Spiegelberg's (1960) terms, "the discovery of certain essential relationships or connections" (Spiegelberg 1960: 680). To see whether the phenomenon has an essential relationship with another phenomenon involves questioning whether the phenomenon being studied would be what it is without this other phenomenon. For example, in this project, a participant could discuss experiencing discrimination or stigma. The question then would be, if lived experience of body weight is the same without discrimination or stigma, an example of how to apprehend whether discrimination or stigma and lived body weight share an essential relationship.

### Chapter Summary

Critical approaches to obesity have provided an avenue to study obesity and body weight through a critical perspective. Previous critical approaches have questioned scientific "facts" and knowledge that have dominated what we know about obesity. However, previous critical approaches have not yet addressed the theoretical maneuver one must make when taking a critical approach to the study of obesity. Beyond critiquing previous work in obesity, those taking a critical approach have the opportunity to create an entire new way of studying body weight. If critical approaches continue to critique the theoretical underpinnings of the dominant approaches in obesity research without providing an alternative framework, critical approaches will be dismissed and forgotten in the array of the work being critiqued. Those taking a critical approach to the study of obesity have recognized the absence of lived experiences in health-promotion policies and practices, critiquing that an individualistic and behavioral approach fails to account for participants' local and relational worlds (ie: Warin, Turner, Moore, and Davies 2008).

However, the philosophical and theoretical basis that allows one access into a participant's world has not yet been described in critical approaches to obesity until now.

The chapter begins with a discussion of dualism as the starting point to understand what a critical approach is breaking away from. Intentionality and symbolic violence are the two major components that are missing from critical approaches to obesity. Symbolic violence is seen as much more harmful than size-based discrimination and stigma because of the illusion that a larger, autonomous society is making decisions that become the accepted standards to which everyone is expected to live by. This is why confronting discrimination and stigma can be seen as extremely overwhelming. Oppressed people are discouraged from facing discrimination because it seems as if they are facing an entire society, rather than (simply), other people. Symbolic violence is also different from "labeling" because labeling can be traced to another individual's actions.

The life-world is described as an active and engaged world where the mind and body are intertwined with everything they know. People are connected to others through their actions. In the life-world nothing is separate from human action and nothing takes the ontological status of something that is separated from human contingency. A brief discussion of embodiment describes how dualism is now passé since the mind and body are always connected to the world and to others. Finally, the first three steps of the phenomenological method is briefly described with examples on how phenomenology can be used to study body weight.

## CHAPTER THREE: METHODS AND DATA ANALYSIS

### Research Approach

Those in health research often use qualitative methods to explore meanings, study institutional and social practices and processes, examine certain barriers or facilitators to health, and to discover how an individual or group experiences a particular intervention (Starks and Trinidad 2007). For the current study, I used a phenomenological approach complemented with a grounded theory methodology. The approach in phenomenology is to study a group of individuals who share or experience a specific phenomenon. Phenomenology involves studying the “general essences” or the “particulars” of the phenomenon, to provide an accurate and detailed description of the phenomenon, to explore adjacent phenomena, and to apprehend essential relationships (Spielberg 1960). The purpose in phenomenology is to study the phenomenon in the context and the life-world in which it is experienced (Schutz and Luckmann 1973). The phenomenologist must enter another’s world and try to see the world as the individual does. The focus in phenomenology is more on the commonalities and similarities participants share rather than the differences (Creswell 2013).

Similarly, grounded theorists study a group of people who have experienced a similar process or experience. Grounded theorists move beyond exploring and describing a concept or phenomenon. Rather, grounded theory is aimed towards developing a theory grounded in real-life experiences that explains how a particular process or life-event fits into the lives of individuals. Grounded theory is rooted in symbolic interactionism that understands processes and meanings as constructed and negotiated through interaction

with others (Charmaz and Belgrave 2012; Starks and Trinidad 2007; Charmaz 2006). Further, grounded theorists develop theories that are based in the experiences of others and are shaped by the participants' perspectives (Creswell 2013). As in phenomenology, the goal is to describe the commonalities of a lived phenomenon; grounded theory requires an open-mind to the theoretical directions that may be taken at the later stages of data analysis (Charmaz 2006).

### Research Design

My data consist of fifteen in-depth interviews using a phenomenological approach complemented with a grounded theory methodology. The focus of the project is on the meanings and experiences of a lived phenomenon, in this case, body weight. However, grounded theory is appropriate because meanings are constructed by participants and their experiences with body weight. The goal in phenomenology is to understand the experience of another as close to how the individual lives the experience as possible, rather than seek some sort of generalization. Further, phenomenology is not concerned with the validity of experience; yet accepts the experience as its own separate unit of analysis (Creswell 2013). Grounded theory shares a similar approach. Charmaz (2006) explains that entering another's world and studying it does not mean that the researcher is able to see it exactly the way the participant does. Rather, the researcher's goal is to see the world as close to the participant's perspective as possible (Charmaz 2006).

I chose in-depth interviewing, as it is often used as a way to explore multiple meanings of a particular phenomenon (Johnson and Rowlands 2012). Johnson and Rowlands (2012) explain that in-depth interviewing can be useful as a complimentary

method along-side other ways of collecting data. However, the authors clarify that the use of in-depth interviewing as the primary research method is appropriate when the researcher is interested in questions that require a deeper understanding than other methods may offer. An example of in-depth interviewing as the appropriate primary research method is when the phenomenon being studied is often taken for granted or when those involved in a similar process experience it differently (Johnson and Rowlands 2012). Charmaz (2006) notes that in-depth (or intensive) interviewing is a negotiated process and should be placed in the context of the participants' experiences. She explains that the process of intensive interviewing "goes beneath the surface of an ordinary conversation" and allows for an in-depth search of a particular topic (Charmaz 2006: 25-27).

Frequently, in-depth interviewing allows the interviewer to gain "deep" understandings of how a set of people experience a particular phenomenon, especially if the interviewer is an outsider to the community. Although I have struggled with my body weight for as long as I can remember, I understand that my experiences with body weight may differ from others. Johnson and Rowlands (2012) explain that researchers who are former or returning members of the community sometimes use in-depth interviewing to investigate how their own experiences are similar to and different from others. Therefore, this type of inquiry involves much more than a self-reflection of my own personal experiences. Johnson and Rowlands (2012) also discuss the issues a researcher may face if she is a member of the community she is studying. The authors conclude that as long as the researcher is aware of potential issues before and during the interview process, the researcher can understand how her personal experiences have the possibility to influence

her inquiry. Yet whether the researcher has been a member of the community she is studying or not, in-depth interviewing “involves an interactive process in which the interviewer and the informant draw on and use their commonsense knowledge to create some intelligible sense of the questions posed and the ensuing discussions about them” (Johnson and Rowlands 2012).

### Sampling and Recruiting

This project grew out of and builds on a previous, small-scale project. For that work, I conducted in-depth interviews with four African American women about meanings given to physical activity. Based on previous literature that labeled African Americans as a “sedentary” population (eg. Sadler and Huff 2007; Siegel et al. 1995), I began wondering what physical activity meant for African American women. In reviewing the literature on African American women as an “inactive population,” I immediately noticed that researchers reporting low levels of physical activity among this group had unique definitions of physical activity that probably differed from those of African American women. For example, Duelberg (1992) asked participants how frequently they participated in any of a list of activities in the past two weeks. The choices were: walking, jogging, hiking, gardening, aerobics, dancing, calisthenics, golf, tennis, bowling, biking, swimming, yoga, weight-lifting, basketball, baseball, football, soccer, volleyball, handball, squash, skating, or skiing (Duelberg 1992, pp. 193). I knew that a deeper understanding into the meanings given to physical activity by African American women was needed. I submitted a research protocol to the Institutional Review Board (IRB) to conduct four in-depth interviews with African American women in South

Miami on the meanings given to physical activity. I received IRB approval and recruited participants through personal references and pre-approved flyers.

After the first interview, I transcribed and began giving initial codes to the data. I noticed that the meanings given to physical activity seemed to be coming from a concern about body weight. I then moved onto the next interview, and after transcribing and assigning initial codes, I noticed that the second participant gave meanings to physical activity that seemed as a means to lose weight the “right way.” Through the use of phenomenology and grounded theory, I found that meanings of physical activity were related and connected to the participants’ bodies and body weight. Most of the women were concerned about their weight as being considered “overweight” by medical standards. Their healthcare providers had advised them to begin exercising because their weight was harmful and a threat to their health. Some participants discussed how unique barriers to physical activity made it difficult for them to lose weight. All four participants gave meanings to physical activity that were grounded in their concern over body weight. Three out of the four participants viewed their body weight as an issue.

Since I had interviewed only four women, I questioned if similar meanings were shared by others. Theoretical sampling is the process in which the researcher seeks to “further develop a theory,” (Charmaz and Belgrave 2012:358) where possible categories and their properties are discovered allowing for tentative categories to be further explored (Glaser and Strauss 1967; Charmaz 2006). The small project allowed me to revisit my research questions and helped me create the current project. Using theoretical sampling, I expanded my sample to include all women, not just those who identified as African

American. I revisited my interview questions and altered them to fit the objectives of the current project.

