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# The American Medical Association's Designation of Obesity as a Disease and its Influences on Experiences of Body Weight

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UNIVERSITY OF MIAMI

THE AMERICAN MEDICAL ASSOCIATION'S DESIGNATION  
OF OBESITY AS A DISEASE AND ITS INFLUENCES  
ON EXPERIENCES OF BODY WEIGHT

By

Brittany M. Harder

A DISSERTATION

Submitted to the Faculty  
of the University of Miami  
in partial fulfillment of the requirements for  
the degree of Doctor of Philosophy

Coral Gables, Florida

May 2017

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The American Medical Association's Designation  
of Obesity as a Disease and its Influences  
on Experiences of Body Weight

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Abstract of a dissertation at the University of Miami

Dissertation supervised by Professor Linda Liska Belgrave  
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In this dissertation, I explored the influences of the American Medical Association's (AMA) 2013 designation of obesity as a "disease" on experiences of body weight. I conducted 31 in-depth interviews with 29 participants considered "obese" by medical standards ( $BMI \geq 30 \text{ kg/m}^2$ ) who had had conversations with a health professional about their body weight since the AMA's policy change. Taking a symbolic interactionist approach complimented by grounded theory methodology, I addressed the following research questions: 1) What are the experiences "obese" people had when visiting a health professional post the AMA's re-classification of obesity? 2) How did the designation of obesity as a "disease" affect the language used in discussions of body weight between the health professional and the patient? 3) How did "obese" patients interpret the language used in these discussions of body weight?

Findings suggest two common themes among participants' experiences: 1) a series of *competing realities* that complicate participants' everyday interactions with others (health professionals and lay persons) and alter how participants see themselves, and 2) life-long, ongoing ties between participants' body weight and selves that are borne from past and recent interactions with others. Findings suggest that understanding

experiences participants had with body weight since June 2013 requires an understanding of past experiences with body weight.

Judging by participant experiences, some health professionals seem to have adopted the AMA's disease model of obesity while others have not, thereby influencing their overall approaches toward their "obese" patients. This includes the choice of language used in discussions of body weight with their patients, the degree to which body weight is seen as an urgent health issue, and the choice of diagnosis and treatment plan, if any. Despite major efforts to standardize obesity treatment, participants' experiences are more influenced by the individual health professional's approach towards obesity and by participants' past experiences with body weight, than by the policy change itself.

Participants' interpretations of obesity as a "disease" also varied; while some were understanding of the AMA's decision, others were highly critical of a disease model of obesity. It's also notable to report that many participants rejected a diagnosis of "obesity" given by a health professional since 2013. Therefore, while the current research approach does not aim to represent a pre-post policy model, findings do suggest that extreme acts of medicalizing obesity, like the AMA's 2013 policy, influence participants' lives and experiences with body weight in overwhelming, and sometimes, detrimental ways.

Participants provided feedback as to how health professionals can improve their conversations with patients about body weight.

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*We must always attempt to lift as we climb. --Angela Davis*

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into your world(s). We don't belong in the margins, and I'll continue to work until everyone knows the many reasons why.

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## CHAPTER 1: INTRODUCTION:

*Although the etiology of obesity is described neutrally in biomedicine as a positive imbalance between energy ingested and energy expended, its public representation is not value free.*  
--Emma Rich & John Evans

### *Overview*

For my dissertation, I critically explored America's "obesity epidemic" and the medicalization of fatness in the United States. I focused particularly on the most recent effort of medicalization, the American Medical Association's (AMA) 2013 designation of obesity as a "disease," to understand the influences this movement has made over the past three and a half years. Despite the overwhelming amount of obesity research published since the 1980's, less attention has been given to the AMA's new classification of obesity, a movement which some argue is "perhaps the most profound act of medicalization in American medicine" (Sadler 2014:143).

I considered the influences this movement has made, especially for those defined "obese" by medical standards ( $BMI \geq 30 \text{ kg/m}^2$ ). Taking a symbolic interactionist approach complemented with grounded theory methodology, I addressed the following research questions: 1) What are the experiences "obese" people had when visiting a health professional post the AMA's re-classification of obesity? 2) How did the designation of obesity as a "disease" affect the language used in discussions of body weight between the health professional and the patient? 3) How did "obese" patients interpret the language used in these discussions of body weight?

To frame and inform the current project, I drew from several bodies of literature including clinical, public health, and critical approaches to obesity, obesity science and knowledge, symbolic interactionism, social constructionism and medicalization, the illness experience, and the construction of language. I conducted 31 in-depth interviews with 29 participants who were considered “obese” by medical standards and had discussed their weight with a health professional since the AMA’s re-classification of obesity. By focusing on the AMA’s designation and its implications, I contribute to an improved understanding of obesity and the experiences of those considered “obese,” and now “diseased,” by medical definition.

In this chapter, I briefly discuss the current state of obesity in the U.S. and provide a socio-historical background of the medicalization of body weight. I challenge the dominant narrative of America’s “obesity problem” and the seemingly objective nature of growing obesity prevalence in the U.S., by identifying historical efforts of medicalization by “obesity entrepreneurs” (Monaghan et al 2010) and other “engines” (Conrad 2005) behind these efforts. I discuss why the National Institutes of Health’s (NIH) re-shuffling of BMI categories and the Centers of Disease Control and Prevention’s (CDC) visual representations of obesity trends are problematic. I discuss the most recent (and extreme) effort of medicalizing obesity, which was the AMA’s declaration of obesity as a “disease” in June 2013, and some responses to this movement. I provide a brief review of the literature, specifically in medicalization and in critical works of obesity that were influential in framing the current project.

*An Obesity Epidemic? The Engines at Work*

Over the past two and a half decades, the obesity epidemic has become defined as one of, if not the most, alarming public health problems threatening the United States. According to the Centers of Disease Control and Prevention (CDC), more than one-third or 34.9% of U.S. adults are obese, followed by 17% of children and adolescents (CDC 2015). Obesity has been named “serious, dangerous, costly” (CDC 2015) and even “deadly” (AMA 2015). In March 2006, the Surgeon General warned that obesity poses a greater threat to the U.S. than terrorism (Tumulty 2006; Borero 2012), after an article in the *Journal of the American Dietetic Association* stated that America was fighting two wars: one against terrorism and another against obesity (Biltekoff 2007). In 2010, the Surgeon General claimed that obesity “threatens the historic progress made in increasing America’s quality and years of healthy life” (U.S. Department of Health and Human Services 2010) and called for the public’s help in combatting America’s obesity crisis.

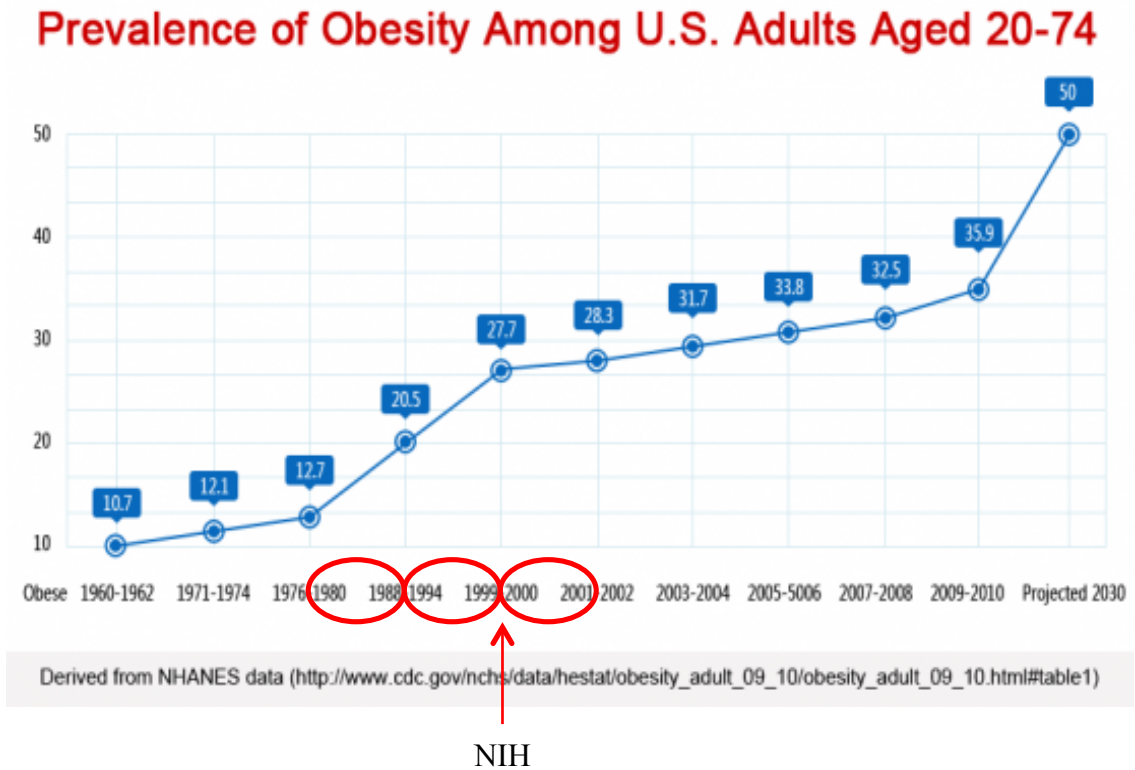
I argue that no other health condition has generated this large of a panic in the history of the United States besides the outbreak of diseases such as smallpox, plague, yellow fever, HIV, and the Ebola virus. However, all of these are infectious and transmittable diseases that require frequent and timely information regarding individual cases for prevention and control (CDC 2015: 1). Obesity is the only chronic condition that has received a similar degree of attention and panic (Boero 2007), however, the amount of attention and panic exceeds even that of the most fast-spreading and deadly diseases. Why is this? Boero (2007) contends that the obesity epidemic has been a victim of mass medicalization, where “unevenly medicalized phenomena lacking a clear

pathological basis get cast in the language and moral panic of more traditional diseases” (Boero 2007: 42).

Prior to the recognition of obesity, itself, as a serious health problem, excess fat was considered dangerous to one’s health because of its relationship to other health problems such as heart disease, stroke, and type II diabetes. These conditions have been identified by the NIH and the CDC as some of the most leading causes of preventable death (NIH 2015; CDC 2015). Therefore, obesity was commonly accepted as a precursor or risk factor to other more serious health problems, meaning that it was not considered an inherently dangerous disease itself. Similar to Boero (2007), I suggest that several strategies were employed to convince the public that the obesity problem is more serious and dangerous than most people would initially believe without efforts of medicalization and such suggestive discourse.

The frequent, yet loose use of the term “obesity epidemic” began in the 90’s as obesity rates were on a slow but steady rise. In 1998, the NIH changed the requirements of weight categories, lowering the BMI threshold for “overweightness,” and then accordingly adjusting the thresholds for “obese” and “morbidly obese.” This move alone suddenly created more than 30 million new overweight Americans (Fletcher 2014; Boero 2012). Claims during this time period that obesity rates were significantly increasing at a rapid pace were true but only in the sense that the standards had changed, which reflected little about the actual bodies that were considered overweight or obese (Fletcher 2014). Below is a graph provided by the CDC that shows the prevalence of obesity among U.S. adults aged 20-74 for the years 1960-2010. Despite the exaggerated point at the right end of the graph reflecting projected obesity rates for 2030, the largest rise in obesity

prevalence seems to have occurred between the time periods (1976-1980), (1988-1994), and (1999-2000), which I indicate with circles and arrows on the graph below:



Interestingly enough, the NIH's 1998 re-shuffling of BMI standards falls right in between those time categories. Another unique feature of this graph is the use of unequal time periods plotted along the x-axis. For example, there are six years included in the time period (1988-1994), where every other time period plotted along the x-axis ranges from a minimum of one year to a maximum of four years. There is also an unequal number of years between the time periods; however, visually, the illusion here implies that they are equal, since there is an equal amount of physical space on the graph between the time periods. For example, one would assume that obesity prevalence in the U.S. skyrocketed from (1976-1980) to (1988-1994), and then again to (1999-2000). However, between these time periods are unequal amounts of years elapsed where there is an eight-

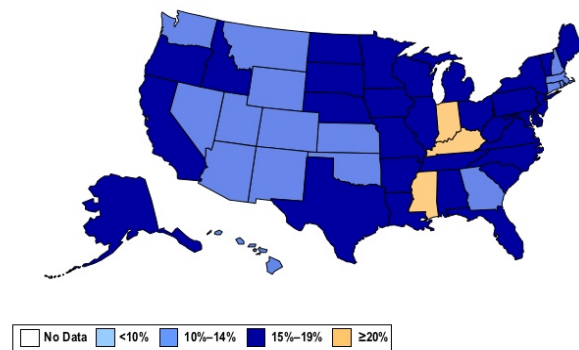
year and then a five-year time elapse between these three time periods, yet only a one-year time elapse between the time periods following.

A graph that plots obesity rates for the years 1960-2010 with ten time periods along the x-axis, like this one, would usually separate the time periods in equal increments of five years. Here, the illusion is created that obesity prevalence in the United States significantly skyrocketed over the past several decades, but—has it really? This graph is one out of only a few of its kind that show U.S. obesity rates over time and are available via a legitimate and credible medical association like the CDC.

The CDC and other medical associations typically favor the use of geographical maps that are color coded to indicate the degree of obesity prevalence in each state. To visually report a change in obesity prevalence overtime, these associations use a geographical map for each year they include in their report. Below are three maps from the CDC used to show the change in obesity prevalence overtime for the years 1997, 1998, and 1999.

### Obesity Trends\* Among U.S. Adults, BRFSS 1997

(\*BMI  $\geq 30$ , or ~ 30 lbs. overweight for 5' 4" person)

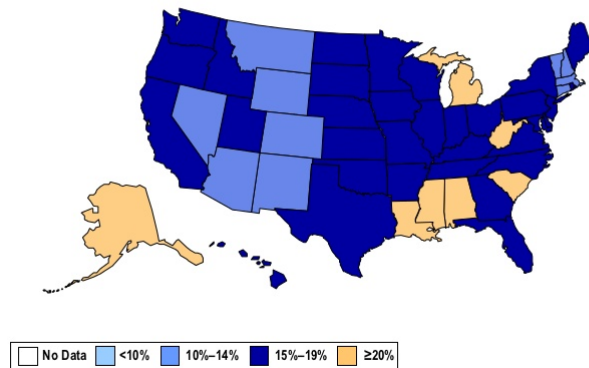


Source: Behavioral Risk Factor Surveillance System, CDC.



### Obesity Trends\* Among U.S. Adults, BRFSS 1998

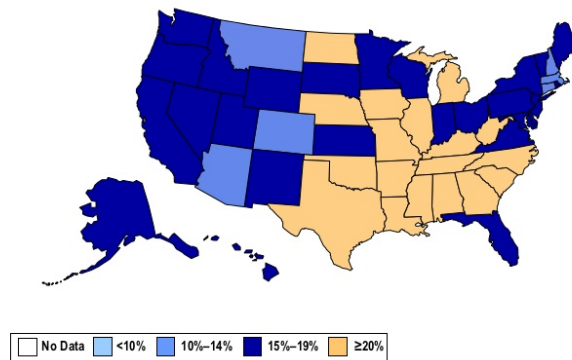
(\*BMI  $\geq 30$ , or ~ 30 lbs. overweight for 5' 4" person)



Source: Behavioral Risk Factor Surveillance System, CDC.

### Obesity Trends\* Among U.S. Adults, BRFSS 1999

(\*BMI  $\geq 30$ , or ~ 30 lbs. overweight for 5' 4" person)



Source: Behavioral Risk Factor Surveillance System, CDC.

Again, although it appears that obesity rates significantly increased in the United States over this time period, the CDC and these maps fail to mention the change in thresholds for weight categories in 1998 by the NIH, suddenly altering the weight label ascribed to millions of Americans. Movements like the NIH's in 1998 have been exceptionally influential in shaping what we know—and what we don't—about the obesity epidemic. All of the notable medical associations and public agencies such as the World Health Organization (WHO), AMA, CDC, and NIH have been working diligently

over the past several years in their efforts to combat America's obesity problem.

However, many of these efforts, like the NIH's in 1998 are questionable at best. It is unknown how much of the obesity epidemic reflects what Campos et al. (2006) refer to as a "real health crisis" (Campos et al. 2006: 55-58), and how much can be attributed to the behaviors and agendas of agencies such as the CDC and the NIH. Either way, it is interesting that such movements occur slightly before new claims are made about rapidly increasing obesity rates in the U.S.

The most recent of these movements occurred in June 2013 when the AMA, at its annual meeting, declared obesity a "disease." This was influenced by the association's collective view of the increasingly troubling nature of obesity prevalence in the U.S., which they argued involves "multiple pathophysiological aspects" and requires advancement in clinical prevention and treatment (AMA 2013; Beal 2013). Some commended the decision, recognizing that the obesity problem needed additional attention. Raising the status of obesity to a "disease" would further legitimize the condition and help increase funding for prevention and treatment. However, opponents argued that this new designation of obesity meant that suddenly, one-fourth of the population had "become" diseased. Further, opponents argued that this would additionally stigmatize those considered "overweight" and "obese" by medical standards (Katz 2014). Sadler (2014) argues that the AMA's resolution to declare obesity a disease is perhaps the most profound act of medicalization in American medicine (Sadler 2014: 143).

*A Socio-Historical Perspective: The Medicalization of Body Weight*

The emergence of obesity as a health problem can be largely attributed to the medicalization of body weight (Gracia-Arnaiz 2010; Conrad 2007; Sadler 2014; Salant and Santry 2006). Medicalization is a process through which conditions become accepted and treated as legitimate health issues (Barker 2010; Conrad 2005). The concept draws heavily from social constructionism to help explain how phenomena are given medical legitimacy by both the medical profession and the public. Brown (1995) offers a typology of several types of health conditions and the level of acceptance given by the medical profession and the public. Where a condition falls in Brown's (1995) typology depends on whether there has been a biomedical definition applied and whether the public generally accepts the condition as a medical problem. Although these categories differ greatly in terms of the degree of acceptance and legitimacy, classifying obesity within Brown's typology is extremely difficult. This is because of the increasing efforts of medicalization that obesity has faced over a relatively short period of time.

The medicalization of body weight in the U.S. can be traced to early origins of stigmatization and the shaming of fat people (Rasmuseen 2012). Rasmuseen's (2012) summary of the medicalization of body weight traces this history to the early 1900's when associations of fatness and laziness gained popularity and started to frame attitudes towards fat people. These early associations initiated the birth of a weight loss industry since companies saw the opportunities to advertise weight-loss foods and slimming underclothes. Gendered stigma faced by women in particular began in the 1920's as social norms of beauty and the bodies were influenced greatly by the fashion industry. At the same time, biomedicine was given a great amount of legitimacy since endocrinology

offered explanations surrounding metabolic processes and fatness. However, medical research in this area kept generating repeated findings that fat people had regular metabolisms, therefore weakening the claims made by endocrinologists. Alternative explanations of over-eating and food addiction led psychiatry to take over in the 1940's and 1950's in an attempt to explain excessive eating and attribute the behavior to over-mothering, oral gratification, and fixation (Rasmuseen 2012).

After World War II, as Rasmuseen (2012) explains, mind-body medicine gained much attention and popularity, and obesity was understood as the byproduct of over-eating in response to anxiety or nervousness with themes of addiction that also had been prominent in the early 1900s. In 1947, the AMA approved amphetamine as the appropriate drug for weight loss, and the pharmaceutical companies claimed that this treatment was safer than alternatives such as thyroid hormone alteration. Another series of advertisements around 1950 introduced risk themes associated with fatness, framing overweightness as “under-diagnosed, progressive, and deadly” (Rasmussen 2012: 886), quickly catching the attention of primary care physicians. By 1951, the Public Health Service, AMA, and life insurance industry announced America's public health problem of obesity. Public health officials and epidemiologists, alongside with primary-care physicians, began to take over.

The importance of the history of body weight as a stigmatized and medicalized condition is important because it highlights the various actors behind these movements over time. Actors have long been identified as imperative to the process of medicalization (Conrad and Schneider 1980) along with their practices and discourse (Halfmann 2012). Conrad (2005) refers to these actors and their activities as the “engines” of

medicalization, whereas Monaghan et al. (2010) refer to those who actively define fatness as a correctable health problem, “obesity epidemic entrepreneurs.” These entrepreneurs, along with their interests and practices, construct medicalized fatness as a social issue or crisis (Monaghan et al 2010: 38). Halfmann (2012) argues that medicalization increases when biomedical vocabularies, models, and definitions (e.g. symptom, pathology) become more prevalent in discourses about social problems, and when biomedical practices and technologies (e.g. measurement, lab tests, risk assessments) become increasingly used to “measure” or quantify these social problems. Further, medicalization increases when biomedical actors and identities become more prevalent, powerful, or salient in addressing a social problem (Halfmann 2012: 190-192).

Many emphasize self-interests as being fundamental to the actor’s motivation and participation in medicalization. For example, Conrad (2005) suggests three factors that underlie the medicalization literature since the 1970’s: power and authority of the medical profession, activities of social movements and interest groups, and organizational (inter or intra) professional activities (Conrad 2005: 4). Since the 1950’s, when primary care physicians became the prominent engines behind these efforts of medicalization, obesity has increasingly become accepted as a public health “epidemic,” a term that suggests an alarming health problem rapidly affecting population health (Boero 2007).

The most recent effort to medicalize body weight was in June 2013 at the AMA’s annual conference, where the association declared obesity a “disease.” Immediately following the AMA’s announcement, news channels and other media reporters spread the word regarding the association’s re-classification of obesity. Public opinion was split. “Fat activists” who resorted to social media outlets were able to garner a small, but vocal

portion of supporters. However, it seemed as if the majority of the public sided with the dominant narrative supported by the AMA's agenda. Although no research has been conducted on public attitudes of obesity following the AMA's 2013 announcement, some supporting arguments included fears of wasted tax dollars, Medicaid funding, and insurance coverage for those who are undeserving. Another outcry mirroring the popular "moral panic" (Boero 2007) of a lazy, unproductive, and socialist society ensued.

In the United States, the prioritization of work, productivity, individualism, and physical appearance produces a culture of hyper-regulation, where bodies become of political and economic concern. The practice of regulating and controlling bodies is a global phenomenon; however, theorizing these practices can be traced back to the influential works of Michel Foucault. In Foucault's *Discipline and Punish: The Birth of the Prison* (1975, trans.1977), a disciplined body emerges from constant surveillance and coercions of power that regulate what the body does--"a calculated manipulation of its elements, its gestures, its behaviors" (Foucault 1975; trans. Sheridan 1977: 138). Here, bodies are separated from their "humanely nature" and reduced to objects with parts, able to be fixed, and subjected to a process of constant scrutiny.

Surveillance of "obese" bodies comes from those in positions of authority and laypersons that hold "overweight"<sup>1</sup> people accountable for their non-normative bodies. For example, Oliver and Lee (2005) found that people view obesity as a result of individual failure and are not likely to support obesity-related policy. They also found that people adopt attitudinal frameworks when viewing obesity policies that are similar to

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<sup>1</sup> Although "overweight" and "obese" are clinically defined as separate categories, all bodies that are assumed to be anything over "normal" are subjected to surveillance in this sense, and some argue that bodies clinically defined as "normal weight" or "under weight" are also frequently subjected to a similar types of surveillance.

those used to frame attitudes on smoking. In this light, individual responsibility to gain and maintain a normal-weight body is expected, and failure to do so translates as a lack of motivation or will power. In Becker's (1993) discussion of the current health promotion movement, he argues that the most disturbing aspect is its tendency to attribute the cause and the solution of a health problem to the individual. This ideology, Becker (1993) explains, rests on the assumptions that everyone has equal chances to engage in health-promoting behaviors while avoiding risky ones, and should do so. By focusing on the "lifestyle" approach, the social environments that create or inhibit how people live are frequently overlooked (Becker 1993: 3-4).