In order to understand how labels of body weight influence the self-identity process, the criterion to participate in this study was that the participant must be considered “overweight”, “obese”, and/or “morbidly obese” by medical standards. Recruiting participants that met these criteria was certainly not difficult, considering that over 65% of adults in the United States are considered “overweight” and about 35% are considered “obese” by medical standards (CDC 2012). Since the goal for the number of interviews was between 15-20, I concluded that observing gender differences was beyond the scope of the current project. Therefore, I recruited only participants who self-identified as women. Exploring gender differences in a similar project lends an interesting objective for future research. However, how gender was perceived to influence the participants’ experiences in the current project was certainly discussed. The final requirement for participating was that the individual must be 18 years of age or older. Concerned with the ethics of social research in discussing topics that may be sensitive to some groups more than others, age restrictions seemed to warrant a more ethical approach in the study of body weight.

The process of recruiting participants involved contacting some personal references, network sampling, and recruiting through flyers. Participants who are considered “personal references” are those who had shared personal experiences with me prior to the creation of this project, but some of whom served as inspiration in guiding my research. Those participants who are a part of “network sampling” are individuals who had been referred by previous participants as potential participants. The remaining



participants were recruited through flyers and had contacted me after I posted flyers in two locations in South Miami (the South Miami Public Library and the metro-rail, Dadeland Station). The flyers included the goal for the research project, the approval stamp from the affiliated university's IRB, the criteria for participation, the incentive for participating, and my contact information. Noted on the flyers was that no medical examinations or tests would be required and those interested in participating should call for further details. Once the potential participant called, I answered any initial questions she had about the project and recalled the criteria for participation. The process of scheduling the interview was one that was a mutually agreed upon: location, time, and date were agreed on by both myself and the participant, however, I suggested places that were open to the public, and in a moderately quiet area to hold the interview.

### Location

Each in-depth interview took place in either Florida or New Jersey. Although both places were convenient for the researcher, they serve as interesting locations for studying body weight. Both Miami and Atlantic City are known for their nightlife, casinos, entertainment, beaches, and shopping districts, and serve as destination spots for travelers and tourists. The emphasis on body image and appearance is hard to ignore, with frequent celebrity appearances and the many "reality" television shows that have recently been based out of Miami and South Jersey.

Most interviews were located in local coffee shops and bookstores. A few interviews were held at the participant's place of residence, and one took place on a bench on the Atlantic City boardwalk. I began each interview with a brief introduction

(for those who I had never met before) and small-talk with those who were personal references. After, I read the oral consent form explaining the objectives of the study, the incentive for participating, and a brief overview of what to expect during the interview. Each participant was given contact information for me, the faculty member who was advising the research project, and the Human Subjects Research Office of the affiliated institution. I explained that participation in the interview served as consent and that with permission, the interview would be audio-taped. I gave each participant the option of not having the interview audio-recorded and explained that pseudonyms would be given to them in order to protect their identity. I explained that all audio-tapes would be immediately destroyed following transcription of the interview onto my personal computer. Before continuing on with the interview process, I answered any initial questions that the participant had.

I brought an interview guide to each interview to make sure I covered all topics of interest. The interview guide included open-ended questions. The interview guide was useful in some of the interviews but most of the time the participants discussed topics that I never thought of asking. The interview guide was not for the purpose of a strictly rigid or structured interview, in fact, the questions changed throughout the interview process depending on what the participant shared. Charmaz (2006) suggests for the researcher to be open about where the discussion may go depending on what the participant has disclosed. She also notes that it is important for the interviewer to pick-up on cues from the participant during the interview to help formulate further questions (Charmaz 2006). About 20-30 questions were asked during each interview that lasted anywhere from 45

minutes to two and a half hours long. At the closing of each interview, the participant received \$10.00 from the researcher which was the incentive for participating.

### Participants

A total of fifteen women participated in a one-on-one interview with the primary researcher: three interviews are from the previous project on physical activity and the twelve remaining participants were sampled for the current project. Although participants were interviewed in either South Jersey or South Florida, participants resided in either state or in New York or Philadelphia. The age of the participants ranged from twenty-four to seventy-six years old. The participants are a racially and ethnically diverse group of women; four of the women self-identified as Black or African American, three as Puerto Rican, three as Italian, and the remaining participants self-identified as White. Of the fifteen women, two had worked for most of their lives and are currently retired. Two of the participants work part-time and eleven are currently working full-time; four of these are enrolled in school. Among the remaining full-time workers are a United States Military Officer, managers and beauty advisors for a well-known cosmetic company, an ultrasound technician and one who works for a local fashion magazine. Of the fifteen participants, nine are mothers; two of them are also grandmothers. All had given birth to their child(ren) except for one mother who shared her experience of adopting. Five of the women are currently married, nine are either dating or currently single, and one is widowed. I created miniature biographies (see Table 1 below) for each participant, including her age and weight label as “overweight,” “obese,” or “morbidly obese.” Other unique characteristics are included. The miniature biographies serve as a way to help readers keep track of “who’s who” throughout the remainder of the paper.

Table 1—Participant Biographies

Participant Pseudonym	Mini-Biography
Heather	Heather is a middle-aged (56 yrs.) mother who is considered “at least” overweight, if not obese. She was always really thin until her hysterectomy, which has been part of her experience with weight-gain. Her gynecologist, oncologist, and primary care physician have all told her that she needs to lose weight. She is not really offended by her doctors telling her to lose weight, and she attributes not being insulted to her age. Heather has diabetes mellities, high blood sugar, and takes medicine for her elevated cholesterol.
Lola	Lola is a 60-year old mother of three who came to the United States from Puerto Rico when she was young. She was always “petite” until she gave birth to her twins. Now, over 20 years later, Lola is considered “overweight” and has recently been losing weight. She attributes her weight gain to her depression that she experienced after she gave birth to her twins. Lola was apathetic about her appearance and her weight until her doctor told her that she needed to lose weight to manage her diabetes mellities and high-blood pressure.
Allisha	Allisha is a 48-year old mother who is currently considered “overweight.” Allisha has struggled with weight since she was a child and resisted going to high-school proms and other events. After her doctor told her she was “obese,” and borderline Type II diabetic, Allisha began the South Beach diet and continues to try and lose weight.
Chrissy	Chrissy is a young (28 yrs) woman who has a two-year old son. She is displeased with her body, which she describes as “disproportionate.” After being teased for her weight for most of her life, Chrissy has lost a lot of weight. She is currently considered “overweight” but is no longer labeled as “obese.” She experienced shortness of breath and fatigue, which made her want to lose weight.
Jennifer	Jennifer is a young (26 yrs) woman who is still considered “overweight” after recently losing ten pounds. She constantly compares herself to her friends who are all thinner than her, but has always been smaller than her sister. After moving out of her parents’ house, Jennifer has started to eat differently. Her friends have noticed her recent weight-loss and make comments about how good she looks. Jennifer feels good but would like to lose 15 more

	lbs.
Kathryn	Kathryn is in her 40s and no longer works outside of the home. She is a single mother of three young children. Motherhood keeps her busy and taking care of the children and herself are her top priorities. Although she keeps busy, she doesn't set aside time to exercise. She finds that others place too much importance on "looking good."
Stephanie	Stephanie is a young (24 yrs) woman who is in the Army Reserves. She is currently "overweight" by Army standards and is concerned about her recent weight gain. Stephanie attributes her weight gain to depression and not being as active as she used to be since she entered into the Reserves. She knows that there will be unwanted consequences if she doesn't make "height and weight" during her next Battle Assembly.
Olivia	Olivia is a 30 yr. old woman who is currently happy with her weight. She is now considered "overweight" but explains that she has jumped back and forth from being "obese" to "overweight." Olivia doesn't consider herself overweight and is more concerned with doing things that she enjoys, rather than being stressed about her weight. She and her sister have tried numerous "fad" diets in the past, which she describes as being unpleasant experiences.
Julia	Julia is in her late 40s and is a single mother of three. She is considered "overweight" but is currently trying to lose weight to fit into her old clothes. Most of Julia's family are obese which keeps her motivated to lose weight. Her job consists of long-days standing on her feet and moving boxes around, which she finds more difficult to do with her current weight.
Mikayla	Mikayla is a young (26 yrs) woman who recently lost 20lbs following surgery. She is currently considered "obese" but is happy because it is the closest she's been to being considered just "overweight" in years. Mikayla considers herself as a healthy person overall and does not feel "obese." She was bullied because of her weight as a child and has learned how to dress her body-type.
Cassidy	Cassidy is in her mid 20's and was recently told by her doctor that she is currently "overweight." She has struggled with her weight in the past, by drinking and smoking to suppress her appetite. Although Cassidy liked the way she looked when she was thinner, she felt unhealthy and considered her behaviors as "dangerous." She is working with her counselor and her nutritionist to come up with a plan to lose weight the "healthy way."

Anne	Anne is a 76-year old woman is currently enjoying retirement. She used to smoke three packs of cigarettes a day and after quitting, she quickly began to gain weight. She is now considered “overweight” and has diabetes. Anne has arthritis, which makes it hard for her to follow her doctor’s recommendations regarding exercise and weight-loss.
Renee	Renee is a young (24 yrs) woman who is considered “overweight” but thinks of herself as being healthy, overall. She used to be involved with sports growing up, but since she has began her music career, she restrains from any activities that may cause injury. Her mom pushes her to eat “healthier” to prevent any medical conditions at a young age.
Nicole	Nicole is in her early 40s and is a mother of 3. She is considered “overweight” although she has recently lost weight. Nicole works full-time and often finds it difficult to exercise once she gets home from work. She is originally from Jamaica. Although she is happy with her recent weight-loss, she currently is trying to lose more weight.
Trisha	Trisha is a middle-aged (50 yrs) woman who is considered “morbidly obese.” A year ago, she was diagnosed with Rheumatoid arthritis, which has contributed, to her rapid weight gain. Trisha is scheduled for bariatric sleeve surgery and is currently in a weight-management program to prepare her for surgery and post-surgery. She must maintain a BMI of at least 40kg/m <sup>2</sup> to qualify for bariatric sleeve surgery and is working on maintaining her current weight.

### Analysis

Following each interview, I transcribed the interview verbatim on my personal computer. Pseudonyms were assigned to each participant as well as any other names or revealing titles that were shared during the interview, such as a child’s name or places of employment. After transcribing the interview, the audio-tape was immediately destroyed. I took notes on any initial thoughts and feelings that I experienced throughout and after the interview. I reviewed each transcription for three to eight hours, providing initial, temporary codes and memos to the data before moving onto the next interview. Data

analysis is not a neutral or objective process. Charmaz and Belgrave (2012) discuss a constructivist approach to grounded theory and how it differs from objectivist and postpositive approaches (Charmaz and Belgrave 2012). The authors describe the constructivist approach as a way to study the experiences of the participants as close to the participants' perspective as possible. Opposed to an objectivist perspective that views the data collection process as a neutral and objective one, Charmaz and Belgrave's (2012) approach assumes that the data "reflect mutual constructions" between the researcher and the participant (Charmaz and Belgrave 2012: 355).

The initial codes did not simply "emerge" from the data. Codes reflect what the researcher's interests are as well as the information that the participant has shared (Charmaz and Belgrave 2012: 355). Following Charmaz (2006), I defined initial codes in an attempt to make preliminary sense of the data and to begin thinking about what the data meant. Initial codes were constructed by reading each transcription carefully, line by line. Further, Charmaz (2006) explains that initial coding requires the researcher to have an "open-mind" to any theoretical direction that will later be developed. As Charmaz (2006) recommends, I also began to code my data as actions, which helps to "curb our tendencies of making theoretical leaps" (Charmaz 2006: 48). Along with initial codes, I wrote down my thoughts, questions, and ideas that came up while I was coding. I kept these memos in a distinct color, so that these thoughts were not immersed in the actual codes, but were useful in reminding me what I was thinking while coding the data. Writing memos also helps to reject any preconceived categories while coding (Charmaz, 2006) and can assist later on in the analysis process to raise codes to "tentative conceptual categories" (Charmaz and Belgrave 2012: 357).

After I assigned initial codes and memos to the data, I re-read through the transcription to start constructing more focused or selective codes. I used the most significant codes, which I based off of the emphasis given to meanings by the participants, to begin sorting and organizing bigger sections of data. Focused coding is when the researcher begins to make decisions as to what initial codes seem more significant or frequent than others (Charmaz 2006: 58). After assigning initial codes, memos, and some focused codes to the data, I was then ready to move onto the next interview. After a few interviews, I was able to start finding similarities and differences in the focused codes from each interview. Through this process, I began noting possible subcategories or “properties” of the categories that exemplified different perspectives of a category (Creswell 2013: 195). I continued to simultaneously collect and analyze data.

Simultaneously collecting and analyzing data allowed me to pay close attention to each interview and the categories that I was beginning to develop from the data. Although an interview guide was present throughout each interview, the result of simultaneous data collection and analysis is sometimes going places that were never anticipated and thinking about new research questions (Charmaz 2006). For example, I began the first few interviews asking the participant’s BMI and weight label, followed by the following question, “Could you tell me about the first time that you or someone else thought you were fat?” After coding the first interview and then the second, I realized that participants were immediately pressured to think of the earliest memory of being “overweight.” I noticed that it seemed difficult for the participant to think of the first or earliest memory, and I was getting short responses such as “1<sup>st</sup> grade” or “when I was 13 yrs. old.” So for the next interview, I changed the question to, “Could you share with me



your experiences of weight, beginning with a past memory?” I kept this question for the remainder of the interviews, since the participants seemed to really open up about their past. Regardless of what approach one takes in grounded theory, simultaneous data collection and analysis is a practice that is agreed upon and used by all grounded theorists (Charmaz and Belgrave 2012: 348). As Charmaz (2006) explains, we [researchers] are a part of the worlds we study and therefore, we construct grounded theories. Grounded theory allows the researcher to develop theories that are grounded in rich data that we “get at” from studying social and subjective life. Theories do not simply appear or emerge; yet, we construct grounded theory once we have gathered rich data (Charmaz, 2006: 2-31).

### Chapter Summary

Through the use of phenomenology and grounded theory, I interviewed 15 women about the meanings given to body weight. Although phenomenology seeks to describe the common experiences of a concept or phenomenon, grounded theory moves past a description of the phenomenon and aims to develop a theory that is grounded in real-life experiences. Both phenomenology and grounded theory seek to view the world as seen as close to the participant’s perspective as possible. Phenomenology and grounded theory recognize that getting an exact view of another’s world is impossible; however, studying the participant’s experience in the context that it comes from is necessary in both approaches. In-depth interviews were chosen as the method to collect data and seemed most appropriate in addressing the research questions. In-depth interviewing is useful when trying to understand multiple perspectives or experiences of a similar process.

A previous project on the meanings given to physical activity among African American women led me to create the current project. After four in-depth interviews, I questioned whether others had similar experiences. I revisited my research questions and made changes to the previous project in the creation of the current project. All changes were approved through the affiliated institution's IRB. Through the use of theoretical sampling, I broadened the sample to include women (18 yrs. +) of all races and ethnicities, not just those who identified as African American. All participants are considered "overweight," "obese," or "morbidly obese" by medical standards. I recruited participants through personal references, network sampling, and flyers that were pre-approved by the IRB. The flyers included the objectives of the current study, the incentive for participating, my contact information, and the approval stamp from the IRB. Flyers were posted in two locations in South Miami. All interviews were held in either New Jersey or Florida, out of convenience for the researcher, but also because both sites were interesting places in studying body weight. I read the oral consent form to the participant that was pre-approved from the IRB and with permission, audio-recorded the interviews. Interviews lasted anywhere from 45 minutes to two and a half hours long. I asked 20-30 questions, some from an interview guide that was brought to each interview. Other questions were developed during the interview by recognizing cues to probe further questions.

Following each interview, I transcribed the interview verbatim on my personal computer and destroyed the audio-tapes. I assigned pseudonyms to each participant in order to prevent their true identity from being revealed. I read through the interview over and over, assigning initial, temporary codes and memos to the data. I identified codes that

seemed significant and developed focus codes before moving onto the next interview. After a few interviews, I created categories by comparing the data and noting possible subcategories. By simultaneously collecting and analyzing data, I was able to develop new interview questions, improve analytic categories, and to pay close attention to the data. I started making connections and organizing the data to understand what it all meant.

## CHAPTER FOUR: FINDINGS

### Findings

Findings address the following: 1) How those who have been labeled (by others and/or self) as “overweight” and “obese” experience these labels and their bodies 2) The ways in which being considered “overweight” and “obese” fit into the lives of the participants 3) The struggles the participants face and how they deal with these struggles and 4) How participants define themselves and what they think of weight being a part of their identity. Some examples of initial codes are provided in Figure 1 (see below). For example, some participants shared how they were embarrassed to see old friends and family. I created the initial code “embarrassed to see friends/family.” Allisha explains the way she felt when recently saw an old boyfriend. She shares:

Just because I was so heavy because I was embarrassed  
the worst was when I was at a wings game and I was married...  
Greg was with me, Lucas was with me... and I saw an  
old boyfriend and I was totally embarrassed.  
I got so red. Like if I were shopping and I would see somebody  
I knew I would probably avoid them.  
I didn't go to my 25<sup>th</sup> reunion because I was heavy (Allisha).

Allisha wasn't the only participant to share feelings of embarrassment. Another participant, Cassidy, shared that she wouldn't eat for three weeks prior to visiting her family in another state. She shared that if she doesn't “fast” before going home, she feels embarrassed in front of her parents about the way she looks because they often make comments about her weight.

Most participants recalled accounts of being harassed and teased for their weight. For example, Chrissy shares her experience in grade school:

Uh.. all the kids in grade school when I was in 6<sup>th</sup> grade....  
 My mom had to call the teacher. I was called 'fat girl'.  
 They had me crying... All of them. It was horrible (Chrissy).