How obesity is framed through the use of obesity metaphors (e.g. "obesity as gluttonous" or "obesity as a result of environment") has been shown to influence public responses and evoke certain emotions (Barry et al. 2009). The public discourse around obesity draws from scientific evidence including themes of causation, guidelines to prevention, quantitative research, "language of risk," and bio-medical narratives of obesity (Rich and Evans; Aphramor 2005). Biomedical discourse has constructed obesity as a problem and disease category via medical examinations, diagnostic manuals, population statistics, and standard measurements (Warin 2011:30). These bio-medical narratives dominate public understandings of obesity while excluding or undermining other important social forces at work (Rich and Evans 2005).

Fletcher (2014) argues that the adoption of the Body Mass Index (BMI) along with the associated standard cut-off points defining overweight and obesity were both crucial in defining obesity as an epidemic. Timmermans and Epstein (2010) explain that despite being formally negotiated outcomes, standards (i.e. the BMI) are exempt from a

level of social involvement, and become part of the “taken-for-granted technical and moral infrastructure of modern life” (Timmermans and Epstein 2010:71). The development of standards involves a process of “constructing uniformities across time and space, through the generation of agreed-upon rules” (Timmermans and Epstein 2010:71). Standards are used to give meaning and order and are useful tools in biomedicine (Pickersgill 2011: 73). Further, Timmermans and Epstein (2010) argue that standards are actually “hard won victories” (Timmermans and Epstein 2010: 74) by those involved. Therefore, as Rich and Evans (2005) argue, public representations of obesity are anything but value-free.

#### *Alternative Approaches to Obesity*

First, I would like to briefly summarize what exactly the dominant perspective in obesity is before I review the literature that challenges it. The most common and widely accepted view of obesity is one that is based in scientific and medical knowledge and centered on the pathology of overweightness (see Aphramor 2005). This type of reasoning is based within positivism, founded by August Comte, which considers science as the only valid form of human knowledge (Callinicos 2007: 65). A positivist philosophy depends on natural and scientific laws, objective reasoning, and belief in human capability to reveal or uncover an existent universal truth. All phenomena are seen as being in their natural state and intrinsically having certain properties and characteristics. An objectivist orientation to obesity seeks to document and describe the reality of the situation (Spector and Kitsuse 1977; Sobal and Maurer 1999), and focuses on the prevalence, patterns, and severity of the problem (Sobal and Maurer 1999).



Therefore, when a negative condition reaches a certain point deemed intolerable, it “self-evidently becomes recognized as a social problem” (Sobal and Maurer 1999: viii).

Clinical and research applications of this reasoning follow a dualistic perspective of the body versus the mind. Dualism is the philosophy that views the mind and the body as two separate entities and deciphers between objective fact and subjective thought (Williams and Monaghan 2013). Through this perspective, all bodies are viewed in reference to the medical model of the body, an objective and universal standard of a normal healthy body (Gabe 2004). Bodies are assessed, measured, and compared to other bodies by using standard units of measurement, including weight in pounds, BMI calculations, and BMI-determined weight categories. These tools help decipher the normal body from the non-normative body (in this case, the normal body from the overweight body) to employ an expert judgment on the body in question (see Armstrong 1983, 1995; Brown 1995; Fletcher 2014). Overall, this perspective promotes treatment and correction of overweight bodies by following a health behavior model. Based within this, one can prevent or correct overweightness by engaging in health-promoting behaviors and by avoiding risky ones. This model follows an “energy-in, energy-out” casual explanation of body weight and treatment is suggested based on such logic. Treatment options have expanded over the past several decades, and weight-loss surgery and dietary drugs have become increasingly popular. Weight-loss surgery alters the amount of food the body is able to physically digest, while dietary drugs curb hunger by blocking appetite triggers in the brain. Therefore, these more extreme approaches are considered a substitute for, or compliment to, lifestyle modifications, however, they follow the same logic.

Therefore, following these assumptions, the obesity epidemic is viewed as a real public health problem that is based in scientific evidence and medical truths (Aphramor 2005). Those who take the obesity epidemic at face-value find the obesity “problem” quite simple since there is only one solution: people need to lose weight. Intertwined with this belief are ideologies of individualism and morality, where the cause and the solution fall solely on the individual (Becker 1993). As mentioned before, concerns of economic cost and productivity also accentuate this viewpoint and attitudes toward obese people (see Boero 2007). As a result, obesity has been defined as a real health problem in need of immediate attention.

It is a common assumption that the link between overweight/obesity and adverse health outcomes has been well-established in obesity research and come from reliable and incontrovertible data (Campos et al. 2006). Further, it is believed that mortality rates increase with increasing BMIs (Campos et al. 2006) and that this relationship has been established in a similar way. However, a closer look at obesity research would suggest a much more complicated relationship between fat and health. My aim is not to discount or disprove the claim that excess fat is unhealthy, although the legitimacy of these claims have been questioned elsewhere (see Monaghan 2005: 304-307; Burkhauser and Cawley 2008; Aphramor 2005). Yet, inconsistent findings among obesity research certainly complicates obesity knowledge. For example, Flegal et al. (2013) estimate the direct effects of weight-classes on all-cause mortality and find that overweightness (BMI of 25-<30) was associated with a significantly lower all-cause mortality, and grade 1 (BMI of 30-<35) of obesity was not associated with higher mortality (Flegal et al. 2013). Similarly, in a study of 74 analytic cohorts including 388,622 individuals, McGee (2005)

reports “little evidence” of increased risk of mortality among those defined as overweight (BMI of 25-<30) and questions the “optimality” of the current classification of individuals as “overweight” (McGee 2005: 94). These findings contrast dominant obesity knowledge, however, those assuming obesity knowledge is unflawed are unaware of such problems. Further, the degree of inconsistency among [obesity] research findings questions the accuracy of obesity knowledge, elements that contradict the exact fundamental principles of positivism that these studies rely on.

So the question remains—how much of the obesity epidemic is “real” and how much of this can be attributed to a moral panic driven by biased interests? Patterson and Johnston (2012) review the realist-constructionist division in obesity research by arguing that the obesity literature has become bifurcated into two contrasting poles: a realist pole and a constructionist pole. While the realist perspective treats obesity as a biomedical fact, a health risk, and a true “epidemic,” the constructionist perspective attributes the moral panic to political interests, cultural values, stigmatization, and an all-around fat-phobia (Patterson and Johnston 2012: 1-5).

Patterson and Johnston (2012) take a critical-realist perspective on obesity that moves past epistemological tensions and beyond familiar dualisms. They draw from the works of Roy Bhaskar and those of Bruno Latour to map out a critical-realist perspective they contend is helpful in understanding “what we know, how we know it, and what actually exists” (Patterson and Johnston 2012: 4) regarding obesity. Their “hybrid” perspective views obesity and the obesity epidemic as products of the interactions between human agents, biophysical actants, and external environmental conditions.

Through this perspective, the question is not whether obesity is “real” or can be attributed to a “moral panic.” Rather, they propose that obesity is a series of “scientific prompts” interpreted by the medical establishment, which extend its authority by sharing its interpretations with others. Patterson and Johnston (2012) draw from Beck’s (1992) “risk society” and propose that the public is dependent on experts to make sense of scientific prompts in obesity. Here, powerful non-medical groups such as the media, food industry, and diet industry “adopt and modify” the medical establishment’s interpretations for their own self-interests. Then, the mass media and public agencies sensationalize obesity as a disease to be feared (Patterson and Johnston: 18). I am not necessarily convinced that obesity research requires a hybrid approach such as the one Patterson and Johnston (2012) provide, nor do I think it solves any epistemological or methodological debate. However, I am interested in the process they propose and its key elements (e.g. power, authority, self-interests, interpretation, language, framing, emotion) that influence public obesity knowledge and beliefs.

A recent, yet growing body of literature seeks to challenge the “obesity epidemic” by calling into question many of the methods and procedures within obesity research and clinical practice. This body of literature is most frequently referred to as “critical works of obesity,” also known as “critical perspectives of obesity,” “critical fat/obesity/weight studies,” and “critical accounts/geographies/biographies of obesity.” These contributions come from a range of disciplines (Monaghan et al. 2010) and offer multiple different perspectives to the study of obesity.

In general, the important commonality that strings this work together is a questioning of, or challenge to, the dominant perspective within the obesity field by

arguing that the “obesity epidemic” cannot be accepted at face value (Oliver 2006; Monaghan 2008; Monaghan et al 2010). This has been done in several ways, including but not limited to: 1) challenging the evidence, measurements, methods, and/or findings of obesity claim-makers (e.g. Aphramor 2005; Campos et al. 2006; Fletcher 2014; Saguy 2013), 2) breaking down the obesity epidemic through either historical accounts or lived-experiences of fat that do not align with dominant narratives (e.g. Boero 2007; Drew 2008; Rasseman 2012) 3) revealing “obesity politics” through the use of language, discourse, power and authority, or media sensitizing (e.g. Ward 2012; Colls and Evans 2009; Kersh 2009; Rail et al. 2010; Gollust 2013), 4) ethical considerations that emphasize stigma, such as a concern over health consequences fat people experience based on stigma rather than excess fat (e.g. Rich and Evans 2005; Muenning 2008; McPhail and Bombak 2015) and 5) providing alternative frameworks of health such as the Healthy At Every Size Approach (e.g. Bombak 2014; Penney and Kirk 2015; Chastain 2015). Although there has been an overwhelming amount of research that explores topics related to obesity (e.g. eating disorders, cultural norms or messages of beauty), these works are only considered a critical account of obesity if they challenge the dominant model in obesity. Overall, critical works on obesity seek to provide alternative perspectives to the dominant framework used in clinical practice and obesity research.

Claims about an ever growing and alarming “obesity epidemic” serve as the starting point for many critical works in obesity. Campos and colleagues (2006) confront four major claims about obesity: obesity is a global epidemic; mortality rates increase with increasing BMIs; well-established and incontrovertible data have proven the link

between overweight/obesity and adverse health outcomes; and long-term weight loss is a practical goal that will improve health (Campos et al. 2006: 55-57). The researchers find limited scientific evidence for any of these claims, thereby concluding that the obesity epidemic is an interpretation shaped by cultural and political forces rather than a reflection of a real health crisis. They provide support for this argument by highlighting the economic benefits leading obesity researchers and organizations have received from pharmaceutical and weight-loss industries. They also note the increasing amount of media attention given to obesity and argue that minorities and the poor receive the most blame for the obesity epidemic (Campos et al. 2006: 58).

Other scholars question claims of the obesity epidemic based on its empiricist logic and belief in neutral objectives that have been used to “build” the obesity epidemic. Murray (2007) directly grapples with empiricism, which she argues defines bodies through clinical ideas of normal bodies and pathology, and is pervasive in medical discourse. She suggests that knowledge of the body (although viewed as empirical truth) is made of cultural meanings, opinions, and prejudices. The social and cultural forces, including the medical profession, that define what makes a body “normal” are taken-for-granted. These meanings however, become embedded in perceptions of fat people and are inter-woven with discourses of gender, race, class, and sexuality. Murray (2007) concludes that a neglect of the embodied self is the consequence of a persistent bodily knowledge that has been constructed via medical discourse and practice.

Some scholars have questioned the accuracy of obesity claims by taking into consideration other growing aspects of society. Crossley (2004) examines claims of the obesity epidemic with contrasting claims of an overly “body-conscious” society. On one

hand, reports of rapidly increasing obesity rates prevail while on the other, the portrayal of a body-conscious society suggests a different relationship between society and the body. He explains that in a body-conscious society, fitness, thinness, and the overall self-monitoring of bodies are paramount and people adjust their behaviors to fit these ideals. Crossley (2004) concludes that obesity rates are social facts and that explanations of a lifestyle approach must be placed in the context of the late-modern society that prioritizes beauty and fitness. Although some argue that obesity is an outward rejection of conforming to societal ideas of beauty and femininity, Crossley (2004) dismisses this on several accounts.

A number of scholars have critically analyzed the influence the media has had in constructing an “obesity epidemic.” For example, Boero (2013) argues that the media does not simply report on already existent social phenomena, but rather the media creates them (Boero 2013: 371). Boero (2007) analyzes 751 articles on obesity published between 1990 and 2001 in *The New York Times* and finds that the number of articles on obesity during this time far exceeded those on smoking, AIDS, and pollution. She outlines three dominant themes in obesity and media research: 1) the framing of obesity in the media; 2) media reporting of obesity research; and 3) media characterizations of, and reporting on, obesity policy. Boero (2013) suggests that the media is intertwined in the production and dissemination of scientific knowledge. Further, the media’s tendency to shift blame on specific populations such as the poor, racial and ethnic minorities, and mothers means that stereotypes of race, class, and gender are continuously reinforced. Her analysis of news articles on obesity published over an 11-year period suggests that

obesity is what she calls, “a post-modern epidemic”—one that draws from the language and discourse of traditional diseases and that stirs a moral panic<sup>2</sup> (Boero 2007).

Many scholars have focused on the language, framing, and discourse used in obesity politics and not just by the media. Rail and colleagues (2012) argue that obesity scientists have favored a particular ideology while excluding other forms of knowledge that shape public understandings of obesity. The authors present nine themes of discursive constructions of obesity and health that support dominant discourses in obesity research. Rail et al. (2010) identify these themes from youth understandings of obesity that include physical activity, eating well, being neither too fat nor too skinny, having other physical qualities, avoiding bad habits, having personal qualities, feeling good, not sick, and having a healthy environment. The authors discuss each of these themes and identify the dominant claims in obesity discourse that shape each of these public understandings of obesity and health.

Expert opinions have also been explored to understand how dominant obesity discourse is created and maintained. Ortiz and colleagues (2015) interviewed 15 US-based obesity experts that provided insight into the frameworks used within dominant understandings of obesity. They find that although experts identify the environmental frame as dominant in obesity prevention and policy, experts expressed difficulty in using this frame because of the multiple factors involved in an environmental model, leading to complexities and vague solutions. Ortiz and colleagues (2015) conclude that some

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<sup>2</sup> Moral panic is a term that refers to a defined societal problem, which takes the form of a moral one through themes of danger, mortality, and outward rejection of the bible or other traditional cultural values. The media is able to shape public perceptions through framing issues in certain ways, often generating fearful public responses towards the problem. Obesity, mass shootings, gay marriage, terrorism, war, and immigration have all been victim to this process, which suggests that these problems are increasingly more prevalent and problematic than they actually are.



experts prefer a more causal model of obesity, where specific factors are identified as causing the obesity problem and which can generate more tangible solutions for prevention and treatment.

Other critical scholars focus on the ethical implications of dominant obesity discourse and politics. Rail et al. (2005) argue that employing scientific “evidence” gives credit and authority to claims of an obesity problem, the causes of obesity, and the proper steps to address the problem. The authors argue that dominant obesity discourse and narratives that draw from these pieces of scientific “evidence” are concerning because they exclude the importance of social influences on understandings of bodies and body weight. They discuss how the relationships between body size, health, and weight are not as significant as scientific experts lead us to believe, and that this discourse portrays the message that thinness is a universal ideal for health and wellness. These messages prioritize body ideals that may come at the cost of more serious detrimental health behaviors or outcomes. Examples of these are exposure to stress, stigma, eating disorders, and substance use. Although this review of critical works in obesity is not an exhaustive review, it serves as an illustration of how dominant obesity understandings have been challenged in various ways.

Previous critical works of obesity have been influenced by multiple philosophical and theoretical traditions. One could argue that any question or challenge to positivism has had some degree of influence. Particularly, any challenge to positivism that has provided alternative viewpoints has set the stage for others to eventually engage in a critical perspective of obesity. For example, social interactionism (e.g. Piedras 2012; Rivera and Paradex 2014), phenomenology (e.g. Murray 2007), social constructionism

(e.g. Boero 2006; 2007; 2009; 2012), critical-realism (e.g. Patterson and Johnston 2012), feminism (e.g. Saguy 2012; Warin 2010), and other areas of post-modern thought (e.g. Firth 2012; McPhail and Bombak 2015) can be considered traditions that have had a great amount of influence on critical perspectives of obesity. Areas such as sociology of the body (e.g. Crossley 2004), embodiment studies, and science and technology studies (e.g. Fletcher 2014) have also had an influence on critical works of obesity.

### *Conclusions*

In reviewing the “obesity epidemic,” I have provided a socio-historical account of obesity in the United States, emphasizing efforts of medicalization by “obesity entrepreneurs” (Monaghan et al. 2005) and other similar “engines” (Conrad 2005) at work (e.g. misleading visuals of rapidly increasing obesity prevalence by the CDC, re-defining BMI categories by the NIH). I have reviewed the dominant model of obesity used in clinical practice and research that has influenced public perceptions and understandings of obesity. I integrated prominent contributions from the literature on medicalization and critical works of obesity to show how obesity has become what we know it as: a real medical problem in need of attention and treatment based in individual failure that contradicts American values. In doing so, my aim was not to discount or disprove the claim that excess fat is unhealthy, although the legitimacy of these claims have been questioned elsewhere (see Monaghan 2005: 304-307; Burkhauser and Cawley 2008; Aphramor 2005), including research indicating that excess fat alone is not associated with poorer health (e.g. McGee 2005; Flegal et al. 2013). Rather, I provided a context for the current project, which was an attempt to understand the influence that the

AMA's designation of obesity as a disease has had on those considered "obese" by medical standards.

In the following chapter, I describe the theoretical framework used and provide a review of relevant literature that was influential in shaping the current project. I explain why symbolic interactionism was the appropriate framework for studying the experiences "obese" people had when discussing body weight, focusing on relationships between language, meaning, and experience. I then draw from the literature in the social construction of medical knowledge, language, and the illness experience and relate the important theoretical and methodological contributions to the current project.

## CHAPTER 2: THEORETICAL FRAMEWORK AND LITERATURE REVIEW

*Understanding what facts and machines are is the same task as understanding who the people are. --Bruno Latour*

### *Overview*

For the current project, I used a symbolic interactionist theoretical framework to demonstrate how the self is tied to others and to the larger society. The relationships between the self, others, and society are critically important in order to understand how efforts of medicalizing body weight, such as the AMA's recent classification of obesity, influences the experiences of those considered "obese." This framework is also important in challenging the seemingly intrinsic nature of "obesity," its accompanied meanings, and language. In this chapter, I provide a description of symbolic interactionism and why it was the appropriate framework for the current project. Specifically, I focus on meaning, interaction, and experience, how the self emerges and develops from social interaction. I discuss several ways a symbolic interactionist theoretical framework is useful in studying experiences of body weight. Major tenants of a symbolic interactionist perspective are particularly important for understanding the experiences of those viewed by others (and therefore often times by self) as "obese" and "diseased."

In the second part of this chapter, I provide a review of the relevant literature that was influential in shaping the current project. I explain how my approach differs from the dominant approach in obesity research. I argue that the "reality" of America's obesity "problem" has been created and maintained through interaction and shared meanings,

rather than representing an objective reflection of reality. I discuss how interaction and shared meanings are fundamental to experiences and understandings of obesity. Further, I explain how accepting the obesity epidemic at face value has been made possible through strategies of obesity entrepreneurs and their language. I conclude with a similar argument made by others, that body weight cannot be studied as an objective fact (Sobal and Maurer 1999), and that focusing on social interaction, language, meanings, and experience is useful in studying the current situation of obesity in the U.S.

A question that I am frequently asked regarding my research is, “So are these people [those considered “obese”] just in denial of their situation [being obese]?” The answer to this question depends on what is accepted as reality, and therefore what constitutes a denial of that reality. In other words, whose perception of the “obese” person reflects the truth? How many realities are possible? These discussions go well beyond a Q&A session because they are rooted within competing epistemologies (ways of knowing) and ontologies (social imageries) of the social world. It is likely that the person who raises this question is referring to an objective reality of the situation versus a subjective point of view. Here, the objective reality would be the “fact” that the “obese” person is undoubtedly obese; the subjective reality, then, is the individual’s misperception, seen as a “denial” of this objective reality, an inaccurate, and therefore, false view of his or her real situation. Treating the objective versus the subjective in this way, as distinctive and separate operating realities, follows a dualistic perspective.

Dualism views fact as separate from and superior to opinion, where the fact mirrors an objective reality and the opinion is associated with a subjective point of view. This perspective, as previously discussed, sets the stage for what we know as, “the

obesity epidemic,” which Fletcher (2014) claims was made possible through the adoption of the BMI. Within dualism, the mind is a blank slate that is able to reflect an exact impression of reality. Further, standards such as the BMI are seen as rigorous and neutral measures, and through a step-by-step procedure, their application enables the researcher (or physician) to uncover truth and unbiased knowledge, in this case regarding obesity. However, the mind is not a blank-slate and cannot simply mirror reality. As demonstrated in the previous chapter, the obesity epidemic has been built on the grounds of perceived objectivity and neutrality (Aphramor 2005), yet has actually been created by and through obesity entrepreneurs (Monaghan 2005), efforts of medicalization (Gracia-Arnaiz 2010; Sadler 2014), and pervasive discourse (Warin 2011).

### *Symbolic Interactionism*

Symbolic interactionism is a distinctive theoretical framework used to study human group life and human conduct (Blumer 1969:1) that views human action as constructing self, situation, and society (Charmaz 2014: 262). This perspective recognizes that human action and interaction constitute society, and that people act in relation to one another (Blumer 1969:7). Symbolic interactionists view reality as continuously created and recreated through social interaction, where people act in response to others. Here, the use of the term “response” refers to the individual who takes into consideration others and the environment through human action, rather than to a more traditional stimuli-response explanation of behavior (Blumer 1969).

This view of the social world is rooted in pragmatism<sup>3</sup>, which rejects dualistic epistemology and views reality as open to interpretation. Pragmatism challenges the possibility of objective knowledge, since humans are actively engaged in what constitutes knowledge. This view of the mind opposes that of dualism, which requires the mind to be passive and to simply reflect or provide an identical impression of reality. Within dualism, this interpretation and manipulation introduce human error, or contaminate otherwise pure knowledge, whereas pragmatists argue that human interpretation is what creates knowledge. Symbolic interactionism is rooted in this philosophy and views the social world and humans as active beings. Human action constitutes reality and this human action is not random. Action, within the pragmatist tradition, is practical because individuals interpret the world and others, and adjust their actions accordingly. Therefore, the world is not passively perceived as it objectively stands, but is actively created and interpreted by humans.

Most attribute the origins of symbolic interactionism to George Herbert Mead (1863-1931) whose work connected the mind and the self to society. Mead was interested in how the individual connects to society and how society shapes individual selves and thinking. He was influenced by Charles Horton Cooley (1864-1929), who earlier sought to understand the connection between society and the individual, emphasizing how the mind shapes human behavior and social facts. In Cooley's "looking glass self," we make sense of ourselves by reflecting on our perceptions of how others see and evaluate us (Belgrave and Charmaz 2015). Mead's theory of the mind and self that emerges out of communication and experience with others has become foundational to symbolic

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<sup>3</sup> Traditional pragmatists include Charles S. Pierce (1839-1914), William James (1842-1910), John Dewey (1859-1952) & George Herbert Mead (1863-1931)

interactionism. Through an active, ongoing process, people construct selves and meanings through social interaction. Herbert Blumer (1900-1987), interpreted and built on Mead's work, coining the term "symbolic interactionism" and further explaining that meanings of actions are what people react and respond to, not the action itself. He makes Mead's contribution to symbolic interactionism evident when he clarifies that meanings are derived from social interaction, and people act based on these meanings (Blumer 1969). Therefore, symbolic interactionism assumes that people act based on meanings that derive from social interaction (Charmaz 2014).

Within symbolic interactionism, people do not respond to things, but to the meanings they attribute to those things. These "objects," which Blumer (1969) defines as, "anything that can be indicated or referred to" (pp. 11), are products of symbolic interaction, and therefore social creations (pp.11). Blumer (1969) explains that these objects can be physical objects (i.e. a desk), social objects (i.e. a physician), or abstract objects (i.e. equality). No objects have fixed or inherent meanings; all meanings are created, learned, and shared through social interaction. Meaning, therefore, is derived from language through a process of "symbolization" (Mead 1934: 78). Mead (1934) explains, "language does not simply symbolize a situation or object which is already there...it makes possible...that situation or object" (pp. 78). Further, meaning is conceived entirely in the field of experience, by the communication and mutual adjustment of behavior among those involved (Mead 1934).

Mead (1934) suggests that through the process of controlling meaning, "the mind" emerges out of language, and develops out of social interactions, particularly through the process of reflexivity (pp. 133-134). Reflexivity, for Mead, is "the turning-back of the



experience of the individual upon himself” (1934: 134), where the individual reflects on the situation, his or her actions, and the actions of others. The key is that the person views his or her self through the eyes of others, from the outside, as well as subjectively, from the inside. This process involves the individual thinking about what the experience meant for those involved and alternative ways the situation could have played out. Reflexivity is a key process in the development of “the mind” because the individual reflects on an experience from the past and internalizes what this means for the present. Similar to the relation to objects, people do not respond to the actions of others, but to the meaning given to those actions (Blumer 1969: 79). Therefore, like objects, no actions have fixed or inherent meanings; all actions are created, learned, and shared through social interaction. Meanings (of either objects or actions) vary among people, time, and place (Blumer 1969; Charmaz 2014).

One of Mead’s major contributions to symbolic interactionism is his concept of “the self,” which has been adopted and further developed in studies of chronic illness (see Bury 1982; Charmaz 1991, 1995, 2006). For Mead, the language process is fundamental for the development of the self. Individuals are not born with a self, since the self arises and develops from social processes. The self is a subject and an object; the self is an object [to itself] when the person engages in a process of reflexivity, takes on the attitude of the other, adjusts his or her actions accordingly, and views him or herself as others may be seeing and evaluating him or her. The self, as Mead (1934) wrote, “...can be an object to itself, is essentially a social structure, and it arises in social experience. After a self has arisen, it in a certain sense provides for itself its social experiences... it is impossible to conceive of a self arising outside of social experience” (pp.140).

Mead and symbolic interactionism are fundamentally important to the development of social constructionism, the major theoretical approach used in critical obesity research. As Hollander and Gordon (2006) argue, consensual meaning constructed through interaction should be the focus for social constructionists, although often ignored by those applying a social constructionist approach (Hollander and Gordon 2006). In the current project, meanings that are continuously created and maintained through social interaction and that influence experience were important. Belgrave and Charmaz's (2015) discussion of meaning based on Mead's (1934) work is useful: "meaning exists within interaction... is emergent and exists in the field of experience" (p. 110). Through this approach, language is intimately tied to interaction and meaning, rather than to an "abstract logic form" (Callinicos 2007:267).

### *Social Constructionism*

Although there are several versions of social constructionism (see Best 1989; Miller and Holstein 1993), Conrad and Barker (2010) loosely describe it as the study of taken-for-granted phenomena and how meanings of phenomena are constructed through social interaction, rather than inherently ascribed (Conrad and Barker 2010). Since meanings are created through interaction, social constructionists agree that individuals create, at least to some extent, reality and knowledge. The degree to which social constructionists attribute reality to human interaction varies depending on the version of social constructionism (Brown 1995). Frequently, the origins of social constructionism are attributed to Berger and Luckmann's (1967) *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*, and their connection between ideas, including

taken-for-granted knowledge about reality, and everyday social interaction (Barker 2010:147). Social constructionism has been influenced by earlier works in the sociology of knowledge, where knowledge does not reflect positive facts but is borne from the social (Merton 1937). Our ideas are social constructions (Barker 2010) and all social phenomena are constructions produced historically through human activity (Berger and Luckman 1967: 123). It is important to note that the goal of social constructionism is not to prove what is “real.” Rather, social constructionists seek to understand how certain social phenomena come to be taken-for-granted (Barker 2010).

A social constructionist approach in studying health confronts similar variations, since constructionists view the biological and social aspects that constitute health in very different ways. Bury (1986) emphasizes that the main proposition of social constructionism within medical sociology is to treat medical knowledge as problematic and as a central issue in analysis. Constructionists within medical sociology have been greatly influenced by earlier writers that problematized knowledge and power, like Marx and Foucault, whose references to medicine and the health field motivated others to start thinking sociologically about critical issues within health (Bury 1986). Social constructionism within medical sociology usually focuses on either the construction of medical knowledge or the social construction of illness, connected yet frequently treated as distinct areas of study (Brown 1995).

There are several bodies of literature that inform the current project. These literatures bring together theory and the study of health and illness to: 1) critically question biomedical institutions and their practices by shedding light on the techniques used by “engines” and “entrepreneurs” and the potential implications of these practices;

2) emphasize the importance of language in discussing health and illness including language used in obesity; and 3) focus on the everyday, lived experiences of illness and the changes these experiences bring to self, identity, and relationships with others.

I begin by reviewing the literature on what others have called “obesity science” and its accompanied knowledge. This research includes the social construction of medical knowledge and the use of standards, technology, science, and mathematics that have helped in shaping the obesity epidemic. I find this area of literature relevant to the current project because it is important to understand the logic used in medicalizing obesity, and how this logic is able to shape policies and guidelines that influence those considered “obese,” including the AMA’s designation. The second area of literature that I review is the construction of language and how impactful language is within the obesity field.

Meaning is embedded in language, and meanings are shaped by, and in turn, influence experiences. This area of literature is important since the current project aimed to explore the language used in discussions of body weight that participants have with physicians.

Following this is a review of the literature that focuses on everyday experiences of living with a certain health condition and the influences illness has on the person’s sense of self, identity, and relationships with others. This area of literature was important in helping to shape the current project because it highlights how impactful health and illness are, and how daily life is often organized, limited, and understood around one’s condition.

Therefore, obesity as a “disease” may have real consequences for those considered “obese” by medical standards, on their day-to-day lives, sense of selves, identities, and relationships with others.

*Obesity Science and Knowledge*

As discussed in the previous chapter, obesity knowledge and associated claims have been questioned and challenged by multiple scholars within critical works of obesity. Obesity science refers to the knowledge about the causes, health effects, and treatments of body weight (Fletcher 2014: 338). Obesity science and the knowledge it produces constitutes an important body of literature for the current project because it has been used to persuade supporters that obesity is a real health problem that must be treated. Therefore, efforts of medicalization, including the AMA's re-classification of obesity and the guidelines for physicians that were released immediately following this announcement (further discussed in Chapter 3), have relied on obesity science and knowledge to implement policy, garner supporters, and increase obesity funding. I review some of the literature in obesity science and knowledge and discuss how this area of research helped shape the current project.

Since 1970, the BMI has become the standard means of assessing individual body weight and population obesity prevalence (Fletcher 2014). Although many health practitioners agree that the BMI is an imperfect measure of body weight, most agree that it is the most widespread and universally accepted measure. In the search for more accurate measures of fatness and obesity, Burkhauser and Cawley (2008) review obesity research and find several issues that make the BMI a flawed measure. They found that the following are all sensitive to the measure of fatness and obesity that the researchers used: definitions of "obesity" which influence the proportion of study respondents who are considered "obese" in a particular study, group rates of obesity, and correlations of obesity with other socio-environment variables often of interest. Burkhauser and Cawley

(2008) condense major findings reported in previous research which raises questions about the validity of obesity research, such as the substantial fraction of study respondents who are misclassified as obese or non-obese when using the BMI relative to percent body fat. In collecting their own data, Burkhauser and Cawley (2008) find discrepancies between genders, racial groups, and employment statuses in relation to previous obesity claims. Similar findings presented by Burkhauser and colleagues (2009) reveal differences in U.S. obesity trends when using the BMI versus an alternative measure of fat known as skinfold thickness. Although Burkhauser and Cawley (2008) suggest that their work encourages the use of more accurate measures of fatness, I argue that in doing so, they have indirectly made the opposite case that seriously questions the use of any measures of fatness.

Social constructionists of medical knowledge argue that beliefs regarding diseases, practitioners, and institutions have been socially constructed overtime, and view medical categories as the outcome of purely social practices (Wright and Treacher 1982). From this perspective, knowledge and ideas about medicine, health, illness, and healing are constructed socially and continuously altered depending on historical and cultural contexts (Jordanova 1995). The study of the social construction of medical knowledge also seeks to explain why some knowledge is favored over other knowledge (Major and Savin-Baden 2011), or “what knowledge counts” (May and Ellis 2001:989). The field has been influenced by previous discussions of the philosophy of science and nature, history of medicine, sociology of knowledge, interests and power within the practice of medicine, cultural differences in understandings and experiences of the same disease, and Foucault’s ideas of medical discourse (Jordanova 1995).

Further, social constructionist scholars of medical knowledge argue that claims of medicine cannot be divorced from medical practice (Jordanova 1995: 362). For example, in May and Ellis' (2001) ethnography of telemedicine clinics, they argue that focusing on the "hardware" in medical service distracts us from the origins of the information produced. Their findings support Latour's (1987) claim that, "Understanding what facts and machines are is the same task as understanding who the people are" (Latour 1987: 140). Here, science and technology are distractions from the socially constructed nature of the "facts." May and Ellis (2001) show that how facts are contested can lead to failure played out through professional practices.

Other scholars have directly challenged biomedical knowledge of obesity and its assumptions. Aphramor (2005), a dietician by training, critically assesses the legacy in biomedical knowledge to view health and obesity in individual terms. She argues that the reductionist "energy-balance" metaphor is inappropriate for explaining fatness. Aphramor (2005) continues by pointing out messages that "size matters" encourage certain narratives that support biomedical obesity knowledge. She identifies the following supporting beliefs: that everyone who is fat is unhealthy and would be healthier and feel better if they lost weight; that weight-loss behavior is risk-free; that sustained weight loss is always and equally achievable with suitable changes and commitment at an individual level; that it is primarily the duty of the individual to fit these norms and not an obligation for the more powerful society to challenge narratives and address inequity, including size-based discrimination (Aphramor 2005: 317).

Further, a universal pathology of obesity and weight gain lead to subsequent universal treatment strategies for weight-loss, which assume that all bodies work the

same. In a paper currently under review, Harder and Belgrave (2017) find that participants provide multiple explanations or causes of their current weight-status that do not align with the dominant “energy-in, energy-out” pathology. Those considered “obese” should be at the center of these narratives (Boero 2000; 2007), because experiences of body weight among those considered “obese” by medical standards could inform health practitioners, obesity researchers, and policy-makers in the accuracy of their assumptions, which influence medical practice and health policy (Harder and Belgrave 2017).

This dispute over obesity knowledge can be considered a “knowledge controversy” (Whatmore 2009), where there exist competing claims and bases of expertise between dominant biomedical institutions and others. A possible solution to knowledge controversies is to redistribute and broaden the definition of “expertise” (Whatmore 2009; Yoshizawa 2012). This is similar to the previous discussion about what knowledge is legitimized over others and “what knowledge counts” (e.g. Major and Savin-Baden 2011; May and Ellis 2001).

For several decades, the mass media has been a prominent source of health and medical knowledge. In general, the mass media creates and reproduces meanings, and therefore, contributes to the creation and reproduction of health and medical knowledge (Lupton 2014, 1999). The media is an important site to understand health constructions and their impacts on different groups, health behaviors, and understandings of illnesses and diseases (Peel 2014). The media can shape public perceptions of the causes of a said problem, who is responsible, and who is affected (Gollust and Lantz 2009). Previous studies have focused on the media as a construction site for health knowledge about a



range of problems including Type II diabetes (e.g. Gollust and Lantz 2009), prescription drugs (e.g. Bradord and Kleit 2015), Alzheimer's (e.g. Peel 2014), HIV/AIDS (e.g. Lupton 1999), smoking (e.g. Viron et al. 2013), and obesity (e.g. Boero 2007; Gollust et al. 2012).

Media constructions of obesity as a public health epidemic can be traced back to the mid 1900's (see Rasmuseen 2012). Boero (2007) traces the "historical emergence" of the obesity epidemic by analyzing 751 articles on obesity published between 1990 and 2001 in *The New York Times*. She finds that more news articles were published during that time on obesity than were on smoking, AIDS, and pollution. Boero (2007) also notes that most of these articles were published since 1998. Recall from the previous chapter that the NIH's re-shuffling of obesity categories happened in 1998, which re-classified over 50 million Americans as overweight and obese. However, as Boero (2007) argues, the media's hysteria over rising obesity rates or a "moral panic" has generated an ideology where public perceptions of obesity are grounded in morality (Boero 2007), and steers clear of mentioning the re-classification act that contributed to the "rise" in obesity prevalence. Additionally, media messages that portray obesity as an issue of individual responsibility have placed the blame on the individual. Similarly, Gollust and colleagues (2012) analyzed images of overweight and obese individuals in *Time* and *Newsweek* during the years of 1984-2009 and found that non-whites were portrayed as disproportionately "affected" by obesity. Further, these images were of non-whites engaging in stereotypical behaviors that reinforce ideas of laziness, lack of self-control, and overeating. Ironically, associations of media use and obesity have been well

documented, attributing this relationship to sedentary lifestyles and overeating (Dietz and Gortmaker 1985; Coon et al. 2001).

Previous research has also given much attention to the mass media's portrayals of societal norms, including messages of beauty, sex, gender, and body image (e.g. Andsager 2014; Thompson 2009; Grabe et al. 2008). The mass media creates obesity knowledge, at the same time shaping public perceptions by defining the "normal" or "healthy" body. Taking into consideration these previous studies, we can conclude that the mass media serves a dual-role: constructing obesity knowledge and shaping public perceptions of obesity and of "obese" people.

### *Language*

The language used in obesity is an important aspect of the obesity epidemic that influences experiences of body weight. Boero (2000) suggests that a focus on language within social constructionist approaches to obesity can contribute to overall understandings of the obesity epidemic. Language, in general, cannot be taken at face value. Ehrlich and King (1992) explain that "language is not a neutral vehicle in the representation of reality and is necessarily laden with social values" (Ehrlich and King 1992: 152). Symbolic interactionism helps to understand language: through interaction, specifically through the use of symbols and gestures, meaning is constantly created and recreated. Language is a process that depends on agreed upon meanings. Frequently, interaction is interrupted because of differences in meanings and interpretations (St. Clair 1982). Through negotiation, these disagreements can be sorted out. However, when there is a lack of feedback in conversation, people leave the interaction assuming that their

views are completely shared by the other person (St. Clair 1982). Therefore, language is not simply a reflection of an objective reality; rather, through language, we define the situation (St. Clair 1987), where reality is made and not found (Rail et al. 2010: 263). Further, Yule (1947) argues that the purpose of studying language is not to reveal accurate or correct representations of the words people use but to understand their meanings within its context. For example, in obesity talk, terms such as “obese,” “fat,” “overweight,” and “large” are historically specific social constructions within themselves (Boero 2000: 156). Boero (2000) argues that the synonymous use of these terms is a denial of the historical, social, and political contexts these words are used.

Language is important in the development and maintenance of other social constructs such as race (Desimone 1993) and gender (Ehrlich and King 1992). Language as a “tool” does not necessarily suggest that language is an objective reflection of reality. The use of language as a tool to convince others to share our worldview reveals “the world and our way of being in it to us” (Dahlstrom 2013: 3). How the language-user frames the issue through the use of language is important in understanding his or her worldview. Ehrlich and King (1992) explain that the social construction of linguistic meaning within its context can help us understand the larger discourse.

Discourses, as Foucault (1973a,b) put forth, are “regimes of truth.” Discourse is the use of language as a hidden strategy, exercised through exerting power and authority, to put forth one’s own worldview, which then becomes circulated and legitimized as “knowledge” or truth. As Foucault wrote, “in every society the production of discourse is at once controlled, selected, organized, and redistributed by a certain number of procedures whose role is to ward off its powers and dangers, to gain mastery over its

chance events, to evade its ponderous, formidable materiality” (Foucault trans. Sheridan 1981:52, ed. Young).

The study of discourse involves an investigation of how we, as language-users, interpret what others intend to convey, make sense of what we read, understand what speakers mean despite what they say, recognize discourse as connected rather than incoherent, and successfully participate in conversations (Yule 1947: 139). In other words, discourse also includes what is not explicitly said, which can include the setting and boundaries that allow language to be used in a particular way. Cheek (2004) explains that discourse involves certain assumptions that often are accepted as taken-for-granted truths. As Altheide and Schneider (2013) illustrate, discourse involves symbolic representations that are enmeshed in a series of other assumptions (Altheide and Schneider 2013: 116). Further, the kinds of framing and including or excluding of certain viewpoints are of importance (Altheide and Schneider 2013). Discursive frames decide what will be presented and how, while excluding all other possibilities. Together, discourses and frames suggest a “taken-for-granted” perspective on how a problem is approached (Altheide and Schneider 2013). Simply put, discourses and discursive frameworks order reality in certain fashions (Cheek 2004: 1142).

Rich and Evans (2005) argue that obesity discourse is based in scientific ‘evidence’ including themes of causation, prevention, language of risk, morality, and individual responsibility. Rail and colleagues (2010) describe obesity discourse as the deployment of language and technologies in the name of “truth” that constitute a hidden political agenda based in obesity science and hegemonic norms (Rail et al. 2010: 262). Obesity discourse has been referred to as a “facist structure” or “an example of micro-

facism” because it is saturated with ideology and intolerance regarding its evidence and knowledge (Rail et al. 2010). Further, they argue that it “operates hand-in-hand with prevailing power structures” (Rail et al. 2010: 262) that assist in the constant surveillance and regulation of bodies.

A critical perspective of dominant obesity discourse involves a discussion of the ethical implications of such discourse and the possible impacts on social identities, lives of people, and cultural understandings of ‘fat’ and of health (Rich and Evans 2005: 342). Similarly, Rail et al. (2010) conclude that obesity discourses are often rearticulated within discursive constructions, and frequently such re-articulation constitutes a valuable strategy which people use to construct identities (Rail et al. 2010: 275).

### *The Illness Experience*

Several conceptual distinctions have been made between disease and illness. For example, Eisenberg (1977) views disease as the “biological condition,” and illness as the “social meaning of the condition.” Kleinman (1988) describes disease as the practitioners’ creation, based on their training and theoretical lenses of their field, that recasts illness in terms of theories of disorder and reconfigures illness problems as narrow, technical issues. Illness, as he describes, is how the person and his or her networks perceive, live with, and respond to symptoms and disability (Kleinman 1988). Gabrielsen et al. (2014) note that frequently, people “get” diseases they will probably have to deal with for the rest of their life but still view the disease as something that can be influenced and dealt with (Gabrielsen et al. 2014: 367). Although there is controversy over conceptual distinctions between disease and illness, social constructionists agree that

the experiences of illness are, at least in part, shaped by social and cultural phenomena (see Brown 1995; Conrad and Barker 2010; Barker 2010).

Social constructionist analyses of illness address how social forces influence our knowledge of, and assumptions about, health and illness (Brown 1995), and question how we come to understand and experience illness. Conrad (1987) argues for a sociology of illness that explores everyday life with illness, focusing on the meanings of illness, the social organization of the sufferer's world, and strategies used in adaptation (Conrad 1987: 4-5). In Conrad and Barker's (2010) review of the literature, they present three overarching constructionist findings in regard to illness: First, some illnesses are embedded with cultural meaning that shapes how society responds to those afflicted and influences the experience of that illness; second, all illnesses are constructed at the experiential level, based on how individuals come to understand and live with their illness; and third, medical knowledge about illness and disease is not necessarily given by nature but is constructed and developed by claims-makers and interest parities. They conclude that the subjective experience of illness must be placed within the context of the person's everyday life and has implications for medical practice and policy that approach illness from a biomedical-deterministic perspective. For example, Anderson (1991) found that among immigrant women, not only did their illnesses contribute to their devalued sense of selves, but their dependence on a limited social network and difficulty communicating with others, including healthcare providers, proved to be extremely difficult in dealing with illness. Conrad and Barker's (2010) emphasis on placing the subjective illness experience in the context of one's everyday life is important in understanding the world-view of Anderson's (1991) immigrant participants.

Origins of the social constructionist approach to illness are frequently traced back to Irving Zola's (1966) article, which challenged the objective nature of illness by presenting cultural differences in the complaints among Irish and Italian patients who were diagnosed for the same disorder. Specifically, he found significant differences in the way patients presented and reacted to their complaints (Zola 1966: 628). Zola (1966) concludes that defining symptoms and problems are part of a social process and that differences across populations are in part attributed to social and cultural differences.

Since Zola's (1966) work, a number of scholars have studied how people experience chronic illness. This work provides meaningful insights into how people experience illness, how these experiences differ and change, and how experiences of illness are intertwined with sense of self and identity. As Charmaz (2006) illustrates, "constructing meanings of health, illness, body, and self is an on-going project for people with chronic illness and disability" (Charmaz 2006: 27). Drawing from Giddens's (1979) view of chronic illness as a "critical situation," Bury (1982) sees illness as a major disruptive experience. Through interviews with rheumatoid arthritis sufferers, Bury (1982) found that people experienced the onset of the condition differently, often "rearranged" their involvements, and re-thought their social relationships and networks. Frequently, functional limitations and embarrassment were reasons for not participating in normal, taken-for-granted everyday activities, which became tiring and frustrating tasks to withdraw from (Bury 1982). Bury (1982) argues that illness is experienced as a biographical disruption, where one's entire life is re-arranged to adapt to a newly confronted reality. Charmaz (2006) also finds that meanings of health and emerging selves are influenced by one's involvement and participation in valued activities that

often change with illness and disability. These meanings influence how people view and act toward their illness (Charmaz 2006: 28), but are not necessarily a biographical disruption.

The illness experience includes how persons view themselves, others, and their conditions. Drawing from symbolic interactionism and Cooley's "looking glass self," we make sense of ourselves by reflecting on our perceptions of how others think, see, and evaluate us (Belgrave and Charmaz 2015). We imagine what others think of us, which can bring upon a range of emotions (Waskul and Vanninni 2006; Charmaz and Rosenfeld 2006). For example, through Johnson and colleagues' (2012) interviews with men with depression, they found that seeking-help often depended on whether the participant considered seeking-help as an independent, masculine behavior or the opposite (Johnson et al. 2012). Gendered perceptions of depression and discourse surrounding the condition influenced the meanings participants had of their own depression and of themselves, which influenced their decisions to seek help.