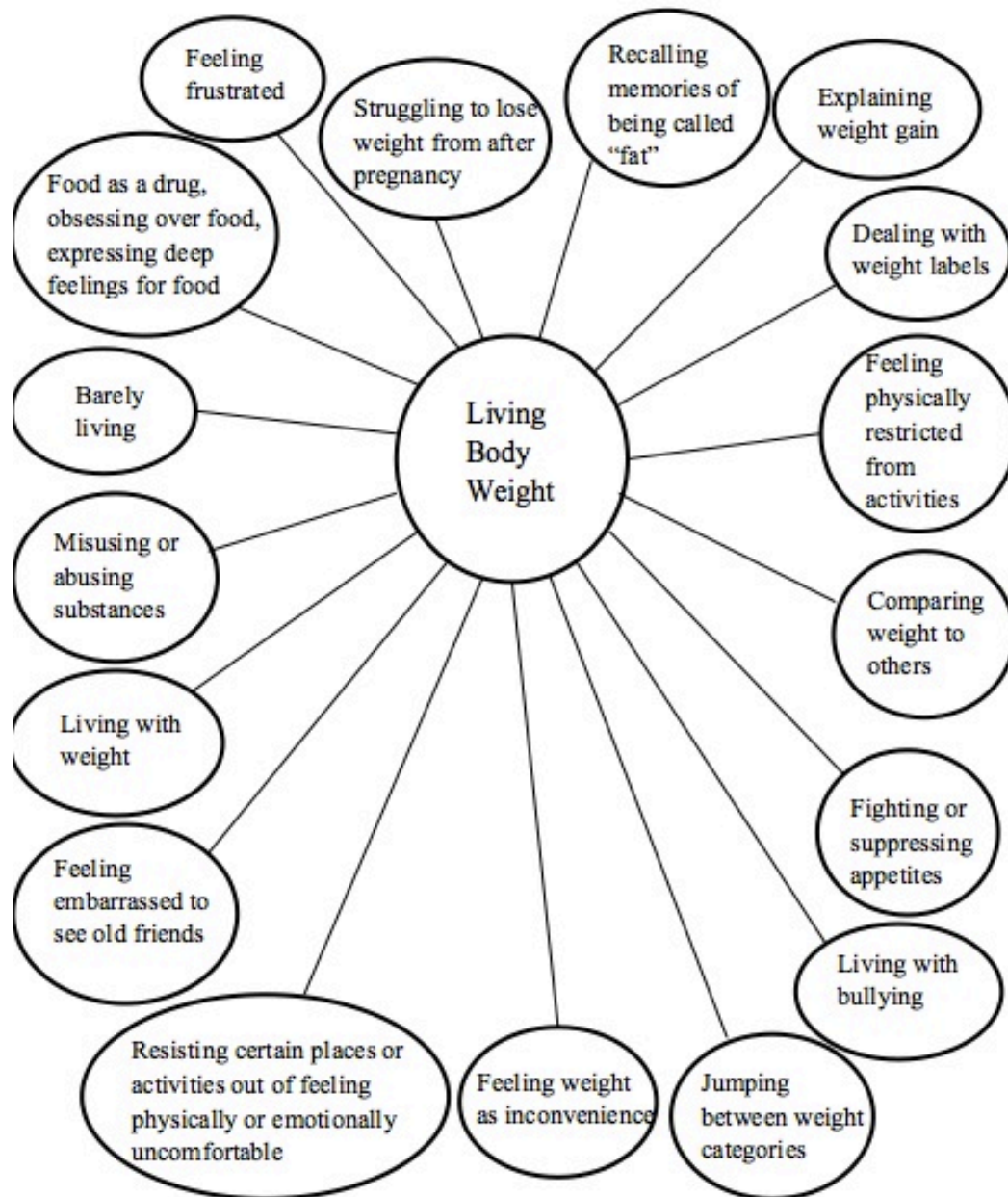
Other participants shared stories of bullying, including the hurtful names and jokes made about their weight. Participants were able to recall the bully's full name and recite exact words that were said. I initially coded these as "living with bullying" and "recalling being called fat."

Many participants gave explanations for their weight gain. As these explanations did vary by participant, I initially coded these as "explaining weight gain." For example, Trisha shared that since being diagnosed with Rheumatoid Arthritis (RA) last year, she has gained over 50lbs., which she discusses as common among women with RA. She explains:

Well when I was diagnosed with Rheumatoid disease  
 I started on a medication called Metha-trexie which is a  
 chemotherapy drug. Very commonly known when women,  
 not just women, some men, but mostly women that  
 start metha-trexia will gain anywhere from 50-100lbs (Trisha).

Other participants shared different reasons for their weight gain including their love for food, depression, pregnancy, recovering from an eating disorder, and quitting smoking up to three packs of cigarettes a day. I assigned these initially as "explaining weight gain." Other examples of initial codes are below.

Figure 1 – Examples of Initial Codes



The initial codes were reassessed in the analytic process later connected in more focused coding, and then used to define seven major analytic themes. I defined seven themes: response to labels, meanings of body weight, perceived restrictions, overt bullying and discrimination, meanings of food, appetite control, and pregnancy and childcare. I provide descriptions for each of the seven themes in Table 2 below.

Table 2—Themes and Theme Descriptions

Theme Name	Description of Theme and Codes
A) Response to Labels	Accepting or rejecting label as “overweight,” “obese,” and “morbidly obese,” label exaggerates, fits, or undermines self-perceived of body image and weight, frequently jumping between weight categories, living with weight diagnosis, accepting or rejecting BMI as a valid indicator of overall “health,” comparing those who are a larger or smaller size, describing body types, self-assessing how they look to others
B) Meanings of Body Weight	Emphasizing the degree of which weight affects their life, emphasizing the degree to which weight affects their self-image, constantly struggling with body weight, finding weight to be a problem, issue, inconvenience, frustration, rollercoaster (yo-yo), obsessing over weight, viewing weight as a health problem, barely living, embarrassed by weight or recent weight gain, describing weight as unpleasant, undesirable, seeing current weight as an accomplishment from a previous weight
C) Perceived Restrictions	Feeling physically restricted from activities, seeing weight as a barrier, living with diagnoses and weight-related issues, believing they are incapable of doing certain things, choosing not to partake in certain activities because of weight, finding difficulty performing day-to-day tasks, feeling limited, resisting situations or places that they anticipate being physically and emotionally uncomfortable

D) Overt Bullying and Discrimination	Experiencing public bullying, torture, hurtful names, fat jokes, Recalling accounts of bullying, teasing, public embarrassment, living with bullying, remembering and recalling exact names of bullies, recalling exact statements or hurtful names, sharing how others have made them feel, calling people mean or rude, remembering the first time that their weight was seen as an issue to others
E) Meanings of Food	Feeling pleasure or satisfaction eating, thinking about food often, eating as a response to a specific emotion or feeling, describing food as a drug, feelings towards food, explaining relationships to and with food or eating, dieting, showing passion for food, comparing eating to smoking, drinking, or using drugs
F) Appetite Control	Telling past or current accounts of suppressing appetites, replacing food with other substances, misusing substance to lose or control weight, denying food, feeling hungry but not eating, resisting food, fighting temptations to eat or overeat, extreme dieting, drinking to forget about food, smoking cigarettes to curb hunger, seeing alcohol or cigarettes as a part of diet
G) Pregnancy and Childcare	Struggling with losing weight after pregnancy, excess weight gain during pregnancy, feeling depressed or apathetic after giving birth for long periods of time, recalling a more desirable weight before pregnancy, running around or chasing children as a part of physical activity or weight maintenance, feeling motherhood as influencing the food they eat, putting others needs before theirs, changing priorities after becoming a mother

Findings are presented around each one of the seven themes. Within each of the themes are subheadings. I reflect on previous literature to compare my findings with past studies on obesity and body weight and highlight the many differences. The first findings presented are those that reflect the participants' responses to labels of "overweight," "obese," and "morbidly obese."



### Response to Labels

Frequently there is conflict between an individual's weight category and their self-assessed weight status. In Flynn and Fitzgibbon's (1998) review of body image among women, they show consistent real differences between women's self-assessed weight and their current BMI category. The authors report major differences in the "attitudinal body images" highlighting the racial differences between Black and White females that have been found throughout the literature on overweight and obese women (Flynn and Fitzgibbon 1998: 14-20). Women who are considered "overweight" or "obese" by medical standards typically feel as though their weight category exaggerates their weight status or portrays their weight status accurately. Rarely do women feel that their weight category suppresses their weight status, although a few participants in this study did believe they were bigger than their ascribed weight category.

#### 1) Agree with Label

Participants also described their weight as compared to others who they perceived to be larger or smaller. Trisha is scheduled for bariatric sleeve surgery in a few months and has been participating in a weight-loss program to prepare her for surgery and post-surgery. Therefore, she is well aware of her current BMI and weight status since she has to keep a minimum BMI of  $40\text{kg}/\text{m}^2$  in order to be eligible for bariatric sleeve surgery. Trisha discussed her current BMI category as an accurate depiction of her current weight status although she expressed her weight as relative to others who share her BMI category but are larger:

“And I’m obese. That is what I am classified as is obese. I am actually classified as severely obese. [Um]... and although the average person that would look at me, you know because I am not the way... or, I may not look like one of those women or men that have huge, huge rolls of skin hanging, I am still obese” (Trisha).

## 2) Feel Label Exaggerates Weight

Unlike Trisha, Mikayla was conflicted with her ascribed weight label as “obese”, expressing that she feels as though she is just overweight. Mikayla also spoke about her weight as relative to others who she feels are larger and whose bodies better represent the label of “obese” than hers:

“Just because I don’t feel like I’m obese. When I think of myself and my body image I don’t think I’m obese. When I think of obese I think of people that are morbidly obese. And I don’t think I fit into that category... I view myself as being overweight, but not as being obese” (Mikayla).

Most participants, like Trisha and Mikayla, either believed that their ascribed weight label (“overweight”/“obese”/“morbidly/extremely obese”) accurately portrayed their current weight status or felt as if the label exaggerated their weight status. However, although very few participants shared that they felt their weight suppressed their current weight status, that is the experience for some.

### 3) Feel Label Underestimates

Julia felt as if she was even heavier than the amount that she saw on the scale when she weighed herself. Although she felt as if she were heavier than her weight, she was still unsatisfied with her current weight:

“I felt a little heavier... or a lot... I like, when I looked at the scale and then looked at me.. I could see it first of all and physically like doing things that were so easier before.. and it doesn't seem like there's a lot in 182lbs but I'm not used to bein that size. I was scared.. I couldn't believe it. I felt this weight on me and I felt like I was carryin it with me” (Julia).