Chronic illness involves a change in how we view ourselves, and our imagined judgment of the judgments others make of us. Physical changes to the body, posed by illness, disability, surgery, a sudden accident, stroke, etc., often alter the social self, social relationships and identity (Rosenfeld and Faircloth 2004). We compare our bodies to others' bodies, and make judgments of bodies and selves based on cultural ideals that have set the standard for a "normal" or "appropriate" body (Monaghan 2006). Further, George and Rail (2006) explain that identity is negotiated in relation to various sets of meanings and practices that people draw from as they come to understand who they are.



The relationship between self-identity and body weight has been well documented throughout the literature. Although studies have explored men's self-perceptions of their bodies, there is an overall gendered trend in studies showing a significant relationship between negative self-esteem and overweightness for girls and for women. Klaczynski et al. (2004) found that negative attitudes toward obesity and thin idealization mediated the relationship between body esteem and gender. They also found that causes of obesity and beliefs in control over weight also were important in explaining the association between gender and body esteem. Schafer and Ferraro (2011) found perceived weight discrimination to be harmful to current self-perceptions. Similarly, Harder and Belgrave (2017) found that experiences of weight-based stigma in childhood were influential to self-perceptions and self-identity well into adulthood. Further, Schafer and Ferraro (2011) report that an increase of health risks associated with functional limitations were higher for those who experienced weight-based discrimination. Here, weight-based stigma or others' perceptions are shown to be harmful to self-perceptions, but also detrimental to physical health. Along with discrimination and weight-based stigma, Mead's concept of temporality as important to the self has been shown to be relevant in studies of chronic illness (e.g. Charmaz 1995; 1999; 2006; Belgrave and Charmaz 2015), and experiences of body weight. For example, Harder and Belgrave (2017) found that body weight was experienced temporarily, as participants often identified with past or future valued selves. The social constructionist approach to illness provides useful insights when studying obesity because, similar to experiences with chronic illness and disability, experiences of body weight influence self and identity. At a time of increasing medicalization of obesity, it is important to understand the experiences of those considered "obese" by medical

standards, and how these experiences may influence our knowledge of obesity and what this means for people considered “obese” and now “diseased” by medical definition.

### *Conclusions*

Symbolic interactionism and the works of George Herbert Mead are useful in shaping the current discussion of obesity. Through social interaction, we engage in a continuous process of meaning-making, which constitutes how we view ourselves, others, and the world. Symbolic interactionism is particularly important in discussions of the self and identity. Senses of selves and identities come from social interaction with others, and the meanings we have of certain phenomena. Phenomena and their ascribed meanings are constructed socially, through interaction, yet informed and reinforced by generally accepted meanings that are often given the status of empirical truths or a reflection of an objective reality.

Both meanings and language hold a significant place in obesity and in the everyday lives of those considered “obese.” Dominant obesity discourses rely heavily on scientific language and medical “truths,” where power and authority operate behind the illusions of objectivity and neutrality. These discourses, however, involve ethical considerations since people draw from discourses to make sense of themselves and others. Through interaction, judgments are made about ourselves through a reflexive process of imagining others’ perceptions of us.

It is important to note that I did not attempt to reveal causal relationships to explain the effects of a certain health policy by examining patients pre and post-policy. As illustrated throughout this chapter, we are constantly engaged in a continuous process

of creating and recreating meanings and therefore, it is impossible to divorce language from experience or to suggest an orderly progression of how these unfold. It is however, possible to focus on experiences people have had, including discussions of weight with their physician since the AMA's 2013 policy and to explore critically the language used since this new designation was made. In the following chapter, I draw from the theoretical contributions and literature discussed here, and explain how I conducted the current project.

## CHAPTER 3: METHODS

*...an honest plurality of voices will open up a space of freedom for the radical singularity of individual and disparate knowledge. When we can witness the emergence of health discourses within which diversity takes center stage; when stories and histories of health and the everyday relations of power, domination, resistance, and struggle may circulate in espaces de liberte, then we can better unpack the play of power in health inquiry and guard against the project of biopolitical governance. --Genevieve Rail, Stuart Murray and Dave Holmes*

### *Overview*

For the current project, I sought to understand the influence that the AMA's designation of obesity has had on those considered "obese" by medical standards. I conducted 31 face-to-face, in-depth interviews with 29 participants who were considered "obese" by medical standards and had discussed body weight with a physician sometime after the AMA's 2013 re-classification of obesity. Using symbolic interactionism complemented with grounded theory methodology, I addressed the following research questions: 1) What are the experiences "obese" people had when visiting a health professional post the AMA's re-classification of obesity? 2) How did the designation of obesity as a "disease" affect the language used in discussions of body weight between the health professional and the patient? 3) How did "obese" patients interpret the language used in these discussions of body weight?

In this chapter, I provide background information that shaped the current project followed by a brief discussion of the importance of qualitative methods in health and obesity research. I then discuss grounded theory methodology as my research approach and explain its usefulness in understanding experiences and language. Following this, I

provide a review of the important institutional requirements and approval processes that were completed before recruiting participants for the project. I then describe in-depth interviewing and the use of a flexible interview guide. Also included are notes on the creation of the interview guide, an overview of the AMA's guidelines for physicians, and how I revised my interview guide throughout the process of data collection and analysis. I include both the interview guide and a recruitment flyer in the Appendix (see Appendix B and Appendix D). Further outlined are the eligibility criteria for participation, as well as sampling and recruitment strategies. I also provide important notes about the sample and location. I describe in detail the process by which I simultaneously collected and analyzed data, and the use of theoretical sampling, as consistent with grounded theory. Concurrent data collection and analysis are discussed in addition to how major themes were drawn from this process with the use of specific examples from the data. Last, I discuss the final stages of the analytical process and how I constructed a theory that is grounded in the data about experiences of body weight. It is important to note that during the process of collecting and analyzing data for this project, I accepted a position which required me to relocate from Miami, Florida to Tampa, Florida. I describe in detail how the change in location, Institutional Review Boards, and academic titles influenced the project.

### *Background*

A few years ago I was working on a project in which I sought to understand the meanings African American women ascribed to physical activity. I explored this topic after realizing that much research in public health and epidemiology continuously

reported low levels of activity among African American women (e.g. Breitkopf et al. 2004; Brownson et al. 2000), some even labeling this population “sedentary” (e.g. Eyler et al. 1999). I was curious as to what it was—about physical activity, or African American women—that led to such persistent findings. Through in-depth interviews with African American women, I began to realize that meanings of physical activity could not explain this disconnect. Instead, meanings of bodies and body weight were at the core of my, then re-directed, research project.

I went on to explore the meanings people gave to phenomena such as “obesity” and “fatness” and to understand experiences of body weight. This involved conducting in-depth interviews with women who were considered “overweight,” “obese,” and “morbidly obese” by medical standards. This is one of the first empirical contributions to critical perspectives of obesity that draw from people’s experiences of body weight. Among several important findings, two have shaped the current project. First, most participants did not identify with their medically assigned weight labels (see Table 1 below for BMI-based weight labels). Second, participants gave different meanings to phenomena such as “obesity,” “fatness,” and “health” that have been influenced by past experiences, yet also influence the value participants gave to certain activities in terms of priority and importance.

Table 1. Body Mass Index and BMI-Based Weight Labels

| <b>BMI Range</b>                             | <b>BMI Category</b> |
|--|---------------------|
| < 18.5kg/m <sup>2</sup>                      | Underweight         |
| 18.5kg/m <sup>2</sup> -24.9kg/m <sup>2</sup> | Normal Weight       |
| 25.0kg/m <sup>2</sup> -29.9kg/m <sup>2</sup> | Overweight          |
| 30.0kg/m <sup>2</sup> -39.9kg/m <sup>2</sup> | Obese               |
| 40.0kg/m <sup>2</sup> ≤                      | Morbidly Obese      |

\*derived from the National Institutes of Health. 2016. Department of Health and Human Services, USA.gov.

Ironically, towards the end of my data collection and analysis, the American Medical Association announced its decision to reclassify obesity, declaring it a disease. My head was spinning, trying to make sense of this announcement while reflecting on the findings from my project. Specifically, I wondered how such experiences of body weight could ever make sense (to participants and also conceptually) in a society that was aggressively committed to the medicalization of obesity.

I started to imagine physicians following the AMA's diagnostic guidelines for obesity (provided in the Appendix A) with a patient that does not identify with his or her medically defined weight label of "obese." I also wondered how patients with alternative meanings for health and body weight would make sense of the new designation of obesity. It concerned me that patients would be forced to re-organize their experiences and meanings to make sense of their worlds in terms of medical diagnostics and clinical practice. Most importantly, I thought about the potential influences this would have on the patient.

It is important to note that some critics question the significance of the AMA's reclassification of obesity as a disease since obesity has been called a disease by other influential organizations and health researchers for some time now. I argue that this specific designation by the AMA, more so than any other previous designation, is unique because of the potential influence it has on the diagnosis and treatment of those considered "obese" by medical standards in the United States. The AMA is the largest association of physicians nationwide, and has the support of both public and private

organizations. Claims made by the AMA are taken at face value and rarely questioned as a political stance driven by self-interests. Further, the Association creates guidelines for both physicians and patients and implements several strategies to ensure the execution of these guidelines. The guidelines that the AMA released shortly after their announcement of designating obesity as a “disease” have serious implications for the clinical practice of treating and managing obesity. The emphasis on a variety of medical treatment options as the solution to obesity has intensified greatly and is reflected in the guidelines posted by the AMA. BMI-based weight categories help the physician decipher between their obese and non-obese patients, and the appropriate treatment options for certain groups based on these categories.

For example, the guidelines state that only overweight patients with a BMI  $\geq$  27 accompanied with related diseases such as diabetes or hypertension should be considered for medication therapy, whereas any obese patient with a BMI  $\geq$  30 should be considered. Medication therapy, or pharmacotherapy, refers to prescription drug treatment that for obesity works by triggering appetite centers in the brain to feel less hungry or to block fat in food. Similarly, the guidelines state that only obese patients with a BMI  $\geq$  35 with accompanied related diseases such as cardiovascular disease and sleep apnea should be considered for weight-loss surgery, whereas all “clinically severe obese patients” with a BMI  $\geq$  40 should be considered. Weight-loss surgery, commonly known as bariatric surgery, reduces the calories consumed by severely cutting down the amount of food that can be physically digested. Additionally, some weight-loss surgeries change the hormonal signals to alter feelings of hunger. From a treatment perspective, these weight-labels are extremely meaningful and even small point differences in BMI-scores



hold serious consequences. These guidelines also suggest that the discussions patients have with their physicians about body weight since this policy change may be extremely different than those had before this recent re-classification.

### *Qualitative Methods in Health and Obesity Research*

Overall, the use of qualitative methods in health research is particularly helpful in gaining insight to how people experience a certain condition or event, explore multiple meanings of a certain phenomenon, and understand complex health processes (Creswell 2013). The use of qualitative methods can contribute to a more in-depth understanding of how people live their lives, the barriers they face, and the choices they make (Starks and Trinidad 2007), as well as how they develop a sense of self and identity influenced by their health (e.g. Charmaz 1994, 1995; Fox 2007; Hinhede 2012). Qualitative health researchers can broaden discussions of health by widening existing parameters for the inclusion of alternative viewpoints. Rail and colleagues (2010), for example, encourage us to “challenge the production of hegemonic knowledge and ask political questions such as: ‘Who decides what is health?’ ‘Who controls health inquiry?’ ‘Who establishes ‘truths’ and in whose interest?’” (Rail et al. 2010: 236).

The use of qualitative methods in obesity research is especially needed in a time of aggressive public health promotion for obese individuals (Lewis et al. 2009) to explore the understandings of obesity among policy makers and those considered overweight (Greener 2010). Health policy, like all types of policy, has a moral dimension that influences how people act toward themselves and others (see Malone 1999). There are underlying assumptions about obese people in health promotion campaigns that

inaccurately depict the behaviors of many obese individuals (Lupton 2014). Research has also confirmed that physicians hold cultural stereotypes of their obese patients, and act towards their patients based on these assumptions (e.g. Foster et al. 2003; Harvey and Hill 2001; Loomis et al. 2011; see Puhl and Heuer 2009 for review). Further, medicalization has been shown to both positively and negatively influence experiences of those suffering from the condition (Barker 2010; Blackburn 2011). Regarding the medicalization of obesity, it is unknown as to whether the AMA's policy will positively or negatively influence experiences of those considered obese, yet it has been suggested that it may do both (Blackburn 2011; Beal 2013; Katz 2014). A more in-depth understanding of individual experiences in obesity is necessary, to shed light on the veracity of previous assumptions, and to further understand how individual experiences of obesity are influenced by the process of medicalization.

*Research Approach: Grounded Theory*

The specific qualitative approach used in this study is Grounded Theory. Grounded theory methodology is rooted in symbolic interactionism and understands processes and meanings as constructed and negotiated through interaction with others (Charmaz 2014; Charmaz and Belgrave 2012). Grounded theorists seek to develop theories that are based in the experiences of others and shaped by the participants' perspectives (Charmaz 2014; Creswell 2013). The aim of grounded theory, accordingly, is to explain how a particular process or life-event fits in the lives of individuals by studying a group of people who have experienced a similar process or experience (Charmaz 2014). Theories are constructed from the data themselves, and therefore are

considered to be “grounded” in human experience (Charmaz 2014). This type of methodology follows an inductive approach to research, where the researcher begins with particular experiences and moves towards a more general set of propositions, constructing theories based on these specific data. Inductive theorizing opens the possibility of novel understandings (Charmaz 2014: 243) and provides rich insight into another’s world (Creswell 2013). Inductive reasoning differs from deductive reasoning, since a deductive approach to research begins with an existing set of theories or hypotheses, and finds data to test (e.g. provide support or lack thereof) these already existing theories.

The origins of grounded theory are typically attributed to Barney G. Glaser and Anselm L. Strauss’s (1967) book entitled, *The Discovery of Grounded Theory*, where they coin “grounded theory” and define it as “the discovery of theory from data, as systematically obtained and analyzed in social research” (Glaser and Strauss 1967:1), and propose several ways in which it can be furthered. They argue that grounded theory is a “way of arriving at theory suited to its supposed uses” (pp. 3) and fills a gap that “theory generated by logical deduction from a priori assumptions” cannot (pp. 3). Since theory based on data is intimately tied to data, they argue that it usually cannot be proven false or replaced by other theories. Their work has been influential in social research because of the way it not only challenged previous methodology, but also provided alternative systematic strategies for conducting research (Charmaz 2014). They argued that systematic qualitative analysis had its own logic (Charmaz 2014: 7) and offered clear guidelines for a new method that they encouraged social researchers to pursue. Glaser and Strauss’s book gained momentum and has become the basis for significant qualitative

research studies, leading to the development of new insights and theories (Charmaz 2014).

Despite Glaser and Strauss's (1967) major influence, grounded theory has faced serious challenges and has undergone much development. In brief, the criticism of Glaser and Strauss' grounded theory is that it mirrors a deductive approach to research, and that although systematic in proposition, the "emergence" and "discovery" of codes and theories were too abstract for followers to understand in practice. Their approach to grounded theory is often referred to as unclear or not transparent because of the ambiguity in which codes "emerge" on their own and assumingly become obvious to the researcher.

Constructivist grounded theory (Charmaz 2014) has developed as a response to the challenges and criticisms faced by Glaser and Strauss's (1967) original version. It recognizes and applies symbolic interactionist understandings of interaction, language, and meaning to the research process, by arguing that the researcher and the participant co-create reality and define situations together (Charmaz 2014). Constructivist grounded theory challenges the ability of the researcher to get an objective or "bird's eye view" of another's world, since he or she interprets what participants say, their experiences, and what those experiences mean. It "adopts the inductive, comparative, emergent, and open-ended approach to Glaser and Strauss's (1967) original statement, while highlighting the flexibility of the method and resists mechanical applications of it" (Charmaz 2014: 12-13). Constructivist grounded theorists argue that codes do not simply "emerge" from the data; likewise, theories are not "discovered," since both are constructed by the researcher based on his or her interpretations of the data. Although critics argue that this type of

involvement on behalf of the researcher introduces personal biases to the data, proponents argue that personal biases are not harmful to research, since researchers' constructions and interpretations are always part of interaction between individuals, and therefore are tied to any research conducted. This type of grounded theory methodology is most aligned with the philosophical and epistemological implications discussed in the previous chapter, which I find most appropriate for the current project.

### *Theoretical Sampling*

Although initial sampling is useful in laying out eligibility criteria for potential participants and assigning initial codes to the data (Charmaz 2014), theoretical sampling is a more focused way of sampling because the researcher collects additional data based on potential categories and gaps within these categories. Frequently, researchers use theoretical sampling to figure out who to interview next and what topics or questions will be addressed. Theoretical sampling is a strategy frequently used in grounded theory where the researcher makes decisions regarding the future collection of data based off of their initial analyses of data that have already been collected. With potential categories and properties of those categories in mind, the researcher collects additional data to further understand these potential categories and properties. Theoretical sampling helps to develop preliminary categories by checking, qualifying, and elaborating the boundaries of categories (Charmaz 2014: 205). It is the process in which the researcher seeks to “further develop a theory” (Charmaz and Belgrave 2012: 358) by revisiting the current categories, finding possible categories and their properties that allow for tentative categories to be further explored and to fill gaps in categories (Charmaz 2014).

Although the current project differs from the previous projects, I see this work as cumulative, where findings or issues from one project or interview help to inform and further develop theory. For example, as discussed in the beginning of this chapter, my small class project on African American women and meanings of physical activity led me to a project on meanings of body weight. This is because during the process of simultaneously collecting and analyzing data, it seemed as if participants' meanings of physical activity were more about their views of body weight. In order to clarify, I conducted additional interviews to ask about meanings of body weight and the relation to physical activity.

Unlike my previous projects, for this one I included people regardless of gender, sex, or race in the current project, and implemented several additional eligibility requirements (e.g. BMI, discussed weight with a health professional after specific date, etc.). Although developing any sort of theories on gender and racial differences is beyond the scope of the current project, participants' eligibility was not contingent on their race or gender.

#### *Dissertation Requirements and Approval*

Following the completion of all prior graduate program work, I was admitted to candidacy in January 2016. My dissertation committee was fully formed by April 2016, consisting of four full-time graduate faculty members. The chair of my committee, Dr. Linda Liska Belgrave, as well as two committee members, Dr. John W. Murphy and Dr. Crystal Adams are from the Department of Sociology at the University of Miami. The fourth member of my committee is Dr. Pamela Geller from the Department of

Anthropology at the University of Miami. The dissertation proposal was successfully defended on June 29, 2016.

Institutional Review Board approval was required for this project since it involved research with human subjects. I was granted University of Miami IRB approval for the study on June 9, 2016 and made slight modifications on June 25, 2016 after my proposal defense. These changes were approved shortly after. The Principal Investigator was Dr. Linda Liska Belgrave, and I was the student investigator and researcher. During the process of data collection and analysis, I accepted a position at the University of Tampa which required me to relocate. I submitted an IRB protocol at the University of Tampa on September 3, 2016 and received approval on September 8, 2016. I was the Principal Investigator and researcher for this protocol, since I assumed a faculty role and was the sole individual affiliated with the institution. Following approval, I continued with my data collection and analysis in Tampa, Florida.

The recruitment flyer was approved by the Institutional Review Board at the University of Miami and at the University of Tampa before any recruitment for the project was initiated. Two changes were made to the fliers based on each institution's respective IRBs. At the University of Miami, the IRB asked that I remove the monetary incentive from the recruitment flyer before posting. These changes were immediately made before printing and posting recruitment fliers. At the University of Tampa, the Office of Student Leadership and Engagement is in charge of approving any fliers to be posted on the campus, regardless if they are IRB approved fliers for research or any other type of solicited announcement. The Office of Student Leadership and Engagement at the University of Tampa required me to include my full name, faculty title, and affiliated

Department. These changes were immediately made to the flyer before printing copies and posting around campus.

It is important to note the ethical implications in recruitment and sampling strategies that restricted recruitment for the current project. Although not anticipated, I quickly realized that recruiting, regardless of recruitment strategy, would be a difficult line to walk. This is because anything beyond a general announcement to a group of people about the study could potentially be harmful, since approaching an individual may give the perception that they visually appear to others as “obese.” I relied on recruitment fliers that I had posted rather than handed out, asked colleagues to announce to their classes about my project, and let anyone that would listen know about my project and that I was still looking for participants. This allowed for a more ethical approach to recruitment, since prospective participants contacted me first.

Although the recruitment fliers did not exclude any gender or sex from eligibility, all participants self-identified as a woman. Several additional strategies were implemented to broaden the sample on the basis of gender or sex, including asking friends and participants to spread the word about the study to their social networks, and posting fliers in approved, yet more gendered spaces on campuses. This strategy rendered even more participants who identified as women, but no participants who identified as men.

### *Research Design*

I conducted 31 in-depth interviews with 29 women considered “obese” by medical standards using constructivist grounded theory methodology. Constructivist



grounded theory and in-depth interviewing work particularly well together, since the researcher and the participant are engaged in a mutual conversation that depends on both parties' meanings and interpretations to make sense of the interaction. In-depth interviewing is a negotiated process between the researcher and the participants (Charmaz 2014; Charmaz and Belgrave 2012). This method can be seen as a "guided conversation" that "goes beneath the surface of an ordinary conversation" (Charmaz 2014: 25). Consistent with the epistemology and theoretical frameworks that often guide this method, in-depth interviewing is an on-going process of interaction where the researcher and the participants come together to create meaning (Charmaz 2014; Charmaz and Belgrave 2012). It is an interactive process where both parties draw from their commonsense knowledge to make sense of the interaction (Johnson and Rowlands 2012). In-depth interviewing is often used to explore multiple meanings of a particular phenomenon, especially when the phenomena being explored is often taken-for-granted or when those involved in a similar process experience it differently (Johnson and Rowlands 2012). In-depth interviewing allows the researcher to gain a deeper understanding of how a person experiences a particular event, condition, or phenomenon. It can be a useful complimentary method along-side other ways of collecting data, or is an appropriate primary research method when the research questions require an in-depth understanding of another's world (Johnson and Rowlands 2012).

I used a flexible interview guide (see Appendix C) which served as a basis for the interviews by providing major conversation points throughout the interview process. The use of a flexible interview guide is helpful because it allows the researcher to ask questions about specific areas of interest while allowing the conversation to go where the

participant and interviewer allow it to. The interview guide was revised several times throughout the process of data collection and analysis. The questions included in the interview guide were created using two major sources: Kathy Charmaz's (2014) guide to in-depth interviewing, and the AMA's guidelines (see Appendix A) that were recently released for physicians to use in talking with their "obese" patients.

### *Eligibility and Recruitment*

The eligibility for participation was that an individual was considered "obese" by medical standards, which includes those with a current Body Mass Index that is equal to or greater than  $30 \text{ kg/m}^2$ , or had been told from a health professional or others (this includes a family member, friend, stranger, etc.) that they were "obese." To be eligible for participation, the individual must have had visited a health professional since June 2013 and discussed their weight in some aspect. This included conversations where body weight was not the primary concern of the visit but came up in conversation. Whether one's conversation with his or her health professional resulted in a diagnosis of obesity did not change one's eligibility. Further, all participants must have been at least 18 years old at the time of the study to be eligible for participation. To avoid interfering with family perspectives on the obesity of youth, no persons under the age of 18 were included. Any individual who expressed interest in participating but did not know either his or her BMI score or BMI-based weight category, or had not been told he or she is "obese" was not considered eligible. Although this did not occur, an exception would have been made for a person who expressed interest in participating and had met the

stated requirements sometime after June 2013, but since had lost weight and no longer had a BMI score of 30 kg/m<sup>2</sup> or higher.

I used multiple recruitment methods to recruit participants for in-depth interviews. These included the use of personal references, snowball sampling, and flyer postings. Personal references included those who previously shared their experiences with me or friends who did not qualify for the study yet expressed willingness to let others know about the project once I began recruiting. I also posted recruitment fliers in several designated posting areas in Miami, Florida and in Tampa, Florida. Following approval from my committee, the University of Miami's IRB, and with permission from the persons in charge of advertising and recruitment at the following facilities, I posted recruitment fliers in designated posting areas throughout the University of Miami, including the Coral Gables campus and the Medical campus, Jackson Memorial Health System facilities, the South Miami Library, and in a local coffee shop bulletin board. After relocating and receiving approval from the University of Tampa's IRB as well as their Office of Leadership and Engagement, I posted recruitment fliers in designated posting areas throughout the University of Tampa campus. A copy of the recruitment flyer is included in the Appendix (see Appendix B). Further, theoretical sampling was used throughout the process of data collection and analysis.

### *Data Collection*

Once a person expressed interest in participating, I reviewed the eligibility requirements, provided more detailed information about the project, and answered any initial questions. If the person expressed continued interest in participating and confirmed

that they met the eligibility requirements, I proceeded to set up a mutually-agreed upon time and location for the interview. All interviews were held in public locations, but in a quiet enough space to ensure privacy. I began each interview by reading aloud the consent form that reviews the objectives of the study, outlines any foreseen or potential risks and benefits, and explains that the participant may stop the interview at anytime or skip over any question without any consequences. I asked the participant for permission to audio-record the interview, and explained that the recording would be erased immediately following the transcription of the interview to a password safe personal computer. I also let the participant know that pseudonyms would be given to ensure their privacy and would be used throughout the transcriptions and any report of the study thereafter. Each participant received a twenty-dollar cash incentive for their participation following the interview regardless of how long the interview was, or if they refused to answer or skipped any questions during the interview.

I conducted 31 face-to-face in-depth interviews with 29 participants and each participant took part in one interview, with the exception of two participants who took part in a separate follow-up interview. Among the two participants, one was contacted by me for a follow-up interview, and the other participant contacted me after experiencing a shocking visit to her physician that she felt was relevant for the project. Although the eligibility requirements included those who are considered “obese” by medical standards *or* those who have been told (by anyone) that they are obese, all 29 participants met both of these criteria, along with the remaining eligibility requirements. Out of the 29 participants, 18 participants were recruited and interviewed in Miami, Florida, while the remaining 11 participants were recruited and interviewed in Tampa, Florida.

### *Sample and Location*

In order to not risk the privacy protection of any participant, I describe the sample in its entirety, with no designated distinction between participants from Miami or Tampa. However, it is important to note the similarities and differences between the two locations. Both Miami and Tampa consist of heterogeneous populations, meaning that people who reside and visit these areas vary in terms of their gender, race, ethnicity, sexual orientation, religion, class, income level, political ideologies, etc. What is common between Miami and Tampa is that both places have a large amount of inequality between those with the highest socio-economic statuses to those with the lowest. Both places have a number of celebrities who own houses or visit frequently for vacations or guest appearances, along with business and tourist-based economies. Business professionals and sports figures often move to Miami or Tampa in hopes of following career aspirations, and the beautiful beaches and night-life serve as tourist attractions for many. Both cities also have high-levels of homelessness and poverty. People are geographically segregated by wealth, and the physical distance between these segregated areas are in fact very close to one another, suggested by concentrated “pockets” of poverty. This often translates to people living under very different conditions who may be reminded of those drastic differences everyday. For example, Miami and Tampa both have booming downtown areas, where many lucrative businesses and white-collar workers reside, work, and play; however, both downtown areas have large homeless populations. Further, just outside of these downtown areas are impoverished communities located just blocks away from wealthy neighborhoods.

Another similarity between the two cities is that they both have well-known colleges and universities, two of them being the University of Miami, Coral Gables campus and the University of Tampa. Both are private institutions with aesthetically pleasing campuses. They draw thousands of students, staff, and faculty members from all U.S. states and international students from a variety of countries. Although both universities take pride in their diverse populations, they share similar cultural norms, where aesthetics in the campus and among its members are highly valued.

The sample consisted of 29 participants, all who self-identified as women, and whose ages ranged from 18 years old to 79 years old. Thirteen participants identified as white, ten as African American or Black, two as Latina, two as Italian, one as Jamaican, and one as Arab-American and also Muslim. There were fourteen participants who were currently enrolled in college, and among this group of college students, two participants had a full-time job, four participants had a part-time job, and eight participants were unemployed while in school, three of whom mentioned being fully supported financially by their parent(s). Among those who were not enrolled in college at the time of the interview, two participants were unemployed, one identified her occupation as a stay-at-home mother, and one participant was retired. Among participant occupations included a high-school teacher, two servers, a tanning salon attendant, three university staff workers, a fast-food worker, an accountant, a university professor, two business women, two student employees, a bartender, a front-desk attendant at a hotel, and a retail sales associate.

*Analysis*

Following each interview, I transcribed the interview on my password-safe personal laptop. Transcribing each interview took anywhere from six hours to eleven hours each, all of which I transcribed myself with the exception of the two follow-up interviews. These two follow-up interviews were transcribed by a professional transcriber and the typed versions of these transcriptions were available within seven business days. The process of transcribing typically takes several hours for each interview because of the constant starting and stopping of the audio-recording, rewinding to the same point in the recording and playing it back several times before a statement is fully transcribed. Some minor issues during transcribing included miscellaneous noises that were embedded in the recording, such as my office fan overpowering some parts of an interview or a participant's cell phone ringing on high volume while she continued her story and ignored the ringing. The audio-recordings were of diverse quality depending on the location of the interview, the tone of a participant's voice, the placement of the audio-recorder, and the pace of the conversation. The more difficult it was to hear what was being said, the longer it took for me to transcribe. There were also a few interviews where the participants' voices seemed distant or low, and moving forward I tried to be more aware of these concerns to eliminate some difficulty for future transcribing. There was one participant who spoke extremely fast, and this interview took around eleven hours to transcribe because I had difficulty keeping up and following the conversation. Because of this, I had to transcribe bit by bit, or only a couple of words at a time with constant rewinding and playback.

Throughout each transcript, I used pseudonyms for each participant, in addition to any other names or revealing information provided throughout the interview such as place of employment. Once the interview was transcribed, I carefully re-read the transcription to check for accuracy. I saved a final version of the transcription in a folder on my password-safe personal laptop. I then destroyed the audiotape of the interview as assured in the IRB protocol and participant consent form. Since I wrote down several personal notes and thoughts following each interview, I electronically entered these at the end of the transcription and highlighted them in red. I did this before beginning to code any part of the interview. Most of these included how I felt that the interview went and my overall general impressions or experience. For example, after interviewing a woman who used humor and sarcasm to talk about her weight, I noted she had tears in her eyes during several points of the interview while attempting to maintain a smile on her face and keep the conversation light and humorous. Another example of a personal note was written after interviewing a woman who shared that she was stressed about her work and her weight so she had not been eating, which I found extremely concerning. I wrote a personal note to follow up with the IRB as to how I should handle the information as a researcher. This case, as well as other ethical considerations, is discussed in detail toward the end of the chapter.

After transcribing and recording any personal notes, I then engaged in early and preliminary analysis of the data. This involves reading the transcription slowly, line by line, and writing down several preliminary memos and initial codes. Memo-writing helps the researcher reject any preconceived categories while coding (Charmaz 2014) and can help later on in the analysis process to raise codes to “tentative conceptual categories”



(Charmaz and Belgrave 2012: 357). Initial codes are an attempt for the researcher to make preliminary sense of the data and to begin thinking about what the data mean (Charmaz 2014). Initial coding shows how the data have been selected and sorted, and requires simultaneously categorizing, summarizing, and accounting for each piece of data (Charmaz 2014: 43). The process of preliminary and initial coding took anywhere between eight and thirteen hours for each transcription, depending on the length of the transcript and the intricacy of the conversation. An example of an initial code is “Up and down with weight in high school, large amounts of weight loss and weight gain.” Another example of an initial code is, “Felt frustrated because the doctor focused on obesity rather than her primary concern.” Initial coding is the first step of analytically interpreting the data and making sense of it (Charmaz 2014: 43).

After assigning initial codes and writing preliminary memos, I re-read through the transcriptions and began to construct more focused or selective codes. During this stage, I compared data and codes to one another within the single transcription. Here, I noted when there seemed to be any similarities or discrepancies between what the participant was saying or expressing how they felt about something. An example of this was a woman who continuously stated she “did not care” about her weight, but also shared multiple experiences with diets and other efforts of weight loss. Another example was a participant who kept insisting she loved her body but also talked about herself and her body weight very shamefully, with a sense of frustration. Focused coding requires the researcher to start to make decisions as to what initial codes seem more significant than others (Charmaz 2014), which I based off of the emphasis given to meanings by the participants, and began to sort and organize bigger sections of data. Constructing the

more focused and selective codes took anywhere from two hours to six hours for each transcription. An example of a more focused or selective code is “family and friends’ comments about her weight is important to her.”

Conducting the interview, transcribing the interview, assigning memos and initial codes, and constructing more focused or selective codes took at least twenty hours for each interview. Therefore, collecting and analyzing each interview took several days, and often times had to be worked on in-between teaching classes or other immediate responsibilities. Because of this, I made sure to keep writing notes on the transcription to help me pick up where I left off, including what I was thinking about or how I felt about something in the transcript. An example of this was a participant who ordered take-out for dinner following her diagnosis of obesity that she didn’t agree with. I didn’t know what this was about, but knew that I would forget to go back to it and think about it if I didn’t write a note before heading to class. The note reads, “In response to the appointment and her experience there, she went home and ordered take-out Chinese food  
\*\*NOTE: what’s this about?”

Simultaneously collecting and analyzing data requires an early engagement with data analysis, which among several other fundamental strategies like constant comparative methods, theoretical sampling, multiple stages of data coding and memo writing at different levels of analysis, is used by grounded theorists to build theory (Belgrave 2014: 387). The process of simultaneous data collection and analysis allows a researcher to be reflexive, to pay close attention to each interview, assign initial and temporary codes without making theoretical leaps, while keeping an open mind to new research questions and categories that he or she begins to develop (Charmaz 2014).

Reflexivity is an important aspect of the research process, and is well-suited for grounded theory since the process of simultaneous data collection and analysis, as well as flexible interviewing, allows for changes to be implemented along the way. Engaging in reflexivity helped me be critical of my own interviewing skills, and while coding the data, I made comments for myself that I reviewed before the next interview. One example of this type of comment to myself was about a participant who became instantly (and increasingly) emotional when talking about how much she had been going to the gym to lose weight. It seemed like she was overwhelmingly frustrated, and there was a point- about two minutes into her explaining why she was going to the gym so much-where I suggested we could switch the topic at anytime based on how I assumed she was feeling.

I wrote a note during the interview for me to revisit the topic later on if the conversation went there again, but it never did. When assigning initial codes and memos to the transcript, I wrote “At this point, she seemed emotional out of frustration, when talking about all of the effort she has put into her gym routine over the past year it seemed as if she got emotional because there were feelings of frustration, but it was very emotional- because of how emotional she got and expressed that it was ‘real intense’ for her, I made the decision to let her know that it was okay and we could stop the interview, but she seemed very sure she wanted to keep going. Because of this, I switched the topic and thought to myself that I could revisit these topics if the conversation went there again or if I felt she was okay to talk about these things again later on.” At the end of the transcript, I wrote another note for myself that reads, “should have definitely followed up on previous comments instead of moving forward with interview. I tend to move on when

I feel participants are getting really emotional about their weight, thinking if it comes back up, I will go back to it.”

This was an important reflexive moment for myself, as a researcher, because I realized that this is something I feel uncomfortable with which can change the course of the conversation. Just because a participant suddenly becomes emotional doesn't mean that I've necessarily messed up as a researcher, although in this particular case, that was how I felt. There is a meaningful difference between pushing uncomfortable topics on our participants and recognizing that participants will unexpectedly become emotional because certain memories evoke these emotions. However, they may still be up for talking about them, and they may even find it important for their hurt and frustration to be shared with others. Moving forward, I became more aware of my own discomfort, and challenged myself to allow the participant to lead this part, even if it meant a few uncomfortable seconds of silence or tears.

After a few interviews, I began to note similarities and differences in the focused or selective codes from each interview. Through this process, I marked possible subcategories or “properties” of the categories that exemplified different perspectives of a category (Creswell 2013: 195). For example, there were several focused or selective codes related to initiating a conversation about body weight and how participants felt about these experiences. Although most participants were not the ones to “bring up” the conversation of body weight with a physician, they had different experiences and opinions about the physician initiating a conversation and the ways in which they did. During this stage of the analysis, I began to mark these potential subcategories by comparing selected codes from the interviews and making connections. This stage in

particular helped me start to figure out what I already knew from the data and what I didn't, as well as some concepts that seemed unclear. An example of this was the concept of "the 200 lb. threshold." Although the first few participants did not bring this up during their interviews, in four consecutive interviews, participants saw 200 pounds as a significant marker, which had several consequences for their behaviors, the way they saw their past or future, and their perception of self. By identifying these unknown or less clear areas in the data, I was able to write down memos of what I needed to ask about that specific topic next time and how far to dig, including possible follow-up questions that would help me address these "unknowns." Wondering if 200 pounds was a significant marker for other participants, I called a past participant who mentioned she weighed just over 200 pounds and asked her about it. I then included a follow-up question about the meaning of 200 pounds in all future interviews if a participant freely shared their weight (in pounds) with me. I did this for participants who were under, right around, or over 200 pounds, to figure out if this was a significant marker and if so, what this marker meant to participants. This is a part of theoretical sampling (Charmaz 2014; Charmaz and Belgrave 2012), where previous data analysis can be used to inform further data collection. I was able to revise my interview questions to ask additional questions or follow-up questions in order to gain more information about a particular topic.

After filling in these gaps in the data, categories became more "saturated" since I was able to begin really refining the concepts. After my concepts were fully saturated, meaning that there is variation in the concepts and that all data are accounted for, I began to categorize major codes and draw themes from these codes (see Table 2 in Chapter 4). I

drew diagrams to help me conceptualize the relationships between the themes and larger theoretical ideas.

The last stage of analysis was constructing a theory that stayed grounded in the data, to address the outlined research questions and to tell a story about how participants have experienced body weight in light of the AMA's efforts. Constructing theory from the "ground-up" that is rooted in rich data means that this theory explains and presents the experiences of the participants as best and as close as possible. This does not mean that the theory applies to a larger subset of the population, such as all people considered "obese," nor does it intend to make these sorts of generalizations and conclusions. In the following chapter, I present my findings organized by major themes with examples from the data. In the last chapter, I connect these findings to a larger discussion of what these mean for those interviewed and the possible implications of these findings. I suggest several unique contributions of the research and I also make recommendations for future research in obesity and obesity-policy.

### *Ethics*

It seems necessary to devote an entire section to ethics here. Overall, body weight can be a sensitive topic for people, particularly for girls and women, people with memberships to certain groups, athletes, those who hold certain occupations, and many who have dealt with body weight for their entire life. In my past research project where I sought to understand the lived experiences of body weight and meanings of phenomena such as "fatness," and "health," I became aware very quickly that most participants had dealt with body weight for their entire lives, and that their body weight- and other related

things (e.g. food, cigarettes, exercise, motherhood, other health conditions) were battles that they were fighting every single day. One participant in the past project, who was preparing for bariatric sleeve surgery at the time, told me that she was so excited to start living. Among most participants, they had suffered from some degree of bullying or discrimination throughout their lives which held meaningful implications for them. A woman who was bullied for her weight in the third grade could recall the bully's first and last name, the seat on the bus she was in, and the exact words the bully used toward her, twenty-odd years later. She and other participants expressed restricting themselves from wearing certain things like shorts, short-sleeves, and bathing suits. Participants also shared a host of social activities that they did not partake in, such as dating, going out dancing, certain sports, and high-school proms or reunions. This project provided insight into just how meaningful body weight is for many people, and taught me that my own experiences with body weight were not the same as others.

My own experiences with body weight are important to mention because I consider myself a member of the communities I study in a number of ways. First, body weight has always been a part of my life and I have heard the comments and have felt the judgments similar to those participants share. It was a shocking moment for me when I found out that I was considered "obese" by medical standards (this was several years prior to AMA's designation), and I remember thinking to myself, "Am I delusional?" I didn't see myself as obese at all, and I would ask close friends and family to tell me a person that we both knew that they considered to have a similar body to me. I did this because, at the time, I felt like I had seen myself as way thinner in mirrors and pictures then maybe I "really was." It was a terrifying thing for me, to think that I saw myself as

thinner than the world saw me. My body weight has fluctuated throughout my life, and the only time I can remember not being overweight was during college when I purposefully restricted myself from eating, abused laxatives, and obsessively weighed myself multiple times a day. During this time, my family and friends were complementing me on my skinnier figure, and it motivated me to keep up the behavior. It came to a point where I was physically exhausted and worn-out. I began to change the way I viewed body weight and started to get back on my feet again. Because of my own past experiences, I needed to stay reflexive throughout this entire project to avoid making any assumptions based on my own experiences.

After relocating to the University of Tampa for a job, in the midst of data collection and analysis, I had to be especially careful that my new title did not impose any ethical problems. There was one participant, a student, who told me she was restricting herself from eating food to lose weight. She told me that she was tired and that it was the only way to keep losing weight a priority while she went to school full-time and worked a job on the side. This was something I really was not prepared for as a researcher or a faculty member. Not knowing (ethically) what to do in the moment, I told her that I could not give her any health recommendations because it was not my profession. I did however, share my own experiences with body weight and the point that I realized it was harmful. I encouraged her to find some other way that worked within her busy schedule if she wanted to lose weight. Following the interview, I called my Dissertation Chair, who suggested I contact the IRB. After contacting the IRB, I emailed the student with the information for the campus Wellness Center. After this experience, I really thought about my new role as a faculty member and what that meant. I also



questioned my obliviousness toward eating disorders being a potential part of participants' everyday lives.

### *Conclusions*

I conducted 31 in-depth interviews with 29 participants who were considered “obese” ( $BMI \geq 30\text{kg/m}^2$ ) and had talked to a health professional about weight since the AMA's 2013 classification of obesity as a “disease.” Constructivist grounded theory methodology and in-depth interviewing were well-suited in understanding experiences of body weight. Participants were interviewed and recruited in Miami, Florida and in Tampa, Florida. A mix of recruitment strategies was used in both locations to recruit participants. Unanticipated ethical considerations in recruitment were addressed. I used both initial sampling and theoretical sampling in the process of data collection and analysis. Common in grounded theory, I collected and analyzed data simultaneously to ensure that my analysis was rooted deep within the data and to avoid making theoretical leaps. It was also important for this study that I stayed reflexive throughout the process of collecting and analyzing data. This involved transcribing, re-reading the transcription, coding line-by-line, assigning initial codes, writing notes, and keeping memos following each interview before moving onto the next. This also allowed for me to pay close attention to each interview and to revise my questions before moving on. Simultaneously collecting and analyzing the data also helped in the theoretical sampling towards the last few interviews. I then took my refined concepts and saturated codes and began to draw larger themes from these codes. Using diagrams and larger memos, I constructed a theory rooted in the data to present participants' experiences as accurately as possible. In the following chapter, I present my findings organized by major themes with examples from

the data. In the last chapter, I connect the findings to a larger discussion of meanings and implications. I suggest several unique contributions of the research and I also make recommendations for future research in obesity and obesity-policy.

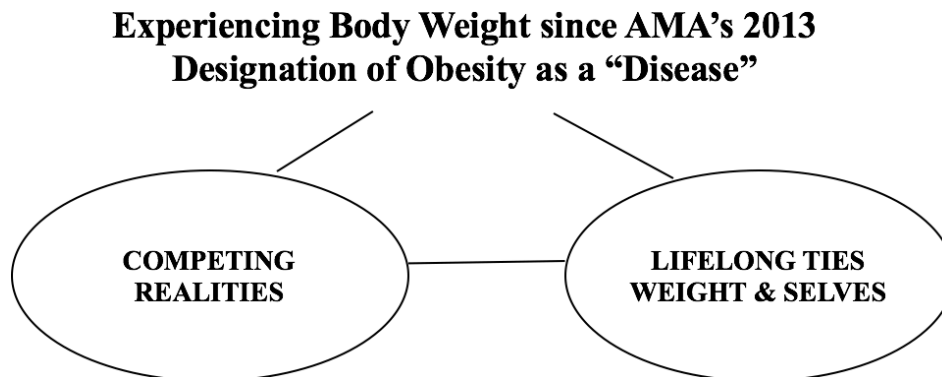
It is important to note that these methods do not generate or allow a “post-policy effect” to be observed, nor was the aim of the project to make these types of inferences or claims. However, by focusing on the experiences people have had since the AMA’s announcement contributes to an understanding of dominant obesity agendas, their discourses, efforts of medicalization, and their influences on meanings and experiences. Hopefully, this project suggests the importance of alternative forms of knowledge and sheds light on experiences and voices that are often marginalized.

## CHAPTER FOUR: FINDINGS

*The clinic—constantly praised for its empiricism, the modesty of its attention, and the care with which it silently lets things surface to the observing gaze without disturbing them with discourse—owes its real importance to the fact that it is a reorganization in depth, not only of medical discourse, but of the very possibility of a discourse about disease. —Michel Foucault*

### *Overview*

In this chapter, I provide a description of the experiences participants had when visiting a health professional since the AMA's 2013 re-classification of obesity as a "disease." I also discuss the language used in discussions of body weight and how these experiences and language influenced participants. Overall, I define two analytical themes (see Figure 1 below) that are central to participant experiences: 1) a series of *competing realities* that complicate participants' everyday interactions with others (health professionals and laypersons) and alter how participants see themselves, and 2) lifelong ties between participants' body weights and selves that are borne from past and recent interactions with others (health professionals and laypersons). Both competing realities and connections between body weight and self are central to a participant's experiences, including visits to a health professional since the AMA's policy change.

**Figure 1.**

Participants' experiences are shaped by a series of **competing realities**, or stark differences in the meanings, understandings, perspectives, and behaviors related to weight, obesity, and health. These competing realities can be between: 1) participants and health professionals, 2) participants and laypersons, 3) participants and popular assumptions about obese people, 4) health professionals, 5) participants, and 6) participants' own language, emotions, and behaviors. Competing realities serve as major challenges for participants, frequently evoke a range of emotions, and influence how participants make sense of "obesity" in general. Competing realities are large disagreements that become obvious to participants through interactions with others (health professionals and laypersons) and that alter how participants see themselves. Competing realities that are contradictions between participants' own language, emotions, and behaviors are often felt, yet rarely shared by participants. In the rare case that participants caught themselves in a state of contradiction, they showed it through emotion, then took a step back and talked about themselves reflexively, critically

analyzing this disagreement between their thoughts and their behaviors to try and reconcile or explain them. I argue that competing realities are embedded in the “obesity epidemic” by operating at the individual or micro level of society, through interaction. Competing realities come to complicate participants’ individual understandings of themselves and of others.