Overall, participants were dissatisfied with their current weight status, both self-assessed and ascribed weight-label, which is consistent with the literature on women and self-image. Guilford-Davenport, Kumanyika, and Wilson (1993) found that most women who are considered normal, overweight, and severely overweight aspired to be anywhere from thirteen to sixty-two pounds less than their current weight status. Participants in this study expressed what their ideal body weight was, whether they were trying to lose weight or not. Fourteen out of the fifteen participants expressed an ideal body weight that was not in accordance with their current weight status.

### Meanings of Body Weight

Most obesity researchers assume that those who are labeled “overweight” and “obese” find their weight status as a major problem. While most participants expressed an ideal body weight different from their current weight status, participants shared different meanings that they give to body weight. A few

participants described their weight status as “life vs. death” placing much emphasis and urgency on their weight status as a problem for their health, social and practical matters, and their self-image. Other participants perceived their current weight status as mostly a concern to their health, discussing associated risks to being overweight and obese. Many participants saw their weight as a “constant struggle” or an “issue” for social, practical, or self-esteem reasons. However, a few women did not see their weight as an immediate concern or a problem, even if they had expressed dissatisfaction with their current weight.

#### 1) Weight as an Inconvenience

Cassidy, a young woman who suffered from an eating disorder and the abuse of laxatives and weight-loss pills, expressed her current weight status as an inconvenience:

“Sometimes I feel like I can’t wear certain things or it takes me a while to get ready for work in the morning... Like eventually I want to be at a place where I can run around without worrying how I look. I feel like by now I’ve adjusted to it, but it is like an inconvenience. Like not being able to wear certain things or feeling uncomfortable in certain places. It’s inconvenient to have to plan things out in advance and work around like how am I going to feel if I go” (Cassidy).

Many participants, like Cassidy, expressed how wearing certain clothes or going places were among the many challenges they face on a daily basis. However, for a few participants, their weight status meant more than an inconvenience.

## 2) Life or Death

When I asked Trisha, the woman who is scheduled for bariatric sleeve surgery in a few months, what she is looking forward to doing after her surgery, she explained how currently right now, she is barely living:

“Well.. um... I’m barely living. Living first....And to be able to look in the mirror and feel comfortable at the person that is looking back at me... Dating. I haven’t dated because I am so unhappy with myself and I have no self confidence that dating has not even been something that I have thought about because you need to have confidence to date and I don’t have it so I am looking forward to dating” (Trisha).

## 3) Health

Unlike Trisha, a few participants strictly saw their weight as a concern to their health. Lola described her lethargic attitude towards her body image and shared how her depression made her not care about the way she looked. However, when her doctor warned her about the dangers of her “full-blown” type II diabetes mellities and her high blood pressure, she decided to try and lose weight. Lola explains:

“...when I went to the new doctor at Cleveland clinic he told me that I needed to help him manage my diabetes and I was getting into high blood pressure and I really did not want to take high blood pressure medication. So after my thyroid went bad, I said I gotta stop, I gotta stop” (Lola).

#### 4) Not all that Important

Other participants did not see their weight status as being an issue or a problem for any reason at all. Kathryn, a single mother of three emphasized the importance of being a “good person” rather than looking good. Kathryn discussed:

“The important thing is to be a good person. That’s all we gotta do, you know. And god willing we will all be healthy. I want to be around for my kids as long as I can.. that’s the important stuff. Not how you look” (Kathryn)”

#### 5) Job

For one participant, Stephanie, being overweight as a soldier in the Army meant not being deployable. Stephanie explained that those who are temporarily overweight face serious consequences in their unit because it means that they are on hold until they can be seen as deployable to their unit again. She shared:

“My commander um, he’s relatively new he’s pretty new and firm on the belief that every soldier needs to be physically fit because that is a huge determination if you are gonna be deployment ready. You always need to be deployable as a soldier in the reserves, at any given day, so if you don’t pass your height and weight, you don’t pass your PT test, you don’t pass any of those basic standards for a soldier, you get flagged. If you miss it more than three times or if you don’t make any improvements after three times of getting weighed, he discharges you from the military. Which is pretty severe because before all these budget cuts, they were keeping everybody” (Stephanie).

The participants shared similar meanings of body weight as the ones that have been discussed. Additionally, others described their body weight as an

embarrassment, an accomplishment [two women who are in the process of losing weight], a constant struggle, an obsession, and a rollercoaster or ‘yo-yo.’

### Perceived Restrictions

Those who have been labeled as “overweight” and “obese” are either physically restricted from everyday activities or feel as if they are limited in the variety of activities in which they can participate in. Schafer and Ferraro (2011) discuss how perceived discrimination and weight-based stigma can affect the health and social positions of many overweight individuals. The authors explain, “Interpretive self-identity processes are borne out of social interactions. . . . and that interpretative processes associated with body weight shape identity and health outcomes” (Schafer and Ferraro 2011: 77).

Participants shared a range of day-to-day tasks that are difficult, if not impossible to do. Many women explained how getting out of bed and getting ready for work in the morning is difficult because of their current weight status. Everyday tasks that participants felt limited in included shaving legs, showering, walking the dog, getting in and out of a car, finding clothes to wear, playing with young children, and blow-drying hair.

#### 1) Harder to Do

Many participants shared similar difficulties in everyday tasks. Julia shared her difficulties getting ready for work and making it through the workday:

...Just no energy wakin up with like minutes to spare to go into work cause I’m just like so just.... I am

just slow, sluggish and tired. You know with work and at work we gotta move a lot of boxes and lifting and I just move so much slower and I would lean on the counter and [gasps.. out of breath noises]. (Julia)

Although many participants found everyday tasks to be difficult or impossible, participants stressed specific activities that are possible, yet uncomfortable. Specific activities that were found uncomfortable for participants included going to the beach or a pool, wearing revealing clothes or dressing “sexy,” attending work-out classes with a group, playing sports, running, fitting into a movie theater seat, hiking, flying on a plane, dating, and seeing old friends. Allisha, a fifty-year old mother of one shared how her weight embarrassed her when she tried to do certain things. She explains:

“I could tell you getting out of the back seat of a two door car I could tell you that I could barely get out of a two door sedan. I would think that whenever I was walking around the room I was always bumpin’ into somebody” (Allisha).

## 2) Fear of Being Judged

Olivia, a thirty-two year old woman whose BMI frequently changes from being considered “overweight” to “obese” and back again, described her fear of getting a massage:

“So I was terrified to go get a massage because I was like, “They’re going to touch me and they’re going to judge me.” And one of my friends was like, ‘They’ve seen worse than you!’ ....So I scheduled a massage.. I have an upcoming massage” (Olivia).



Similar findings have been found and supported in previous work on obesity stigma. Lewis et al. (2011) explore how obese individuals perceive and respond to obesity stigma in everyday situations. Inspired by the works of Link and Phelan (1995; 2001), Lewis et al. (2011) define three types of obesity stigma: direct stigma (ie: being teased for weight), environmental stigma (ie: not fitting into a seat on an airplane), and indirect stigma (ie: fearing public humiliation). Although mostly all participants in the current study shared experiencing at least one out of the three types of obesity stigma outlined by Lewis et al. (2011), some everyday tasks were perceived as physically impossible to do. However, the tasks perceived as physically impossible (ie: shaving) and other activities found physically difficult (ie: playing with children) have not been previously accounted for in research regarding obesity stigma.

#### Overt Bullying and Discrimination

The lingering effects of obesity stigma have been explored and shown to be harmful to the self-concept (Mustillo, Hendrix, and Schafer 2012). According to the authors, the effects of obesity stigma are particularly harmful for young girls because the effects “linger” into early adulthood. Most participants in the current study have shared how “direct obesity stigma” (using Lewis et al. types of stigma) has lingering effects for their self-esteem. Trisha shared:

“The pre-judgments that are placed onto overweight people are very harsh. Um, and I experience for the first time myself, this past year because I was with two other women who are probably about 100lbs

heavier than I am, each of them, and we were going out to get something to eat. And we happened to be at a place that was almost like a buffet. I was in Punta Cana on vacation. And I heard a gentleman say when we walked by, “That’s it ladies, Go ahead. Go fill your plates and he made like an oinking sound” (Trisha).

Mikayla expressed still being uncomfortable wearing shorts because of the way she was bullied as a child including harsh names such as “fat cow.” Mikayla explained:

“...and I remember ... this is why I don’t wear shorts... when I was in elementary school and I was wearing shorts and I sat down and like... I don’t know how to describe it but you know when you’re thighs like .... Like you sit down and they kind of spread out? Well I was sitting next to a skinny girl and she was like, ‘You have really big thighs.’ Yeah. That’s also why I’m really self-conscious about not standing wearing shorts but sitting wearing shorts. I don’t even think I own a pair of shorts” (Mikayla).

### Meanings of Food

Overeating as a behavior among overweight and obese individuals has been studied in psychological literature on obesity and health. Addiction to highly processed foods has been added in the *Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition (DSM-IV-TR)* and is referred to as “food addiction,” a new diagnosis whose criteria is similar to other substance dependence diagnoses (Gearhardt et al. 2012).

However, obesity stigma, as mentioned before can affect the self-esteem, social positioning, and health of an individual. Therefore, being shamed or feeling

humiliated to go out to eat or eat in public may be mistaken and diagnosed as “binge eating,” “overeating,” or “food addiction” because those who are shamed in public for eating may wait until they are in the privacy of their own homes to eat.