A participant’s experiences are also based on **lifelong ties** between body weight and self, connections that can be traced back to childhood and that continue to play an important role in a participant’s interactions with others. Through interaction, participants learn that body weight is a paramount feature of others’ perceptions of them. Early on, participants begin to see themselves through the eyes of others, as “bigger” or “fatter” than ideal, and are constantly reminded of this through interactions with both health professionals and laypersons (e.g., family, friends, romantic partners, peers, strangers, etc.).

Some participants have developed an alternative view of themselves as beautiful, criticizing popular standards of bodies and beauty. However, through participants’ narratives, lifelong ties between body weight and selves reveal that participants first learn (through interactions with others) that they are “bigger” or “fatter” than is ideal. After a long struggle with body weight, some participants come to see themselves in a more positive light, encouraged by an alternative social media movement, whose activists see fat as beautiful and fight against harmful fat stigma. Findings suggest that understanding participants’ experiences with body weight since June 2013 requires an understanding of past experiences with body weight. These past experiences happened well before 2013 but are relevant for the current project since the past is an ongoing feature of constructing

a present self. These newer experiences — that is, since the AMA’s policy — are influenced by participants’ lifelong ties between their body weights and selves, ties that participants bring with them when visiting a health professional.

Since this project is the first to empirically assess the influences of the AMA’s policy change on those considered “obese” by medical standards, it is important to note some more descriptive yet key findings that provide early insights to (medical) obesity practice since the AMA’s policy change. Through participant experiences, some health professionals seem to have adopted the AMA’s disease model of obesity, while others have not, thereby influencing their overall approaches to their “obese” patients. This includes the choice of language physicians use in discussions of body weight with their patients, the degree to which body weight is seen as an urgent health issue, and the choice of diagnosis and treatment plan, if any. Despite major efforts to standardize obesity treatment, participants’ experiences are more influenced by the individual health professional’s approach to obesity and by participants’ past experiences with body weight, than they are by the policy change itself. Participants’ interpretations of obesity as a “disease” also varied: while some were understanding of the AMA’s decision, others were highly critical of a disease model of obesity. It is also notable to report that many participants rejected a diagnosis of “obesity” given by a health professional since 2013. Participants provided feedback as to how health professionals can improve their conversations with patients about body weight.

Overall, findings suggest that the AMA’s policy has had immediate and meaningful influences on many participants through their experiences with others and by facing popular societal and medical depictions of *obesity as a disease*. Therefore, while

the current research approach does not aim to represent a pre-post policy model, findings do suggest that extreme acts of medicalizing obesity, including the AMA's 2013 policy, influence participants' lives and experiences with body weight in overwhelming and sometimes detrimental ways.

In this chapter, I present both analytical themes with a description of the theme and its several components, as well as descriptive findings supported by direct quotations from participants. I integrate previous research throughout the chapter to show how findings from the current project further support or challenge existing knowledge and understandings of obesity research. Since this project is the first to examine experiences of body weight since the AMA's designation of obesity as a "disease," I note new contributions when appropriate. In the following chapter, I discuss these findings in light of the AMA's policy, how participants' experiences challenge *obesity as a disease*, the implications of this project, and avenues for future work.

### *Categorizing Experiences with Health Professionals*

I categorize interactions with health professionals based on how participants distinguished between past interactions and recent or current interactions. When participants said that the interaction was "recent," I asked them to clarify if they remembered when so that I could decipher between a) interactions with health professionals that occurred sometime before June 2013, and b) those that happened after. It is necessary to give a definition of health professionals, since I make this distinction an important part of the project. I based my definition on the World Health Organization's (WHO 2016b) definition of health professionals and those included in this broad

occupational category. Health professionals are those who study, diagnose, treat, and prevent illness, injury, and other physical and mental impairments, in accordance with the needs of the populations they serve (WHO 2016b). This group includes medical doctors (both generalist and specialist practitioners, including public health doctors), nursing professionals (including public health nurses), midwifery professionals (including public health midwives), dentists, and pharmacists (WHO 2016b). This does not include complementary medical professionals, paramedical practitioners, dieticians and nutritionists, physiotherapists, or other therapy-related occupations (WHO 2016b). In describing participants' experiences visiting a health professional, I include interactions with health employees, or with others who work in a health professional's office and who participants defined as meaningful to their visits. This group includes physician assistants, medical students, medical emergency technicians, and office staff, all of whom are specified as such when included.

Findings suggest that health professionals' views of obesity and body weight changed after the AMA's policy change, a change that is meaningful. The 2013 policy change introduced a formal diagnosis category for obesity, including diagnostic manuals and nationwide encouragement for health professionals to implement this new protocol into practice. Prior to this policy change, similar diagnostic categories were defined for eating disorders and for food addiction, but obesity itself was rejected as a psychiatric diagnosis in the American Psychiatric Association's Diagnostic Statistical Manual in 2010 (Marcus and Wildes 2012). Therefore, prior to June 2013, health professionals could talk about obesity as a "disease" with their patients but did not have a formal diagnosis category that was available to diagnose it as a "disease," nor was there a



diagnosis category of obesity as a “disease” that was widely recognized and used to diagnose patients. Prior to the AMA’s policy change, there was a lack of pressure from a nationwide association for physicians to follow a standard protocol for obesity, which is actually one of the fundamental arguments by those who support the AMA’s decision. There was also no insurance coverage for weight-loss surgery or prescription drugs aimed to treat obesity, with some exceptions for those who were considered morbidly obese ( $BMI \geq 40 \text{ kg/m}^2$ ); in these cases, this coverage was dependent upon the patient’s specific type of insurance coverage.

Recent and current interactions with health professionals and health employees include participants’ experiences in a health professional’s office sometime during or after June 2013. The American Heart Association (AHA) insists that doctors are “being urged” to treat obesity as a disease under new guidelines released by the AHA, the American College of Cardiology, and The Obesity Society. These guidelines have been adopted from the AMA and they state that the concept of *obesity as a disease* is at the heart of revisions to the guidelines (AHA 2013). In an article featured on the AHA’s website, the co-chair of the committee that wrote the guidelines states, “Telling patients they need to lose weight is not enough. We want healthcare providers to own the problem. Just like they own the problem of glycemic control in a patient with diabetes, they need to own the problem of weight management” (AHA 2013:1).

Findings from the current project suggest that experiences when visiting a health professional since the AMA’s policy change are both similar to and different from experiences participants had with health professionals in the past. The main difference is that many participants have been formally diagnosed with obesity; obesity becomes a

major, if not the sole, concern of the visit, and many health professionals and participants consider the severity of the participants' weight differently.

Overall, I define two analytical themes that are central to participant experiences: 1) a series of competing realities that complicate participants' everyday interactions with others (health professionals and laypersons) and that alter how participants see themselves, and 2) lifelong, ongoing ties between participants' body weights and selves that are borne from past and recent interactions with others (health professionals and lay persons). Both competing realities and lifelong, ongoing ties between body weight and selves are central to participants' experiences, including visits to a health professional since the AMA's policy.

#### ANALYTICAL THEME ONE: COMPETING REALITIES

I define *competing realities* as stark differences in the meanings, understandings, perspectives, and behaviors related to weight, obesity, and health, and can be between: 1) participants and health professionals, 2) participants and lay persons, 3) participants and popular assumptions about obese people, 4) among health professionals, 5) among participants, and 6) participants' own language, emotions, and behaviors. I realized pretty quickly that there were differences between participants' perspectives and those of health professionals, and that these differences influenced participants somehow. Throughout the process of collecting and analyzing data, I began to see disagreements all over, and not just between participants and health professionals. At the final stages of data analysis, I began to put the pieces together and see the bigger picture: A host of differences or

clashes among participants, health professionals, and laypersons, that operated at the micro- or individual level of society through interaction, and that influenced participants' everyday lives and sense of selves. I refer to these clashes as "competing realities."

In the current project, competing realities serve as major challenges for participants, frequently evoking a range of emotions and influencing how participants make sense of "obesity" in general. Competing realities are large disagreements that become obvious to participants through interactions with others (health professionals and laypersons) and alter how participants see themselves. Competing realities that are contradictions between a participant's own language, emotions, and behaviors are often felt but rarely shared by participants. In the rare case that participants caught themselves in a state of contradiction, they would show it through emotion, then take a step back and talk about themselves in an objective way, critically analyzing this disagreement between their thoughts and their behaviors to try and reconcile or explain them. I argue that competing realities are embedded in the "obesity epidemic" by operating at the individual or micro-level of society, through interaction.

The seven major competing realities discussed in this section are: 1) between health professionals' prioritizations of weight and participants' main complaint(s), 2) among health professionals' regarding of their approaches towards a disease model of obesity, 3) between health professionals' diagnoses of obesity and participants' self identities regarding their weights, 4) between medical definitions of obesity and participants' own definitions of obesity, 5) between a disease model of obesity and participants' views of weight as a risk to health, 6) between popular explanations of obesity and participants' narratives of weight status, and 7) between the weight-loss

behaviors among participants, and often, internal competing realities within participants regarding these issues. Until public health promotion and health practice in obesity recognize the lived experiences of those who are considered “obese,” these competing realities will continue to generate irrelevant and impractical solutions, and to complicate the lives of those considered “obese” by medical standards.

*1. Competing Reality: Health Professionals’ Prioritization of Weight Over Participants’ Main Complaints*

Through participants’ experiences, I found that obesity was a major, if not sole, concern of health professional visits, and not by participants’ choices. Conversations about obesity often occurred during a visit when participants had a complaint (or complaints) about something other than body weight. In fact, participants left these visits feeling as though their concerns were not addressed or were under-addressed because the health professional prioritized obesity as the main concern, which redirected the visit to address the health professional’s concerns instead of the patient’s. Among participants who experienced competing realities between their own priorities and their health professional’s priorities, some felt a range of emotions including frustration, anger, confusion, anxiety, and guilt. Many participants reported mental and physical health consequences because their main concern was not shared by the health professional. Some participants were mistreated for their main complaint because of a health professional’s prioritization of body weight, and some suffered even worse consequences as a result.

For example, one participant, Jamie, with a lesion of untreated Methicillin-resistant Staphylococcus aureus infection (MRSA) on her neck, sought treatment concerning the growing and urgent lesion. During her fifth visit to a health professional concerning her MRSA, she realized that her main concern was not shared by the physician. She was diagnosed with “obesity” and was urged to get lab tests for weight-related conditions that she showed no signs of. The conversation about her MRSA comprised five minutes of the visit, while the conversation about obesity constituted about 40 minutes of the visit. Further, there were two medical students present for the entire visit and the physician was showing them how to enter her two diagnoses into the computer. Jamie described this scenario:

Also, while I’m sitting there, she’s also teaching the med students how to input things into the system. I’m sitting in the examination room and she says, ‘Okay, so her primary diagnosis is MRSA and then her second one is obesity. We go into DX2, diagnosis two, and we type in ‘obesity.’ Then after we type in ‘obesity,’ all these other things will come up. We’re going to check off that she has high blood pressure, that we need to check her for her cholesterol. We need to check her for pre-diabetes and we need to check her thyroid.’

Jamie did not show any signs of weight-related conditions, and she was upset that the physician saw her body weight as the main concern when her main concern was the lesion of untreated MRSA. Jamie interpreted this as the physician “excited to have a chance to show the students a real-case scenario of obesity.” She also said that she did not get the lab tests and will never return since she refuses to go to a doctor who looks at her weight as the only risk factor for other diseases.

Another participant, Marie, sought psychiatric treatment for her bipolar disorder, but just a few minutes into the visit, realized that the psychiatrist was more concerned

with her weight than with her manic episodes. The psychiatrist did not prescribe the recommended drug for bipolar disorder because of the cited side effect of weight gain. Assuming that Marie would rather risk having a manic episode than gain weight, the psychiatrist prescribed a drug that was ineffective for her. Inappropriately treated for bipolar disorder, the participant suffered from manic episodes that tragically led to a child custody battle that she lost. She said:

And she looked at me, I was across the desk in the chair. And she looked at me and said, ‘Well, I can’t give you what I’m supposed to because you obviously can’t afford the rapid weight gain associated with this medication.’ And I trusted her, you know, I was manic. I was desperate. I thought she knew what was best for me.

Since being effectively treated for bipolar disorder, Marie has reflected on her current situation, in light of her ineffective treatment and the magnitude of its outcome for her. She remembers feeling “devastated and stupid” for allowing a health professional to prioritize her body weight over her bipolar disorder, since she knew how bad her manic episodes were, and since this was what caused her to finally push herself to visit a psychiatrist after months of struggling. Overall, Marie feels like a “new person,” but trying to disentangle her manic episodes, her experiences with body weight, her visit to the psychiatrist, and her loss of custody of her children seemed to be impossible for her. She was critical of the AMA’s decision because she didn’t agree with the pressure placed on physicians to prioritize weight, since prioritizing weight may mean ignoring an immediate health concern. She was also skeptical of psychiatry’s involvement in weight-related matters, and felt that an effective prescription drug with weight-gain as a cited side effect should not be seen as bad or dangerous for overweight patients suffering from

mental illness. She thought that the emphasis on body weight as an urgent health problem was dangerous, especially for patients like herself, whose lives could be completely changed if not treated properly.

Participants felt a range of emotions when a health professional prioritized weight over their main complaint(s). Jamie was frustrated and felt “depersonalized” with the approach her health professional took towards her:

I was really frustrated that instead of talking to me about the primary reason I went there, most of it was more focused on the obesity. I did feel fat shamed by a medical professional... I didn't think it was a good approach to medicine. I felt very depersonalized. It was a very depersonalizing experience because it was, 'Okay, let's just look at her numbers and not her as an entire person.' She didn't want to ask me if I thought I needed to lose weight. She didn't want to ask me if I was healthy or happy with my body. The assumption that since I'm overweight I must either eat unhealthily or be inactive, I think, is also very narrow-sighted.

Although Jamie provided more of a critical view of the health professional's approach, her feelings of frustration and depersonalization from the visit stuck with her. Feeling depersonalized by a health professional, and believing that the “numbers” (pounds) were more telling to the health professional than anything she had to say negatively influenced how Jamie thought about herself. Weight became the paramount feature of the health professional's (and the med students') perceptions of her. Her refusal to undergo lab tests or to return to a health professional that saw her body weight as the highest priority, was also important implications of this type of approach.

These findings call into question current dynamics between health professionals and their patients; more specifically, these findings challenge the discourse of an overall trend towards a “shared” or “patient-centered” (see Guadagnoli and Ward 1998)

approach to health care. The physician-patient relationship has seen a tradition of study in medical sociology for over six decades, beginning with the concept of the “sick-role,” introduced by Talcott Parsons (1951). Parsons (1951) explains that the patient is obligated to seek competent help and to cooperate with the caregiver. Additionally, the sick person is responsible for trying and getting better (Parsons 1951). Although the sick-role was originally limited to acute illnesses, a later development by Parsons (1975) also accounted for chronic illnesses. This traditional notion of the physician-patient relationship places the physician as knowledgeable and therefore in power over the interaction. However, this model has been criticized as placing the physician at the center of the physician-patient relationship, which reduces understanding of the patient’s agency over his or her own health. Guadagnoli and Ward (1998) argue that the physician and patient relationship has changed over time and that patients are increasingly viewed as consumers with rights to knowledge and a say in their healthcare options. A model that places the patient at the center of the physician-patient relationship assumes that the patient has been provided knowledge of his or her condition and of its severity, is offered treatment options by the physician, and has a say in the appropriate course of action (Ong et al. 1995).

In the current study, the assumed overall trend towards patient-centeredness is not reflected in participants’ experiences, since their experiences reflect a more Parsonian model of the physician-patient encounter. Policies like the AMA’s may be pressuring health professionals to take control in their interactions with “obese” patients, especially when there is a competing reality between the health professional’s priorities and the



patient's priorities, and when the patient does not see his or her body weight as the sole or even a major health concern.

Last, participants' experiences may be simultaneously similar to and very different from those of patients who are dealing with a "contested illness" (e.g. Barker 2002; Barker 2008; Conrad and Barker 2010). Contested illnesses are illnesses that are experienced by the patient that medical experts cannot find an explanation for and are characterized by "a host of disturbing symptoms" (Barker 2008:22). Sufferers are often diagnosed with an "unexplained syndrome"<sup>4</sup> (Barker 2008: 22). There seems to be some parallel between participants' experiences in the current study and those of contested illness sufferers when visiting a health professional. There is a unique power struggle between the health professional and the patient as to who decides what "real" health concerns are experienced, how they are defined, and who legitimizes them.

Physicians typically become frustrated with contested illnesses and, by extension, their sufferers, because diagnosis is a major goal of physicians during the physician-patient interaction (Barker 2010), and because physicians view disease as a biological process that can be categorized and treated. Barker (2010) explains that for the physician, diagnosis represents categorizing and coding the patient experience and indicates a protocol for treatment. However, those with contested illnesses typically seek a diagnosis for a condition that is unrecognized by the medical establishment, which seems to be an inverse or subset of participants' experiences with obesity in the current study. Health professionals provide diagnoses for things not of interest to participants while ignoring participants' actual concerns. Future work in the illness experience, medicalization, and

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<sup>4</sup> More popular contested illnesses include fibromyalgia syndrome, chronic fatigue syndrome, irritable bowel syndrome, chronic pelvic pain, and tension headaches (Barker 2008:22).

physician-patient communication may be suited to investigate the parallels between “obese” patients and “contested illness” sufferers when visiting a health professional.

2. *Competing Reality: Variety Among Health Professionals’ Approaches Towards a Disease Model of Obesity*

All participants were told that they were “obese” by a health professional since the AMA’s policy change. However, there seems to be variation among health professionals’ approaches towards *obesity as a disease* and the language used on behalf of health professionals in telling their patients they are obese. While some participants were actually diagnosed with obesity, others were told that they were considered obese and were advised to lose weight. Among those who were diagnosed with obesity, the approaches to diagnosis and treatment varied.

Most health professionals initiated a conversation with participants about losing weight, which for most included suggestions to change their diet, exercise regimen, or overall lifestyle. Some participants were given formal paperwork with their diagnosis of obesity, while others were not given anything. Still, others said that the health professional was “entering things in the computer,” but most participants were unaware of what was being entered, and left without any formal paperwork. An exception to this was Jamie, as mentioned earlier, who knew what the physician was entering into the system because the physician was teaching the medical students in front of her. Others were prescribed blood work or other lab tests to check for an abnormal thyroid. Some participants were referred to a specialist, including being given a list of nutritionists, and one participant was referred to a weight-loss specialist within the practice.

One participant, Cassandra, visited a new health professional since moving to college and was asked if she had considered weight-loss surgery, which she had not considered. The physician told her that he would let her try to lose weight but that he would monitor her progress and reassess the options in a year or so. Cassandra was confused as to why the physician brought up weight-loss surgery as the first treatment option, as no alternative solutions were mentioned during the conversation. The health professional did say that he would “let her try and lose weight,” but Cassandra assumed that he was telling her to alter her diet and exercise since he did not explicitly recommend another course of action. Although Cassandra said that she “wasn’t even upset” that the physician saw her body weight as problematic, she was upset with the extreme approach the physician took to her body weight, since she views weight-loss surgery as a “terrifying and dangerous procedure.”

Most health professionals requested a follow-up visit with participants. Two participants said they had followed up, and both experienced similar conversations in the follow-up visit. Several participants said that they had avoided their physician since they were told that they “had obesity.” Some participants mentioned finding a new doctor after their experiences of being diagnosed with obesity.

### *3. Competing Reality: Health Professionals’ Diagnoses of Obesity and Participants’ Own Weight Identities*

Among the participants who were diagnosed with obesity by a health professional since 2013, most disagreed with a diagnosis of obesity, which caused a competing reality between health professionals’ categorization of the patient and the patient’s

categorizations of herself. Many participants did not agree with the diagnosis of obesity, either because they did not see obesity as a “real” disease, they did not see themselves as “obese,” or both. The most frequent finding was that participants believed their BMI weight-label exaggerated their current weight status, explaining that they see themselves as “a little bigger than normal” or “could lose some weight” but outwardly rejected their BMI weight-label of “obese.” Most participants either saw themselves as “overweight” or rejected the use of BMI-weight labels altogether. Some participants who were considered “morbidly obese” by medical standards accepted the “obese” designation but rejected being labeled “morbidly obese.” For example, Brenda said that she “agreed that her weight was a problem and that she had always been obese” yet despite her BMI of 52 kg/m<sup>2</sup> (morbidly obese is defined as having a BMI  $\geq$  40 kg/m<sup>2</sup>), she did not see herself as “morbidly obese,” and explained that she was “still able to move around and do things unlike people who are 600lbs.” There was one participant who accepted her BMI-based weight label of “obese” as an accurate depiction of her current weight status. Some participants were highly critical of obesity being measured solely based on the BMI, and argued that their BMI did not reflect their health or health behaviors. For example, Corinne explains the competing reality between being “considered” obese by medical standards and her own lack of identification as obese:

I’ve always been a little bit bigger, ‘cause like I say, I’m more body...and it was...I guess I’ve technically always been obese — since I can remember, really, but it never felt like I was obese, because of the way my body — my fat hangs, I should say. It’s never been, you know, unsightly.

Corinne described her BMI-based weight label as “nothing new” but she expressed feeling like visits to health professionals always served as a reminder that she is “known as obese by doctors.” Based on the perceived assumptions and judgments that some participants felt, their experiences discussing body weight with a health professional were negative, describing the visit as “disheartening,” “disappointing,” and “hurtful.” Jackie, who didn’t “feel obese,” couldn’t recall the exact language that was used during a past interaction with a health professional, but she did remember how it made her feel:

I don’t remember what language was used. I can’t remember. I just remember one time, being really offended, because I don’t feel obese. I don’t feel, you know, fat, and this is what they’re telling me basically that I am.

Participants also had unique understandings of “disease,” which influenced mostly how they saw the personal relevance of the AMA’s designation of obesity and how they made sense of their experiences in light of this policy. Although none of the participants agreed that obesity was a “disease,” some participants were understanding of the AMA’s decision. For example, Steph said that she understood how weight was a real health issue for some people and that some people needed to lose weight to improve their health. However, despite her own BMI of 38 kg/m<sup>2</sup>, Steph did not see her body weight as problematic. She was understanding of the AMA’s policy, but did not see the personal relevance of the policy despite being considered “obese” by medical definition. On the other hand, participants were highly critical of the AMA’s new classification of obesity as a disease. Nicole said:

I think it's problematic to classify weight as a disease because weight... There's so much that goes along with it. So, if you're overweight or medically obese, that means that you're diseased? That means that you're unhealthy? You might not necessarily be unhealthy. If you're just looking at BMI, half of the NFL would then be considered as being diseased... it's very shortsighted to just look at body weight as a disease. I think that's a scapegoat and I think it's a way to demonize people... obesity doesn't kill people. Heart disease attached to obesity might kill people, just like heart disease attached to a healthy person might kill someone.

Nicole felt like a disease label of obesity "demonizes" people. In demonizing people, the medical profession draws on popular obesity discourse that blames the problem on the individual and his or her failures. Through this perspective, there are well-known standards and expectations that "obese" people are not living up to, and participants are reminded of this dominant discourse in their interactions with health professionals. Like Nicole, Ellie did not think obesity was a "disease," either. She said:

I personally don't think it's a disease because, for me, diseases need treatments and medications to regulate it and get rid of it. With the right diet, exercise, and lifestyle change, you're cured of obesity, I guess? So I wouldn't count it as a disease. Maybe it's an epidemic... because a lot of people are obese, but I don't think it's a disease.

Violet agreed, explaining that "it's not fair to categorize obesity as a disease." She thought obesity was more about someone's environment and economic status than something within the body that can be treated through medication. Olivia said that obesity isn't a disease because "you don't contract it." Participants with fluctuating weight, or participants who experienced rapid weight gain or loss over short periods of time also saw weight as temporary, which influenced their opinions of obesity as a "disease." For example, Jessica said:

I don't think so. I think it's a condition, you know. I think it's a state that you're in currently. There are diseases that are treated, and you're cured from them. I feel like we shouldn't use the word 'disease' for a state you're in.

Although previous research has yet to report on public opinions of obesity as a “disease” since the AMA’s policy change, researchers have put forth several arguments based within theoretical distinctions between obesity and “traditional diseases.” It is argued that obesity is a risk factor that can possibly lead to a host of more traditional diseases, but it is not a disease itself (Hofmann 2016). Disease is also viewed as a distinct and meaningful medical category separate from others such as “illness” and “epidemic” (see Cassell 1976; Eisenberg 1977; Cott 1986; Kleinman 1988; Brown 1995; Conrad and Barker 2010), which suggests an entirely different perspective and treatment of obesity. Further, diagnostic ‘utterance’ (Jutel 2016) and the power of diagnosis (e.g. Jutel 2016; Bury 1982; Fleischman 1999) have been viewed as negative and even harmful for the patient. Hofmann (2016) concludes that obesity does not fit within the biomedical definitions of disease. There are several definitions of “disease” (see Table 4 in Appendix), and distinctions between “diseases” and “illnesses” (see Table 5 in Appendix). However, it has been argued that obesity, although not an abnormality in the function of the body, can be considered a socially-defined disease (Hofmann 2016). Socially-defined diseases are behaviors, phenomena, or conditions that are seen as aesthetically concerning or offensive, immoral, or not adherent to social norms (Hofmann 2016). However, Hofmann (2016) and Boero (2007) argue that socially-defined diseases are constructed in order to present themselves in a traditional biomedical disease fashion.

In the current study, participants did not see obesity as a disease. This finding contradicts medicalization research, which argues that frequently, patients are relieved when their experiences are legitimized by the medical profession because it takes individual responsibility off of the patient by recognizing the shared experiences of a set of people as a “real” health concern. As Barker (2010) explains, diagnosis is often favored by the patient because it gives medical recognition and legitimacy to their condition and related experiences. Often, diagnosis takes the individual blame off of the patient by legitimizing their condition as a biological and medical issue that is shared by others (Barker 2010). However, some reject the medical categorization or label of their current condition, where human variation in shapes and sizes has been medicalized (Barker 2010).

Diminished individual blame as an influence of medicalization has yet to happen with obesity, and Barker’s (2010) explanation is not supported by the current findings. Possibly, dominant obesity discourse that frames obesity as an individual problem with individual-based solutions (e.g. change in lifestyle, diet, and exercise) may be preventing this feeling of relief among participants, and may alone distinguish the medicalization of obesity from other medicalized phenomena. Further, this may not be relevant for participants who do not see themselves as obese in the first place. Future research in medicalization and the illness experience should examine whether obesity is different than other medicalized phenomena in this regard. Additionally, future research in public attitudes towards obesity should distinguish the attitudes of “obese” people from those not considered obese by medical standards, to see if they are, in fact, different at the population level.



#### 4. *Competing Reality: Medical Definitions of Obesity and Participants' Definitions of Obesity*

Although all participants were medically defined as obese, participants defined obesity in their own terms, which included much more extreme depictions of obesity than included in the medical definition of obese. Findings suggest that participants use others as a source of reference when defining “obesity” and when thinking about their own bodies. Participants frequently referenced media representations of obesity that some participants used to define “obesity.” Such media representations included discussions about several television shows such as, “*My 600-lb. Life*,” “*The Biggest Loser*,” “*Real Life: I’m Addicted to Food*,” and “*My Strange Addiction*.” Participants used these representations of “obese” people and of certain behaviors of “obese” people to construct their own meanings of obesity. Some participants, in explaining that they do not consider themselves obese, offered examples of people they did consider to be obese. Extreme representations of “obesity” as shown in the television show, “*My 600-lb. Life*,” aligned with some participants’ views of obesity. Participants explained why these people are obese, and how these people differ from them. Much of participants’ explanations included descriptions of what obese people look like, through their perspectives. For example, Anne said:

You know, obese, like those *really, really*...I mean, *really*, big people you see on T.V., where the rolls of fat are just hanging. I mean, they can barely get out of bed. They can’t walk. And I think, ‘Oh my heavens.’

Similarly, Jamie said:

I think people who are obese are the people that can't move, that have physical immobility because of their weight. I'm thinking about the show, '*My 600-lb. Life*,' where they haven't gotten out of bed in years...they have a sack they go to the bathroom in so they don't have to get up, and people just bring food to them in their bed.

For many participants, extreme media associations of obesity influenced how they defined "obese," but also served as a way to differentiate themselves from "obese" people. Participants saw themselves as very far from these particular media representations of "obese" people, and therefore, "obese" was an inaccurate depiction of their bodies and themselves within their own definitions of "obesity." Future work in media representations of obesity could explore the extent to which extreme representations of obesity influence individual views of obesity and the "obesity epidemic." More specifically, it is unknown whether members of the general public associate these extreme visuals with all "obese" people, since these extreme representations are in fact, extreme examples of obesity and do not accurately represent the 35.7% of U.S. adults considered "obese" by medical standards.

Participants also used other media representations to differentiate between societal ideals and realistic bodies. In doing so, many participants saw themselves as "normal," or like realistic bodies, more so than "obese" bodies. For example, several participants mentioned how the average size of women has changed over time, and some even said that the average is even considered obese. For example, Steph said:

...and I know our sizes, as a country, as a world, are changing our average sizes. You know, like women run to like a size 16, is our average woman's size, I think. Four years ago it was like a 12 or a 14... we're getting bigger as a people.

Similarly, Brenda thinks that “ideals” do not match reality. She said:

We see these models and actresses that have these bodies and we think we’re supposed to be like that. But it’s not realistic. That’s their job, to maintain a certain weight or appearance, so those expectations shouldn’t be for all women.

Some participants differentiated between ideal bodies and realistic bodies, which did influence their definitions of a “normal” body. Further, these definitions of “normal” bodies then influenced their definitions of “obese” bodies, which participants considered much bigger than the normal body. Most participants used these visuals more so than BMI-ascribed weight labels, and saw themselves as normal or somewhere between “normal” and “obese.”

Another influence on participants’ meanings of obesity was thresholds. I define threshold as something significant to participants that defines when weight is “problematic” or not, in a general sense or personally. Two common thresholds participants discussed were immobility or physical limitations based on weight and “the 200-pound. mark.” Immobility or physical limitations based on weight was a meaningful distinction to participants in thinking about weight as problematic or not. Many participants said that body weight is not problematic or harmful unless weight has caused immobility or physical limitations of day-to-day activities, such as walking, climbing one or two sets of stairs, breathing, or getting out of bed. To some participants, these types of limitations, if based on weight alone, defined weight as a problem. Some participants drew from media representations of “obese” people and the immobility or physical limitations of people on the show. Others drew from experiences with family members,

particularly parents and grandparents, whose weight became a barrier to doing simple, day-to-day activities.

Many participants said that approaching 200 pounds made them start thinking about their weight as problematic. Many participants who felt this way started dieting immediately after they found out that they were approaching 200lbs., weighed right around 200lbs., or weighed more than 200lbs. Despite 200lbs. being a threshold for some participants in seeing their weight as problematic, participants did not realize that they weighed around 200lbs. until they stepped on a scale. Prior to the scale reading a number that was 200 or close to 200, participants “had no idea” that they weighed that much, nor did they see their weight as problematic, because they did not “look 200lbs.” nor experience any physical limitations because of their weight. This finding suggests that although some participants rejected weight labels or did not see themselves as “obese,” 200lbs. was a meaningful threshold for participants. Again, dissociating themselves from extreme representations of obesity may contribute to this competing reality, and future work in media representations of obesity should further explore the relationship between extreme representations of obesity and self-identity.

##### *5. Competing Reality: Disease-Model of Obesity and Participants' Views of Weight as a Health Risk*

Findings also suggest that meanings participants held of phenomena such as “obesity,” “disease,” and “health” influenced how participants saw themselves and how they identified. In turn, these meanings influenced participants’ interactions with others, such as agreeing or disagreeing with the use of the BMI in general, the accuracy of their

BMI-based weight label, their acceptance or rejection of a diagnosis of obesity, their opinion of the AMA's policy, and their understanding of their experiences within a disease model of obesity.

While some participants saw "obesity" as a health phenomenon, others saw it as a social phenomenon where obese bodies are not socially considered aesthetically pleasing bodies. Some participants agreed that obesity was a combination of a health phenomenon and a social phenomenon. Overall, participants saw "obesity" as a health phenomenon when immobility and physical limitation (based solely on weight with absence of other health concerns) are experienced. Some participants thought that "obesity" was a health phenomenon only if there were other "co-morbidities" or "weight-related health concerns" involved. Other participants disagreed, and did not think that obesity itself was a health phenomenon, but some agreed that high blood pressure, Type II diabetes, and cardiovascular disease were health problems. Many participants viewed "obesity" as strictly a social phenomenon; some personally felt this way and others specified that although they personally did not consider it as such, they thought "society" did.

Participants' meanings of "health" also varied which influenced how they viewed themselves and also how personally relevant they saw the AMA's new classification to be. Out of 29 participants, there was one participant, Kylie, who saw herself as unhealthy. She said:

I don't feel healthy. It's not that I don't think I look healthy, I just don't feel healthy...my asthma causes me to get winded going up two flights of stairs...I'm just not physically healthy.

All other participants saw themselves as “healthy,” and gave several reasons why they believed so based on their definitions of “health.” Many participants referred to specific behaviors, while others referred to the absence of illness. Definitions of “health” for some participants meant living a “healthy lifestyle,” which they defined through specific behaviors such as being active, through intended exercise (e.g., visits to the gym), playing sports, or “constantly moving” (e.g., an on-the-go lifestyle, multiple jobs, busy schedules), diet (e.g., eating vegetables, chicken, fish, salads, etc.), small portions, or rarely dining out. Participants also defined “healthy lifestyle,” as not engaging in certain behaviors like smoking, drinking alcohol, or “binge-watching Netflix.” Some participants explained that assumptions cannot be made about someone’s health based solely on weight or BMI.

The current findings support previous findings reported by Lewis et al. (2009), who explored perceptions of public health messages in Australia. Among those considered at least “obese” by BMI standards ( $BMI \geq 30\text{kg/m}^2$ ), they found that some participants rejected popular public health messages of obesity and claimed a healthy lifestyle. Among these participants, some did not see themselves as “obese” nor “unhealthy,” and argued that public health messages depicted obese lifestyles inaccurately. One participant in Lewis et al.’s (2009) study referred to pictures of overweight people eating hamburgers and thick shakes, and argued that these messages did not represent his behavior since he “doesn’t eat a hamburger and large chips everyday” (Lewis et al. 2009:5). Future research could explore the competing reality between popular lifestyle depictions of obese people and the actual lifestyle behaviors of

those considered “obese” in the U.S., given the disease label of obesity by the AMA and the public health messages of obesity in America.

6. *Competing Reality: Popular Explanations of Weight Gain and Participants’ Narratives of Weight Gain*

According to the popular “energy-in, energy-out” explanation of body weight, weight gain is the outcome of too many calories ingested without an equal amount of energy expended. From this explanation, popular notions of weight gain as an individual moral failure are justified, since it is assumed that the individual’s weight gain stemmed from personal problems of gluttony, laziness, and lack of motivation or willpower. However, in the current project, participants’ own narratives of how they came to be of their current weight status do not, either fully or partially, match the well-known formula that leads to weight gain. This suggests that there is a competing reality between popular explanations of weight gain and participants’ own narratives of weight gain. Further, many participants practiced behaviors towards diet, exercise, and/or overall health that are at odds with the dominant pathology of overweightness.

Findings suggest that some participants have come to their current weight status through different paths, including weight gain as a side effect from a treatment or injury. One participant, Victoria, experienced a 50-pound weight gain from a rheumatoid arthritis drug without any changes to her diet or physical activity. Another participant, Steph, gained 23 pounds from a knee injury and ineffective physical therapy, which put her off of her feet for four months. Kylie recently gained 20 pounds from an injectable form of birth control, which her gynecologist recommended based on the frequency,

length, and severity of her menstrual periods. Since on the new birth control, Kylie no longer misses work or school because of her menstrual periods, and hasn't been hospitalized (like before) for excessive blood loss. Another participant, Tiffany, gained 60 pounds from steroids, which she took to treat shingles. Tiffany's experience was unique because of the rarity of developing shingles at a young age. She describes her situation and the unwanted weight gain from her treatment:

I got really sick when I was in first grade. I developed shingles. So they put me on a bunch of steroids, which made me go up like another 50 pounds...when I was in first grade. And I was bigger than all of my classmates. I had a friend come up to me and say, 'Tiffany, you always get really skinny and then you get really big every other year.' And it's like...I was on the medications for another year after just to make sure it wouldn't come back, it wasn't like I was purposefully gaining weight.

Other explanations of weight status included childbearing and child-rearing, extremely busy lifestyles, familial or cultural norms, and slow metabolism. Other participants explained their weight gain as a consequence of quitting previous behaviors that they viewed as more harmful to their health than excess body fat. Participants also saw themselves as healthy overall, and saw their current behaviors as healthier alternatives to past behaviors. To them, eating more was a "healthier choice" compared to drinking alcohol, smoking, abusing laxatives and weight-loss supplements, or depriving themselves of eating at all. Participants were proud to have quit such "risky behaviors," even though it meant gaining weight since the time they quit. For example, one participant explained that smoking three packs of cigarettes a day kept her weight down for most of her life. Several participants shared past experiences with alcohol, smoking, or other drugs.



Findings from the current project suggest that *obesity the disease* and the dominant “energy-in, energy-out” explanation of weight gain do not account for multiple pathologies that are actually reflective of participants’ experiences. Participants’ narratives should be at the center of dominant obesity discourse (Boero 2000; 2007). Further, future work that explores participant narratives of weight gain should be used to inform obesity treatment and dominant obesity knowledge. The competing reality between popular pathologies of weight gain and actual experiences of weight gain make tackling the obesity problem or redefining obesity discourse difficult tasks. Until public health promotion and health practice in obesity recognize the lived experiences of those considered “obese,” this competing reality will continue to generate irrelevant and impractical solutions.

#### *7. Competing Reality: Weight Loss Behaviors Are Inconsistent Within and Between Participants*

Participants shared a wide variety of weight-related behaviors. These behaviors differed for individual participants over time and these behaviors differed amongst participants. This suggests that there is an internal competing reality between participants’ own weight loss behaviors that contradict one another, and a second competing reality among participants regarding weight loss behaviors, given the variety of responses from participants.

Most participants attempted to lose weight several times, some for their entire lives. Participants discussed dieting and exercising for periods of time with the intention of losing weight. When asked about previous efforts to lose weight, one participant,

Jessie, replied, “I’m always on a diet.” Some participants discussed long periods of dieting and exercise and provided several reasons why they had stopped a certain diet.

Overall, participants engaged in periods of strict diet and exercise, followed by periods of eating poorly or not exercising much at all. These periods ranged from years at a time to a few days. For example, Sam said:

This is really bad – I’m off and on when I want to lose weight. Like, last week I bought Swiss rolls and Oreos when I went grocery shopping. This week, I bought strawberries, pineapples, and spinach. So, I go back and forth. I had all this fruit in my fridge, but last night I made myself nachos.

Sam defined this “back and forth” behavior as “really bad.” However, she didn’t share feelings of guilt or regret about eating certain foods. In fact, she was more critical of others not eating what they want to eat based on pressures to maintain a certain figure. At the same time, she shared her own efforts to lose weight throughout her life, including recent efforts to eat healthier foods. Some participants described their efforts to lose weight as “extreme,” “obsessive,” and “compulsive.” For example, Nicole said:

I can get rather obsessive and compulsive. Sometimes I wear a fitness tracker, but then I find myself getting obsessed about making sure I get 10,000 steps in a day. It becomes consuming. Then, when I do get into a, ‘You need to lose weight, get healthier,’ type of mindset, I find myself getting on a scale three times a day.

While some participants used both diet and exercise to lose weight, others found one “easier” to do than the other. For example, some participants preferred to restrict food intake altogether, rather than restricting certain foods or increasing the frequency of exercise. Reasons for this included limited time, cost of healthy food options and/or gym

memberships, and exhaustion from school or work. Others found frequent exercise more “doable” than dieting because the gym increased energy levels and decreased their stress levels, while citing the high cost of healthy food options, limited time or energy to prepare and cook healthy meals, and preferences for certain kinds of foods. For example, Ellie said that she will go to the salad counter at school for lunch, but after looking at the options, decides that she really doesn’t want a salad, chooses chicken fingers and fries instead, and “convinces herself” that she will go to the gym the following day. Several participants mentioned limited healthy food options that are affordable and convenient, especially on college campuses or near participants’ places of employment.

Some participants explained that they got frustrated with a certain diet after not getting the results they had expected. Other reasons for stopping a diet included the cost of gym memberships or healthy and organic foods, busy schedules with work, school, or raising children, lack of convenient healthy options, lack of time to prepare and cook meals, and unsatisfying low-calorie foods. One participant explained that if she “cheats” on a diet, that one time turns into the end of the diet for her because it takes her a while to get “back on track.” More immediate priorities such as school, work, childcare, and saving money were common explanations for eating behaviors among many participants, and some were the enjoyment of certain foods. For Violet, cost and convenience were main barriers to healthy eating:

Well, because there’s a lot of times where, if I can’t afford to get fresh produce every week or every month or anything like that...If I can only afford to go to McDonald’s to get my food or if I can only afford like off-brand cereals which is probably going to be higher in sugars and fats or whatever than, say, your wholly organic...that’s something that, unfortunately, is a part of my economic sphere.

Jessie also said that cost and time were barriers for her, and that she only has frozen foods at her house. She also eats at work because they have a plan for employees so they can eat from the buffet for only a few dollars. The buffet usually includes macaroni and cheese, ribs, chicken, mashed potatoes, French fries, chicken tenders, tacos, and chicken parmesan. Although she knows that these are not the “healthiest options,” she eats at work a lot because of the low cost and the convenience for employees.

A few participants shared that they had previously suffered from self-starvation, abuse of laxatives or weight loss pills, and obsessive exercising. One participant, during the time of the interview, stated that she was not eating:

I do exercise sometimes. Lately--like, this past month and a half--I haven't really been eating that much. I probably only eat dinner through the day and that's it... just--kinda self-conscious about my weight.

In an attempt to lose weight while keeping up with her hectic schedule of school and working 30 hours a week, restricting herself from food was the only way that she was able to “diet.” However, this was her attempt to lose weight because she was self-conscious about her weight.

This finding was unexpected, and as mentioned briefly in Chapter 3, I referred to the IRB for guidance after the interview. Similar to my own obliviousness that eating disorders could be a part of “obese” participants’ experiences, health professionals should be aware that these behaviors are not restricted to individuals who appear (on the surface) to be suffering from an eating disorder. These narratives support Lewis et al.’s (2009) claim that obesity may actually pose more harmful implications for mental health than physical health. This is because weight-based stigma is common, and public messages of

conforming to an ideal body begin to influence individuals at an early age (Muenning 2008; Lewis et al. 2009; Mustillo et al. 2012). The social pressures associated with staying thin are detrimental and should be taken seriously by health promoters and medical practitioners. A broader understanding of individuals' experiences with body weight should be known before health professionals assume certain weight-related behaviors and promote weight loss practices among their patients. Those who are self-conscious about their weight may be desperate to lose weight (Muenning 2008; Mustillo et al. 2012) and in light of time limitations or economic barriers, they may be more likely to engage in extreme and dangerous efforts to lose weight.

#### ANALYTICAL THEME TWO: LIFELONG TIES BETWEEN BODY WEIGHT AND SELF

Participants' experiences were also based on lifelong ties between body weight and selves, connections which could be traced back to childhood, and which were important in terms of participants' interactions with others. Participants learned, through interaction, that body weight is a paramount feature of others' perceptions of them. Early on, participants began to see themselves through the eyes of others, as "bigger" or "fatter" than is ideal, and were constantly reminded of this through interactions with both health professionals and laypersons (e.g., family, friends, romantic partners, peers, strangers, etc.).

Some participants had developed an alternative view of themselves as beautiful, criticizing popular standards of bodies and beauty. However, participants' narratives revealed that they first learned (through interactions with others) that they were "bigger"

or “fatter” than is ideal. After a long struggle with body weight, some participants came to see themselves in a more positive light, encouraged by an alternative social media movement, whose activists see fat as beautiful and who fight against harmful “fat stigma.” Findings suggest that an understanding of participants’ experiences since June of 2013 requires an understanding of their past experiences with body weight. These past experiences happened well before 2013, but are relevant for the current project since the past is an ongoing feature of constructing a present self. These newer experiences since the AMA’s policy were influenced by participants’ lifelong ties between body weight and selves, ties that participants brought with them when visiting a health professional. Participants’ lifelong, ongoing ties between body weight and selves were evident through their experiences with others that traced back to childhood. “Others” include health professionals and laypersons (e.g. family, friends, romantic partners, peers, strangers, etc.). Interactions with others from childhood were influential to participants and continued to influence the way they saw themselves in the present. Lifelong, ongoing ties between body weight and selves were more influential to participants’ experiences when visiting a health professional since 2013 than the AMA’s policy change, itself. In other words, participants had 18-79 years of experience with body weight that come to shape their recent interactions with health professionals.

Findings suggest that past experiences of body weight were meaningful for participants, and that participants drew from past experiences while making sense of the present. It is important to note that it is not an objective past experience that comes to influence present experiences. Rather, it is the way participants have come to understand the past through interpretation and meaning that matters for the present. For example,

Nicole's current understanding of past experiences were important, and she described how she understood a particular past experience differently at the time of her interview:

Weight has always been a part of my life...it's always been...I remember when I was in maybe, fifth or sixth grade, my mother took me to a nutritionist. Which, looking back on it, I feel is actually ridiculous. Because as a fifth grader, you're ten. Like, you're not making your eating decisions when you're ten. I wasn't going to the food store, I wasn't the one making dinner. So to me, looking back on it, I don't know what my mother was thinking...I remember being ashamed of having to go to a nutritionist, because I was taken out of school for it and I didn't want to have to tell people that I was going to see a doctor to learn how to eat better.

Nicole says that before, she was ashamed to tell others she was seeing a nutritionist for her weight, but looking back now, she feels like it was "actually ridiculous." She continued to say how these past experiences shaped the way she saw obesity:

...Everything that they were telling me, 'Oh, eat better.' Okay, well my mom gives me food. 'Be active.' I am. So, that's also why I don't like adhering to this idea that it's [obesity is] a disease, because I've been like this my entire... You know? Even though I said like, I look back, I was actually really skinny in high school.