Some participants expressed their weight as an issue in terms of food. Food is often times perceived as a substitute for worse or more dangerous behaviors, such as drug and alcohol use. Many participants explained how food plays a role in their everyday lives. Allisha shared:

“It’s constantly on my mind and heaven for me... will be... able to eat anything I want. I love to eat... I don’t drink, I don’t smoke... but I believe that food is like a drug to me. It’s like a drug. It’s as bad for me as any kind of drug that somebody would take or smoking cigarettes or drinking. ...Whether I’m happy or sad, I eat. It’s my gin and tonic. I think about it all the time” (Allisha).

Other participants shared similar experiences in terms of the role food plays in their everyday life. When I asked Trisha what she meant by calling herself an “emotional eater,” she explained:

“When I get stressed out, I eat. I feed my, I feed my sorrows. Like you know there are people that have a bad day and you know they can’t wait to go home and have a drink? I don’t drink. I don’t drink alcohol. Um. I can’t wait to get home and I’ll pick up.. uhhh a bag of Oreo cookies (haha) and umm... I will eat half of the bag of Oreos” (Trisha).

The role of food in the everyday lives of those considered overweight and obese by medical standards has not yet been adequately addressed. However, psychologists studying eating behaviors have posited psychological explanations for why obese individuals choose food over other stress-relieving behaviors. For example, Epstein, Leddy, Temple, and Faith (2007) explore how behavioral choice theory may be used to explain food and exercise behaviors. They argue that alternative commodities, or substitutes, may be chosen when the cost to obtain the preferred commodity becomes too high (Epstein et al. 2007: 887). In this project, participants explained how they felt, overall, healthy. Participants took pride in abstaining from alcohol, smoking, and other drugs but felt that eating was not the best solution even when they shared stories about choosing food over other substances. To them, eating more was a “healthier choice” compared to drinking alcohol or smoking, although they did not take pride in overeating.

### Appetite Control

Similar experiences were shared by those participants who had used alcohol and smoking as appetite suppressants in the past. Participants were proud to have quit drinking and smoking but had gained weight since the time they quit drinking and smoking. Anne, a 76-year old woman who is now retired, shared how smoking three packs of cigarettes a day kept her weight down for most of her life. After quitting smoking “cold-turkey,” Anne shared how her weight-gain is a consequence of quitting an unhealthy habit. She said:

“And like I said, when I would eat things  
I shouldn’t have over the weekend, on Monday,  
I would go right back to dieting the rest of the week.  
Watched what I ate, put the cigarette back in my mouth.  
I smoked three packs a day. That’s a lot of cigarettes.  
Now you know why my weight was down because I was  
never hungry like I am now you know... I can be riding  
down the street and the first thing that comes to mind is,  
“Oh! What am I going to eat when I get home?” And  
all I can think about is putting all these different things  
into a sandwich and you know that’s not healthy  
but that’s the way it is. And I hope to cut that out” (Anne).

Although Anne wasn’t happy with her current weight, she expressed how she was proud that she had quit smoking. Another participant, Cassidy, shared that she was unaware that she was “overweight” until her doctor recently told her. When I asked how she felt about being told she was “overweight,” she discussed how she wasn’t upset about the news because of her past experiences with laxatives, weight loss pills, alcohol and smoking. She explained:

“... I started drinking  
and smoking cigarettes to curb my hunger  
and to keep my mind off of food. But exercising  
started getting harder for me and I would always  
feel sick to my stomach... Now I am considered  
overweight. So now I have to lose weight again.  
But I’m taking my time because I want to do  
it the healthy way and not get into bad habits again” (Cassidy).

Even though Cassidy plans to lose weight, it seemed as if she would rather be considered “overweight” than to be a “normal” weight while using substances to control her appetite, calling them “bad habits.” She said that people who mention her recent weight gain are unaware of what she was doing in the past to keep her weight down and they didn’t know what she’s “been through” with her weight. She said:

“They kept telling me that I was gaining weight. . . .  
But in my mind I knew I had to get back to normal  
or at least more healthy than I was. And now I eat normal.  
And I feel better than before. I don’t think I look  
great but I feel better” (Cassidy).

Besides the psychological research that was previously discussed, those studying obesity and body weight have not addressed food as a part of life. Eating as a stress-reducing behavior is only one aspect of the role of food. In this study, food wasn’t only expressed as a behavior, but more so, a significant part of the participants’ everyday lives. Participants shared that they think of food all of the time even when they are not depressed or stressed. For Anne and Cassidy, who were once considered to be of “normal” weight, but used substances in the past to suppress their appetite and keep their mind off of food, suggesting that food played a role in their lives before they were considered to be “overweight” or “obese.” Therefore, unlike previous researchers have suggested, the findings from this study may mean that food plays a role in many people’s lives, whether they are considered to be medically overweight or not.

### Pregnancy and Childcare

Experiencing pregnancy and motherhood influences the way that women feel about their bodies and particularly, their body weight. Warin, Turner, Moore, and Davies (2008) put two women’s experiences with food and their bodies in the context of the everyday practices of motherhood. They conclude that mothering is “at odds with the individualistic approach of current health-promotion messages” since mothers place others’ needs before their own (Warin et al. 2008: 107).

Although some participants in the current study shared similar experiences to the participants in Warin et al.'s (2008) study, there were two experiences that differed. One participant, Lola, discussed how pregnancy didn't really influence her weight gain. After giving birth to her twins, Lola shrunk back to 105lbs., a similar weight to before she was pregnant. It was only after the twins were born that she began to gain weight. Lola explained:

“In my twenties, I mean I didn't have my first pregnancy until I was in my 30s, I weighed about 105 lbs. I don't think I ever weighed more than 110lbs. I gained 30lbs with my first, I lost 20lbs but I just never.. I don't know whether it was laziness or tiredness or depression but I just didn't care and I let the weight come back on. So ever since I got pregnant after the twins I went up to 170lbs with the twins. And uh... I dropped down to 150lbs, but again I just was not interested, I was very apathetic about it” (Lola).

Lola was apathetic about her appearance after her second pregnancy and attributes her weight gain to possibly her depression, laziness, or tiredness. The difference between Lola's experience and those of the participants in the study of Warin et. Al (2008) was that Lola did not lose interest in looking good by placing others' needs above hers, but she was disinterested in getting out of bed to do many things besides mothering. In Warin et al. (2008), the two mothers experienced food and their current bodies as part of being a mother, by running around and taking care of others' needs, the two mothers did not place much importance on losing weight relative to the importance they placed on all of their other responsibilities. Another participant in the current study, Heather, shared her experience of mothering differently. Heather adopted a son and therefore, has never experienced pregnancy. She said:

“Well, it’s a little different for me, you know, because Shane is adopted so I can’t say that I was thin and then I gave birth and then I was fat or anything... I think motherhood, if anything, has kept my weight a little down because of all the running around kinda thing. You know, as they need you less, and as you slow down, you know that’s not good” (Heather).

For Heather, the responsibilities of motherhood, if anything, kept her weight down until her son became old enough to take care of himself. Since he has gotten older, Heather has gained weight. Heather’s experiences are also unique compared to the experiences of the two mothers in Warin et al.’s (2008) study, who experienced that placing others’ needs before their own kept them from losing weight. Heather shared that the responsibilities of motherhood kept her weight down until recently when she no longer had the same responsibilities of childcare.

The purpose of Warin et al.’s (2008) study was not to examine the influence motherhood has on body weight. Rather, the authors focus was to understand how size is embodied, experienced, and articulated within gendered and class-based lifestyles (Warin et al. 2008: 98). While doing so, the authors found that food and bodies are situated within the context of motherhood for two women who view the responsibilities of motherhood as an absolute priority since being a mother wasn’t seen as a role, but instead, their identity. As some participants in the current study shared similar experiences when it came to motherhood, others saw it as a particular stage in their lives that changed the way they viewed and experienced their bodies.



## Chapter Summary

All fifteen women are considered overweight, obese, or morbidly obese by medical standards. One participant has had weight-loss surgery in the past and one participant is scheduled for bariatric sleeve surgery in a few months. Four women shared past struggles with eating disorders including anorexia and misuse of laxatives. Three women talked about their experiences with alcohol and smoking and the effects that they believe drinking and smoking has on their current weight status. Most of the participants are currently unhappy with their weight and/or body image, some of who have lost weight but are currently still considered “overweight” or “obese”.

All participants shared experiencing weight-based discrimination from strangers and/or family and friends. Although a few participants found the media helpful in relaying health information and weight-loss tips, most participants shared how the media has reinforced stereotypes of being fat. Fat stereotypes included laziness, gluttony, indulgence, selfishness, and carelessness, all of which participants said that they had and currently experience on a day-to-day basis. Most participants stated that weight-gain contributed to their unhappiness and their inability to recognize themselves in photos and through a mirror. The women shared everyday struggles including getting dressed, fitting into clothes, moving around, playing with children, getting in and out of a car, fitting into a movie theater seat, walking their dog around the block, shaving, showering, getting ready for work in the morning, etc.

Most of the women shared medical problems that they believed interact with their body weight and/or their weight-loss efforts including arthritis (regular and rheumatoid), diabetes, high blood pressure, high cholesterol, breast-cancer, pregnancy, miscarriage, hysterectomy, and other medical surgeries. Participants described their weight as an “issue”, a “rollercoaster”, a “yo-yo”, a “constant struggle”, an “obsession”, an “accomplishment”, an “embarrassment”, and/or a “health concern.” Some participants described their weight as a part of them, while others described their body and their weight as a separate entity.

## CHAPTER 5: CONCLUSIONS

The findings from the current study have implications for the study of body weight and weight-based policy. By reflecting on in-depth understandings to body weight, I offer at the very least, possible explanations as to why programs and policies have not been successful in deflating obesity rates. Better yet, I explain how in-depth understandings of body weight may be helpful in challenging previous assumptions of “overweight” and “obese” people, can encourage full inclusion and integration of larger people, and may empower people to re-think “obesity” and “fatness,” beginning at a young age. It is important for those taking a similar approach to body weight to further expand meanings of body weight and how these meanings can help redefine the way body weight and obesity is approached in research, health-practices, and policy efforts.

Participants in the current study gave multiple meanings to body weight, which differed among participants. Since multiple meanings of body weight exist, this means that those who are medically labeled “overweight” do not share the same meanings of being overweight nor do they have the same experiences. In other words, those considered “overweight” are a heterogeneous group. The same goes for those who are considered “obese” and “morbidly obese.” By treating each weight group as a homogenous group, one fails to recognize the multiple meanings and experiences that persons have regardless of a shared weight label. Also, those who share weight labels do not look the same nor do they feel the same about their bodies. Within the multiple meanings given to body weight, some participants shared that they were “barely living” (Trisha) while others did not place much emphasis on their weight at all (Kathryn). Therefore, to assume that a universal meaning of body weight applies to all people

ignores the actual meanings that individuals give to their weight. Also rejected is the assumption that weight-loss is the ultimate goal for all people considered “overweight” and “obese.” I conclude that a universal meaning or approach to body weight is insufficient in our efforts to understand obesity.

Another major finding in this project is that most participants do not agree with their label as “overweight,” “obese,” or “morbidly obese.” This finding is of particular interest given the recent announcement by the American Medical Association defining obesity as a “disease” (AMA 2013). If individuals do not accept their weight label, they may be conflicted if or when they are diagnosed with overweightness or obesity. The implications of being diagnosed with “overweight” or “obesity” align with Brown’s (1995) concerns of “conflicted diagnoses.” Brown explains that diagnosis often serves as a tool for social control because it locates the parameters of normality and abnormality. Further, diagnosis authorizes medicine to label and deal with people (Brown 1995:39). In the case of body weight, the AMA’s announcement defining obesity as a “disease” is concerning because it indicates a further move toward the bio-medical model, diagnosis based on universal criterion that is rooted in individual responsibility. The bio-medical model emphasizes diagnosis and treatment, with the ultimate goal of weight-loss. While some participants accepted the label as “overweight” or “obese,” most rejected the label, explaining that the label exaggerated their weight status. A few participants felt that the label underestimated their weight, however, this was rare. If a person rejects their weight label, it is probable that they will reject a diagnosis that is based on the weight label and the label’s criterion. The major concern here is that diagnosing a person as “obese,” whether they agree with the diagnosis or not, medically labels them as abnormal. The

second major concern is the treatment following the diagnosis will be based off of irrelevant understandings of body weight, as I suggest through the participants' experiences.

Additionally, many participants shared still being considered “overweight” or “obese” after having recently lost weight. For these women, their current weight was an accomplishment, even though they were still labeled as “overweight” or “obese.” Further, a participant who struggled with a past of eating disorders and abuse of laxatives and alcohol for weight loss (Cassidy) shared that her doctor told her she was now “overweight.” Health professionals should be aware of the person’s history before advising the patient to lose weight, since such advice could be harmful for people like Cassidy. Additionally, individuals may resist a physician’s suggestions for weight-loss if they do not feel that their weight is that important, such as two women in this study. It should be accepted that weight-loss is not a goal for some people, even if they are labeled as “overweight” or “obese.” Further, participants shared explanations for weight-gain and their current weight status that are not included in an “energy in-energy out” explanation of what causes excess weight. Therefore, I conclude that health professionals should be cautious in giving weight-loss advice, since the suggestions given may not be relevant to the individual’s experiences as I suggest through the current findings.

Another finding in this study was that participants felt physically restricted from participating in specific activities. Further, many participants shared that they resist certain activities or places because they anticipate feeling physically and emotionally uncomfortable. In both instances, participants were conflicted with their physical environment. Since our physical environments are built for the “average” size individual,

decisions made about the width of doorways, size of back-seats in cars, and the size of chairs are a few of the many ways that decisions are made on an everyday basis that exclude larger people. Decision-making at the expense of larger people is a prime example of how larger people are the victims of symbolic violence. Being more conscious of all sizes when making such decisions could make many places more accessible and comfortable for all people.

Many participants experienced overt bullying and harassment about their weight, from some of their earliest childhood memories to recent everyday encounters. Through this project, I confirm that weight-based bullying occurring at a young age has lingering and harmful effects that carry-on into adulthood. For a participant who lives in Miami year-round to not own one pair of shorts because of a rude remark from her childhood shows how much these incidences can shape self-perception, even twenty years later. Being bullied for weight as early as eight years of age has consequences that should be taken seriously. The way parents, teachers, or role models socialize our youth is important regarding the meanings of body weight and assumptions made of larger people. An example of ways we can educate the youth on obesity is to create programs in schools that tell the stories of those considered overweight and obese. Similar programs have been implemented regarding tolerance for lesbian and gay persons, the consequences of drinking and driving, and teen pregnancy. Empathetic understandings may be accomplished by elevating personal experiences that combat popular assumptions about a particular set of people. Many of the assumptions of larger-people, such as they are lazy or that they cannot control their eating, are also rejected throughout this project and hopefully future research and policies will address these assumptions as well.

Throughout the project, I reveal the multiple meanings that participants have of food. Some participants described food as their “gin and tonic.” Although participants felt that their connection with food was harmful to their weight, many saw food as a healthier alternative compared to alcohol and other drugs. Other participants shared abusing laxatives or smoking up to three packs a day to suppress their appetite. Even for participants who used other substances to suppress their appetite, food plays a major role in their everyday life. Health promoters that fail to recognize these significant meanings of body weight and food are at loss and health promotion messages should be reassessed to take into account these experiences. Additionally, some participants shared discomfort eating in public settings such as school cafeterias and restaurants. Programs (e.g. First Lady, Michelle Obama’s *Let’s Move!*) that promote healthy food choices in elementary schools by cutting back on sodas and high-processed foods are limited because they ignore these feelings of stigma and discomfort that some experience at a young age. If those who feel stigma and discomfort when eating in public restrain from eating food throughout the school day or work day, healthy eating habits (which is a primary goal of many of these programs) are not being practiced.

Other significant findings reveal how pregnancy and childcare influence body weight. While some found that “running around” or “chasing the kids” kept their weight down, others shared how they’ve gained weight since having children, since they put others’ needs in front of their own. Some mothers shared experiences of depression and apathy regarding self-appearance. Through creating and reinforcing ideals of motherhood and beauty, some people, (through advertisements and other media outlets) may place pressure on the mother because she may feel expected to live up to these cultural ideals.

She may also feel that her experience with pregnancy and childcare are abnormal compared to what she has read or has been told about motherhood. The participants' experiences challenge these ideals by suggesting that pregnancy and childcare influence the mother and body weight in many different ways, and are also at odds with health promotion messages, as previously suggested by Warin et al. (2008). Redefining the ideals about motherhood and body weight are possible through future research aimed toward understanding these experiences. Also, sharing stories and experiences that conflict with ideals of pregnancy and childcare may encourage conversations that redefine the experiences of motherhood.

#### Future Research and Limitations

I argue that previous approaches to obesity include five major assumptions: 1) It is necessary to measure, record, and report body weight; 2) There are objective and unbiased methods to gauge body weight; 3) There is a universal measure of body weight that applies to all people; 4) Those considered "overweight," "obese," and "morbidly obese" live with the intent of weight-loss; those who are not considered overweight work to prevent pre-obesity and obesity; and 5) Being "overweight" or "obese" reflect poor health status and this relationship is recognized by all people. Some possible future directions that sociologists may move towards include confronting these assumptions that I argue are embedded in the previous literature.

Primarily, sociologists could expand the meaning of body weight and allow participants to share how they feel about their bodies by explaining how they "live" body weight. Secondly, sociologists can challenge previous findings reported by a lot of these



studies, with newer and more relevant definitions and categories that have been created by those considered “overweight,” “obese,” and “morbidly obese.” This challenge of previous findings align with McKinlay’s (1996) idea of the sociology of epidemiological findings; that many of these findings reported may in fact have issues operating at the systematic level. These issues are overlooked throughout the research process, and are passed down and adopted by other researchers who take for granted that these measures of body weight as being applicable to all groups. Thirdly, studies (e.g. Young 2002; Sanderson 2002) aimed towards developing policy suggestions regarding low-cost, affordable childcare, more and better jobs in these areas, putting physical activity, recess, and art back into public schools, and low-cost family recreational activities should be considered by anyone studying obesity or body weight, in general. For example, researchers that recognize systematic barriers may explain why parents may not be raising their children in sports at a young age. Possible reasons may be because of the cost of equipment, uniforms, costumes, and other participation fees, including the cost of trips for away games and competitions. Another example is the extent that low-cost, affordable housing, healthcare, and childcare are extremely important for many individuals’ weight and overall health.

In the current study, the sample of participants was limited since there were not enough participants to draw meaningful conclusions about differences between gender, race, class, and age. However, it is important to understand the meanings of body weight for all people. How women and men live body weight may prove to be entirely different, which would be important to know for research and programs that use the same approach for men and women. Likewise, access to food, healthcare, and clean workplaces probably

influence how different people experience body weight. These other meanings should be further explored. This study was also limited to studying body weight in two areas: Florida and New Jersey. Although this project is one of the first of its kind in the United States, studying the meanings of body weight in different locations would lend important insights into the degree of importance placed on body image and body weight. Studying the meanings of body weight in places that do not glorify a “normal” weight as much would be an interesting future direction. Last, since I have struggled with body weight for my entire life, my approach to studying body weight may be different from someone who is an outside member of the community. Future research in this vein would provide even a deeper understanding of body weight beyond the scope of this project.

A more meaningful understanding into how body weight differs by individual experience or by community or geographic regions is an area in this line of research that sociologists can be extremely helpful. In addition to some of these preliminary ideas, sociologists may help in redefining the measures of body weight, overweight, and obesity that are used in these studies, taking into account the meanings that the participants themselves have of body weight and how it fits into their daily lives. This would highlight changes we can make at the systematic level that McKinlay (1996) mentions, and a look into how these epidemiological findings have been created with these systematic influences currently at work.

### Qualitative Research and Body Weight

It has been long debated whether human rights and social change should be considered as the purpose of qualitative inquiry. Denzin and Giardina (2010) argue that

ethics, human rights, and making a positive difference in the lives of those who are oppressed should be at the center of qualitative work. For example, the authors state that it is the duty and the obligation of qualitative researchers to “make the world visible in ways that implement the goals of social justice and a radical, progressive democracy” (Denzin and Giardina 2010:14). Most qualitative researchers view the participant or the community of interest as an “expert” since it is they who have lived through a specific process or share a common experience.

Many times, one of the goals of qualitative research is to provide a “deep” or “in-depth” understanding to assumptions and meanings that are often taken for granted about how a certain set of people live their lives (Johnson and Rowlands 2012). By asking questions that address how power is embedded in the production of knowledge, qualitative researchers are able to speak the truth (Rail et al. eds. Denzin and Giardina 2010). The “truth” is telling others’ stories with advocacy and accuracy, keeping the story in the context that it comes from (Erickson 2010). Human rights and ethics have found their way into the agendas of many qualitative researchers because often times, qualitative research reveals truths about a group of people that often conflict with the assumptions that others have. Quite frequently, research findings have implications that go beyond the scope of “just a qualitative study,” when researchers feel morally obligated to give a voice to those who have been misunderstood and oppressed in society (Denzin and Giardina 2010).

Qualitative research has an important place in the area of obesity research. Our work can give a voice to those who live body weight on a daily basis. By expanding the work in obesity research to include the meanings and experiences of those considered

“overweight” and “obese,” we may continue to provide new and more ethical approaches to body weight research and weight-based policies than previous approaches have. I recognize the difficulties in studying body weight or taking an alternative approach to obesity. Medicalization, stigma, and beautification or the ideals of beauty are difficult to deconstruct in the area of obesity. However, if we do not take-on these difficult conversations, no one will. It is our responsibility to address how larger people have been misrepresented and mistreated in previous obesity research. Tolerance of larger people is not enough. We must continue to share the experiences of those considered “overweight” and “obese” until all people are integrated and treated as equal, regardless of body weight.

### Chapter Summary

Through my findings, I reveal consequences to the way researchers and health professionals have studied obesity and how these findings conflict with many underlying assumptions of body weight. For example, participants expressed multiple meanings of body weight, and these meanings differed among participants. Therefore, I conclude that a universal meaning or approach to body weight is insufficient in our efforts to understand obesity. Further, participants shared explanations for weight-gain and their current weight status that are not included in an “energy in-energy out” explanation of what causes excess weight. I conclude that health professionals should be cautious in giving weight-loss advice, since the suggestions given may not be relevant to the individual’s experiences. Additionally, my findings are at odds with many pre-assumptions of overweight and obese people. For example, most participants reported

consciously thinking about their weight, which for some included dieting for most of their lives.

I argue that it is critical to challenge popular assumptions of obese people beginning at a young age, which may include programs in schools that elevate personal experiences of “lived” body weight. I also emphasize the importance of research that explores the experiences of pregnancy and childcare and how these experiences may or may not influence body weight. Multiple experiences of childhood and pregnancy would assist in challenging the ideals of motherhood and bodies. Furthermore, my findings reveal major challenges and constraints participants shared regarding physical and social environments. Lastly, findings from this project support previous literature that report lingering effects of weight-based stigma from childhood into adulthood.

I discuss how this project was limited and how future research may address these limitations. Additionally, I suggest specific contributions that sociologists can provide in the study of body weight and obesity. I recognize that taking on obesity as a social researcher is a rather difficult task. Obesity in particular is difficult because of the two dominant areas that must be deconstructed: medicalization of body weight and the ideals of beauty. However, it is our responsibility as social researchers to elevate the experiences and share the stories of those who are misrepresented and whose voices are often silenced and dismissed.

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## APPENDIX A

### Social and Behavioral Sciences Form

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**A verbal consent script may be used when a waiver of written consent has been granted. This script is read to the potential subject.**

#### VERBAL CONSENT SCRIPT

#### *The Expanding American Waist-Line: Critical Approaches to Obesity and the Lived Experience of Body Weight*

Hi, my name is Brittany Harder and I am involved in a research study called *The Expanding American Waist-Line: Critical Approaches to Obesity and the Lived Experience of Body Weight* with Dr. Linda-Liska Belgrave, Dr. John Murphy, and Dr. Doris Ugarriza at the University of Miami.

#### **PURPOSE OF STUDY:**

We are asking you to take part in a research study because we are trying to learn more about what women experience regarding their body weight. You will be asked questions in a one-on-one interview with myself. The length of time for the interview is estimated to be an hour long and you will only participate in one interview. The location of the interview will be a place that has been mutually agreed upon between us.

The interview questions are designed to capture the meaning you give to body weight, how you think of body weight, and what influences may have contributed to these meanings. A couple of questions ask about your daily responsibilities, which for you, may include responsibilities around the house or at work, if you work outside of the home. The interview will be audio-recorded. We do not foresee any risks to your participation in this interview. If at any time, you would like to stop the interview, you may stop participating. You are allowed to pass on questions that you may not want to answer and/or skip questions that you would like to later return to. If you wish for the

interview to not be audio-recorded, you may still participate; however, the interview's estimated time will be expanded so I will be able to write extensive notes throughout the interview. There are no direct benefits to this study.

You will receive compensation as an incentive for participating in this interview. The compensation is \$10.00. You will be given this gift directly following the interview.

The audio-tapes will be immediately destroyed right after I transcribe the interview onto my personal computer, which will take place within 24 hours of the interview. The audio-recordings will not be shared with anybody else; however, the typed transcribed notes from the interview will be shared with the Principal Investigator of the study, Dr. Linda-Liska Belgrave. In addition, we ask for your consent to use any information from the interview in a research paper. Any direct quotes will be tied to your pseudonym within the paper. It is a very good possibility that the paper will be presented in an annual conference and/or at the University of Miami.

The audio-tapes will be destroyed within 24-hours following the interview. However, the typed transcribed notes from the interview will be stored in the personal desktop computer where I reside. I will show the Principal Investigator, Dr. Linda-Liska Belgrave the transcribed notes in her office, which is located in the Sociology Department at the University of Miami.

Your participation is voluntary. You can decline to participate, and you can stop your participation at any time, if you wish to do so, without any negative consequences to you.

Do you have about an hour to participate in this research study now or later? If later, let's schedule an interview time that fits your schedule and mine.

By you answering the interview questions that I will ask, this means you consent to participate in this research project. Do you have any questions?

If you have any questions or concerns about the research, please feel free to contact Brittany Harder at (954)-303-6150, [b.harder@umiami.edu](mailto:b.harder@umiami.edu) or feel free to contact Dr.

Linda-Liska Belgrave at (305)-284-6129, [l.belgrave@miami.edu](mailto:l.belgrave@miami.edu). Our work address is 5202 University Drive, Coral Gables, FL 33124.

If you have questions regarding your rights as a research participant, contact the University of Miami, Human Subject Research Office at (305)243-3195.



## APPENDIX B

### *Interview Guide*

- 1) Do you know your BMI? Could you share it with me?
- 2) Tell me about your weight. How do you feel?
- 3) When, if at all, did you first experience someone telling you that you were overweight or noticing that you felt like you were overweight? What was going on in your life then?
- 4) What was it like? What did you think then? How did you respond? Who, if anyone, influenced your actions? Tell me about how he/she or they influenced you.
- 5) Could you describe the events that led up to you feeling overweight or others describing you as overweight?
- 6) How would you describe the person you were then?
- 7) Tell me about your thoughts and feelings at a time that you or someone else thought that you were overweight?
- 8) Who, if anyone, was involved? When was that? How were they involved?
- 9) What, if anything, helps you handle these thoughts and feelings?
- 10) What positive changes have occurred in your life since \_\_\_\_?
- 11) What, if any, negative changes have occurred in your life since \_\_\_\_?
- 12) How, if at all, has your view of yourself changed since then?
- 13) Who, if anyone, has been the most helpful to you through these experiences? How has he/she been helpful?
- 14) Tell me how you go about your typical day. What do you do?
- 15) Where do you see yourself in 5 years? 10 years? 20 years (if appropriate)?
- 16) How, if at all, has the media influenced your experiences?
- 17) When do you feel the most comfortable? The least?
- 18) How do you feel about your body?
- 19) After having these experiences, what advice would you give to someone who has just discovered that he or she feels overweight or is being labeled as overweight by others?
- 20) Tell me how you would describe the person you are now. What most contributes to this?
- 21) Is there anything else you think I should know to understand you or your experiences better?
- 22) Is there anything you would like to ask me?