Similarly, past experiences with others were meaningful for Ellie. Ellie recalled a specific interaction in middle school, and remembered having to "stand up for herself all throughout school." She said:

I remember this clear as day too, something like, 'Oh my dad works at a bakery.' He [a student in class] turned around and said, 'Oh, that's probably why she's so fat.' He didn't say it to me, he whispered it to his friend...and I'm just like, 'I'm so fat. I wouldn't have boobs for you to stare at if I wasn't so fat. Goodbye.'

For Ellie, this experience, among other past experiences she shared of peers commenting on her weight, did not deter her from wearing "revealing" clothing such as swimsuits or crop tops. However, Ellie's experience was quite different than other participants'. For

example, Tiffany said that past comments about her weight made her feel self-conscious about what she wore, despite the hot Florida weather:

... and I don't have revealing clothes. I try to cover up as much as possible 'cuz I don't want people to see more fat than they should on my body, so, anywhere I go I just try to cover up as much as I can... it's hot in Florida, but I feel self-conscious about it.

The connection between the past and the present is not unique to this project. Many have theorized about this connection (e.g., Mead 1934; Charmaz 1991, 1995) and have demonstrated the significance of the past and the present for those living with impairment (e.g., Bell et al. 2016), disability (e.g., Hindhede 2012), chronic illness (e.g., Aroll and Howard 2013), and terminal illness (e.g., Shapiro et al. 1997). This has also been an important connection for those who have experienced particular life events such as war (Coleman and Podolskij 2007), homelessness (Meanwell 2013), domestic violence (e.g., Katz 2015) and other forms of abuse (Woodiwiss 2013; Klein and Janoff-Bulman 1996), self-harm (e.g., Brown et al. 2007), surgery (Bradby 2012), midlife crisis (e.g., Hermans and Oles 1999), career transition (e.g., Lee and Schallert 2016), stroke (Ellis-Hill and Horn 2000), self-employment (Tomlinson and Colgan 2014), and aging (Ryff and Lawton 1991). Some of this research focuses on reminiscing (e.g., Fivush and Nelson 2006), self-evaluation and adjustment (e.g., Gunderson and Johnson 1965), and recovery of some sort (e.g., Woodiwiss 2013), and all studies have focused on the past and the present as they relate to self, identity, and relationships with others.

Past interactions with others include interactions that participants had when visiting a health professional's office anytime before June 2013. Although the AMA declared obesity a "disease" in 2013, some health professionals and scholars considered



obesity a disease long before the AMA's designation (see Rossner 2002; Heshka and Allison 2001; Kopelman and Finer 2001; Bray 2006; Jung 1997). This is also evident in participants' experiences visiting a health professional prior to the AMA's policy. Most participants were told multiple times throughout their lives that they were "obese" by health professionals, and by at least two different health professionals. Primary care physicians (PCP's), gynecologists, and nurses were the most frequently mentioned health professionals. Others included surgeons, physician assistants, medical technicians, cardiologists, and dermatologists. Current findings do not imply that one category of health professionals, such as nurses or medical students, were more or less likely to view obesity as a "disease" than any other category, and therefore, these findings cannot speak to any meaningful differences in this regard.

Despite the formal unavailability of a diagnosis category, some participants had been told by health professionals prior to June 2013 that obesity was a disease and that they had it. Others had been told that their BMI score fell "within the range of obesity" but without mentioning the word "disease." Many participants were told throughout their lives that their BMI was "above average" for their weight and height class. Others were told that they were "overweight" or "at risk for obesity" even when their BMI was within the "obese" range. Only one participant out of 29 was never told by a health professional prior to June 2013 that she was "obese." This participant, however, had a BMI of "normal or average" for her entire life until sometime during 2014.

Some participants were told by health professionals that obesity was a "serious health problem," "a risk factor," and "an epidemic." A few participants mentioned that a health professional referred them to a nutritionist regularly to get their weight "under

control” or to “regulate their eating behaviors.” Most participants were told by a health professional about making changes to diet and exercise.

Some participants had a primary care physician who, through medical records, tracked their weight over the course of several years. Therefore, some participants anticipated conversations about weight, especially if they knew that their weight stayed the same or if they had gained weight since their last visit. Anne, a 79-year old woman with Type II diabetes, said that she would get anxious several days before a doctor’s visit because she knew he would tell her to watch her weight. She said:

...and you know, I knew, I knew it was something that I was supposed to be paying attention to but before you know it, I had another appointment coming up and I would say to myself, ‘Oh shit, he’s gonna say something.’ So, I would try to eat a little less the days leading up to try and make the pounds go down a little, you know?

Anne talked about how low-carb diets or going long periods of time without food caused serious problems for her sugar level, considering that she was supposed to be managing her diabetes. For Anne, her PCP was concerned about her weight because of her Type II diabetes, and equally emphasized other factors besides her BMI, such as blood pressure and sugar levels. Another participant, Jackie, said that when she was younger, her pediatrician kept a chart that had her weight on record over the course of ten years. Her pediatrician “would always” say something to her about her weight:

She just brings up the weight chart, she looks at it, and she’s like ‘Jackie, it keeps going up...you went down a little bit, but then you went back up. What’s going on?’ I’m just like, ‘I obviously gained weight.’ I don’t really know...when she just looks at me and she gives me that look, I’m just like, ‘I don’t know what you want me to do. I’m not going to lose it overnight.’ ... She just like – I hate that look. That disappointing look like, ‘You were doing so well two years ago.’ I’m like, ‘that was two years ago.’

Other participants, such as Jamie, who also visited a nutritionist during her childhood, recalls her pediatrician talking to her mom about her weight and telling her mom that something needs to be done while she “would sit there and listen.” Another participant, Julia, said that she remembers her doctor talking to her about losing weight and her mom making it worse:

I think my mom was egging him on, ‘She eats this, she does that.’ And I’m like, ‘Mom, shut up. Sit in the corner and be quiet. Literally shut up and sit there. My side, Mom. My side.’

For some participants, a health professional’s emphasis on weight deterred them from scheduling annual check-ups or seeking treatment for a health issue, including a common cold, signs of sickness or an unidentified illness. There were a few participants who recall “years” of not visiting a doctor because of the health professional’s emphasis on body weight, which they knew of from prior experiences. For most participants, this wasn’t seen as impactful, and they mentioned the use of home or over-the-counter remedies. However, for one participant, Steph, this meant something much more. Steph went “about three months” with signs of mono, but refused to see her doctor because of the “fat shaming” she experienced during a previous visit:

I remember my throat killing me and my body aching. At first I thought I had a cold and wanted to wait it out. After, probably about two weeks, my mom kept saying, ‘Steph, let me make you an appointment,’ because she knew it wasn’t just a cold. I honestly did start to worry but I could not go because of how fucking shitty he made me feel about my weight just a few months before that. Now looking back, it was stupid and I could’ve just went and insisted that we not talk about my weight at all.

After months of pain, feeling lethargic, and “achy,” Steph’s mom made her an appointment with a new doctor that wasn’t taking new patients, although this doctor agreed to see Steph after her mom explained the situation over the phone. She was diagnosed with Mononucleosis and was treated with several weeks of antibiotics and rest. Other participants had different experiences with health professionals. Some health professionals saw body weight as “concerning,” but their overall approach, including “the way they talked about it,” and their “attitude” did not make participants feel bad. For example, Gina’s doctor would only mention her weight when she lost weight since the previous visit, but did not mention her weight if Gina herself did not mention it. She said that her doctor’s “positive attitude” made her want to lose weight, but did not make her feel bad if he noticed she had not.

However, despite the various approaches that health professionals took in monitoring and discussing body weight with participants, all participants mentioned that they were encouraged to lose weight by a health professional sometime in their lives. Further, health professionals suggested some form of behavioral modification, whether it be a general suggestion of dietary changes and exercise, or a specific diet. Some participants were told by a health professional to control portion sizes and one participant was told to “try eating slower.” Another participant, Monica, was recommended to eat specific foods and to keep a journal of her food intake.

Although many participants’ interactions with health professionals included views of body weight as problematic, participants had also visited health professionals who did not. For example, one participant, Laurel, said that one time, she went to a doctor who

asked her about her diet and level of activity and concluded that she seemed to be healthy, which, to Laurel, was what “really mattered.” Another participant, Sam, said that her pediatrician “...always used to tell her that being overweight ‘wasn’t necessarily a bad thing.’” One participant, Marie, whose father is a cardiologist and served as her PCP for her entire life, said that her dad “never focused on weight, necessarily.” She said:

Honestly, I can’t remember him [her father] ever even weighing me or making me get on a scale. Now, what he did do was make all of us line up...like once a month or something. We would line up, all six of us, and he would check our heart rate, our blood pressure...his thing was sugar. Salt and sugar. If we had a high blood pressure, he would say, ‘Okay now, cut out the sodas and the chips,’ you know, all that stuff. But he never focused on weight, necessarily.

For many participants, past interactions with other kids at school were the most influential in shaping self and identity. In fact, many participants’ past and current selves and identities are still influenced by these past interactions. For example, Francesca used to be outgoing until her interactions with other girls in first grade made her uncomfortable about herself:

When I was little, I remember I was in first grade. I was outgoing at that point, I was talking and cheery, and then I remember these two girls—they started pointing and laughing at me. They were picking on me, and after that I just became so reserved. I didn’t do my work. I didn’t talk to the teacher. They thought I couldn’t read so they failed me, and that just made it worse for me...not wanting to talk to people. And having a hard time making friends, and that’s the reason why I’m the way I am now. Really shy, don’t talk to people.

For Francesca, this interaction had immediate influences on how she acted in school, both inside and outside of class. She began failing classes and had a difficult time making friends. Currently, Francesca describes herself as a “shy” person, and says she has been

ever since the interaction with the two girls in first grade. Many participants were bullied by their peers, and these earlier interactions had immediate influences on their selves and identities, and in various ways, have influenced a current sense of self and identity. For example, Nicole recalls an interaction from the third grade with another student on the bus. Twenty years later, Nicole still refuses to wear shorts no matter how hot it is because she was once told that her thighs were “spread out” and “too big.” Nicole currently plays an intramural sport on Friday nights and recently, another player was taken aback by her performance on the field, since he had preconceived assumptions of her ability based on her body weight:

I had one player be like, ‘Wow. You really surprised us by how fast you could run.’ I was like, ‘Why is that surprising?’ They’re like, ‘Well, you know, fat people are typically slow runners.’ There’s this association. I’ve had people on the team say, ‘Wow you really surprised us, you know? You’re pretty athletic for a big girl.’

Nicole was aware of assumptions that others had about her and about other “big girls.” She explained that the assumption is that “big girls” are big because they do not exercise and therefore cannot be athletic. Nicole described her life of sports and her participation in other forms of physical activity, such as running, walking, and dancing. She considers herself very active, although others assume otherwise. Another participant, Lindsey, a first-year college student, moved to the University excited to join an athletic team, especially because she was one of the best on her team in high school. However, during the first tryout practice of the semester, the coach demanded that every one be weighed in front of the group, and he called out each person’s weight. Lindsey and two other “bigger girls” were embarrassed when the coach publically weighed them, and they were even

more embarrassed when the coach began to talk about heavy people slowing down the team:

He made it all about the team...that simply from a math perspective, that more weight automatically meant a slower team. Then he kept going, talking about how if there's more weight, it will be too hard for the team to carry us... I was so embarrassed because it was obvious that he was talking about me and the two other girls. We left the tryout so upset and disappointed, and decided not to be on the team.

For others, past interactions with romantic partners or past hookups influenced how participants saw themselves, such as how worthy or attractive they were. For example, Romey was dating a girl who left her for someone else, and afterward, Romey was depressed for several months. She explains that she didn't want to do anything, go anywhere, or see anyone. Romey says the breakup was so hurtful that she wondered if anyone would ever want her:

... so I kinda just beat myself up everyday because I didn't think anybody would want me. It hurts, it really do[es]...she was actually the first girl I've ever dated...throughout our relationship, the comments she would make would lead to me thinking I was fat. I had told her, I think that I'm too big and you're going to find someone who is skinnier...and a couple of weeks later, that's what happened.

Some participants, particularly those in college, mentioned how dating is really uncomfortable based on recent interactions with others. Participants discussed how social media dating applications such as *Tinder* and *Bumble*, and social media networks like *Facebook* and *Instagram*, are popular ways for people to meet and "hook up." There were several participants who recently met someone through social media and based on profile pictures, bios, and small-talk, arranged to meet in person. However, participants were

taken aback when finally meeting their date in person, since many dates seemed disappointed despite having already seen participants' online photos. For example, Jen felt awkward when her date changed his mind about hanging out once he saw her in person for the first time:

The guys you meet here, um, it's actually weird. Like most of them aren't interested because you're a bigger person...like this guy, he saw me online and my friends sent him a picture of me or something and he was like, 'Oh, she has a pretty face.' Then we met in person and he was like, 'Oh...you're, big' and I didn't know what to do, it made me feel horrible...so I am going to wait awhile to date here.

For a freshman in college like Jen, this type of interaction early on in college has influenced how she feels about herself, but also, has suggested to her that all guys at the university see her in a similar way. She felt uncomfortable, awkward, and she said it made her feel "horrible." Since she does not want to go through a similar experience again, she does not plan on dating in college for awhile. Another participant, Heather, said that she has met many men on social media dating apps but does not intend to meet any of them in person. She says she is hesitant to meet men in person because she knows that they will not like her. On social media apps, Heather feels comfortable interacting with men since she chooses how men see her. For her, this means taking close-up pictures of her face and of specific body parts without having to show her entire body at once. She enjoys the attention and the comments from men on these apps, and says that she has no desire to meet them in person.

Some participants talked about certain areas of their body that draw the most attention from others. The stomach, or "gut" was an area that many participants wished they could get rid of. For some, dressing in a way to hide or cover their "unsightly" areas



is important, and is often inconvenient or uncomfortable. Getting dressed in the morning or for a certain event was a problem for many participants, since some mentioned not having money for new clothes when their old clothes became too tight. Others talked about not looking in the mirror while getting dressed or not getting dressed in front of anyone, including a roommate or a sibling. All participants who purposefully used clothing to “cover up” mentioned how uncomfortable it can be in the Florida weather. A few participants also said that others question them about wearing a lot of clothing, and sometimes pressure them to remove it if they see that the participant is hot or if wearing a lot of clothing is inappropriate in a particular setting, like the pool, a formal event, or going out at night to a bar or club.

For many participants, their sense of self was influenced by past interactions with family members, including parents, siblings, grandparents, and extended family. Problematizing weight, name-calling, controlling food portions, and constant questioning were several common experiences participants had with family members. For Sam, past interactions with her dad shaped how she saw herself, her body, and all men:

My dad, I mean, I guess he's the one who's supposed to be the father figure in your life and he's the one who made me feel bad about my weight. He brought me his wife's jeans one time and was like here, you need jeans or whatever. Well they were huge... and it hurt me that he thinks I would fit in these...and he never called me pretty. He would comment and yell at me about my weight all the time. He would designate me portions of my food and I was like 13. He was like the issue with me about my weight and also [be]cause I thought every guy was going to be like that.

Interestingly, findings suggest that participants with “overweight” and “obese” parents had similar experiences with their parents. For Cass, her parents, both considered

“obese,” harassed her about her weight since she was six years old, calling her “fat,” “chubby,” and asking her “why she looks like that.” Another participant, Kristen, felt that her parents were embarrassed by her because every time the family dined out, they gave her a look of disgust as she ate. She explained this as “monitoring and controlling,” especially at restaurants and special gatherings with family and friends. Now, Kristen only eats certain foods and small amounts around her parents, and waits until she’s back home to eat a full meal. Kristen said:

And I hated it. Because we would go somewhere to eat since my mom never felt like cooking. And they would order for me...Just for me, not for my brother. So the food would come out and they would just be looking at me. They wouldn’t even eat until I was finished eating because they needed to make sure I wasn’t being sloppy or eating too fast. My mom would say, like, aggressively...she used to get mad about it. She’d say, ‘Slow it down. The food’s not goin’ anywhere and you’re acting like you haven’t eaten in days.’ And I remember not even wanting to eat the food, I didn’t even wanna be there.

Many participants said that comments from their parents about their weight were the most persistent and also the most hurtful. Parents’ comments were about food, clothes, health, laziness, and overall appearance. Jackie describes the specific language her parents used when “nagging” her about her weight:

When I was younger, my parents...my mom’s always been like ‘Oh, you need to lose weight. You’re too heavy. You’re not healthy. It’s not good for you,’ blah, blah, blah.

Similarly, Olivia described her parents’ words as “harsh,” and recalled common phrases:

They’re like, ‘Oh Olivia, you’ve got bigger. You’ve gained weight. You’re not skinny anymore.’ It got to a point where my mom was like, ‘Yeah, you used to be really skinny and now you just gained all this weight. You should stop eating so much food.’

Findings suggest that past interactions with others influence the past and the present for many participants. Earlier experiences of bullying cannot be dismissed as unimportant or irrelevant, since these experiences have shaped how participants see themselves, and have influenced everyday processes including getting dressed, dating, and eating. Past experiences also influence each participant's sense of self, including how attractive or worthy they think they are to others.

Participants discussed past experiences with weight and future plans regarding their weight. Some participants identified with an "average" or "normal" weight for themselves, suggesting that typically their weight is within a certain range but currently is an exception. Past selves, including a thinner figure or an athletic figure, were referred to as accurate depictions of participants' current bodies, normally. For example, some participants discussed past experiences playing a sport, noting that they are still muscular but simply need to "tone." Others referred to an earlier self as an ideal body for them and planned to go back to that body. Some participants mentioned keeping clothes that no longer fit them in their closet because they planned to some day fit back into them. Other participants talked about their future goals and how weight plays a part. For example, Ellie said:

I would like to travel, go overseas, go to... You ever see the pictures of like Bora Bora and the cabins on the water? I would love to do that, but then I'm like, 'If I do that and I want to take pictures. Like, I'm not going to post a picture of my stretch marks.' I'm just like, 'Maybe when I'm skinny, I'll do that.' I do have those thoughts.

These findings align with findings from a previous project (Harder and Belgrave 2017) which suggested that body weight and weight identity are not experienced or understood as "fixed" phenomena. Many participants understood their current weight status as

temporary, and therefore, identified with a past or future weight status. Fluid weight identities are at odds with how dominant obesity research and clinical health practice have dealt with body weight. Researchers and clinical health practitioners taking this dominant view actually assess a temporary body, yet treat that assessment as if it were actually fixed (e.g., Caixas et al. 2013; Lesko and Peaceman 2012) which causes conflict for women who view and experience their bodies fluidly. These findings are also supported by Belgrave and Charmaz's (2015) discussion of Mead's (1932) view of temporality, which shows us that, "we see the past and project the future through the eyes of the present" (p. 110). Further, these findings support research in chronic illness, disability, and addiction, which shows a current sense of self largely shaped by a past or future self, sometimes even by preserving a past self (e.g., Rosenfeld and Faircloth 2004). Experiencing body weight as temporary challenges the biomedical and disease models of obesity. For example, many participants mentioned "phases" or "time periods" in which they obsessed over losing weight, while at other times they felt satisfied with their weight status, including identifying with a past or future valued self.

While many participants have dieted for most of their lives, some participants considered their weight as a part of themselves. There were two common reasons participants gave for coming to this meaning of weight. The first was frustration after long periods of unsuccessful dieting and exercise, where participants changed their perspectives regarding the importance of losing weight and the value attached to weight. The second was participants who described their bodies as "always being like this" or embracing their bodies for a reason other than out of frustration at not being able to lose weight. For example, Violet recently "came to terms" with her body:

I've also come to terms, actually really recently, with the fact that I will probably never be a skinny person, because it's just not how I'm built. If I can work on making myself healthier and just work on keeping myself strong and fit, then that's really all I need to worry about in my life.

When asked what made her “come to terms” with her body, she explained that her family was worried about her weight and made comments to her about it. She started going to the gym 4-5 times a week and initially wanted to lose 100 pounds. But, after not seeing much weight fluctuation at all, she started focusing on other goals at the gym, like being able to do more push-ups than before. Her trainer at the gym was really excited about her progress, even though she had not lost weight. She said:

I was like, well, ‘I’m not losing weight, but I can run longer. I can lift more weights... I’m never going to lose weight, but my body’s stronger. My heart’s stronger’... and I’d go and I’d be like, ‘Hey, so last week I could only do like 30 squats, but this week I can do 50 without getting tired’... and she’d [her trainer would] be like, ‘That’s awesome!’ I would still feel encouraged, in that I was still making small changes, even though my weight wasn’t really going anywhere.

For some participants, having a “certain body type” such as being “naturally big-boned” or playing a certain sport during earlier years influenced how they described themselves.

For example, two participants mentioned softball as being a part of their lives up until recently, and attributed “bigger thighs” or “a lot of muscle” to playing softball. Other participants mentioned body weight as a part of their entire lives, and the same was true for their families. For example, Sam said:

I come from a big family—big meaning chubby, fat, overweight, obese. Me personally, I was pretty thin-ish. I’ve always been very voluptuous, been a big body... well, I’ve

always been a little bigger... 'cause like I said, I'm more body... I guess I've technically always been obese, since I can remember, really, but it never felt like I was obese, but of the way my body—my fat hangs, I should say. I've never been, you know, unsightly.

Some participants felt positively about their bodies. For example, Jessie was recently taking photos for a friend's school project. The photos were seductive and revealing, and she thought she looked beautiful. Her sister, however, disagreed. She told Jessie she looked fat and she should be embarrassed. Jessie brushed her sister's comments off because she was really happy with how she looked, and the friend whose project it was for liked the photos, too. Other participants felt positively about their bodies and had embraced a "curvier" shape. However, embracing their bodies and seeing themselves in a positive light was a "coming of age" for many participants. After years of struggling with body weight and trying to lose weight, some participants now have a new perspective of themselves. Here, being over the "normal" weight is part of participants and who they are. For example, Nicole said:

I love my body for who it is. I've embraced the fact that I'm a little curvy or I'm a little overweight and that it's part of who I am.

Findings suggest that body weight is an explicit aspect of the self. Regardless of how participants' weights have influenced their lives, participants always saw themselves through their perceptions of how others saw them. Through interactions with others, participants felt that others saw their body weight as indicative of who they were as people. Because of this, body weight was a paramount feature of the self for participants.

Because body weight is a part of the self for participants, conversations with health

professionals about weight were personal. Obesity is difficult for participants to talk about because of the lifelong ties between body weight and self, and for those who have struggled with body weight for most, if not their entire lives, and those who consider their body weight as part of them. Some participants were not necessarily against *obesity the disease* per se, but were highly critical of their experiences discussing body weight with their health professional, which frequently led to suggesting better practices for health professionals when talking about body weight with their patients. For example, a participant who was told by her physician that she needed to really “focus” on her weight, was offended by the assumption that she was not already focused on her weight. The doctor had no prior weight to compare to her current weight, and did not ask her questions about her current diet and exercise, so this participant felt that it was unfair to assume that she was not putting effort into losing weight. Other participants suggested that health professionals ask before initiating a conversation about weight:

If obesity is something, or body weight, or whatever, is something that needs to be handled, it needs to be, ‘I would like to have a conversation with you about your body weight. I know that you have a meeting you need to get to. Let’s schedule up another appointment to talk about it,’ or something.

Jamie also felt like the physician could have approached her in a more holistic way. She was unsure if the physician’s approach seemed impersonal because she was training medical students during the visit, or if the physician always treats her patients impersonally. Jamie said:

I felt like I turned into a problem that needed to be fixed and that her concern was about fixing the problem in a very non-holistic way. I think it [my visit] would’ve been better.

Or at least ask me things about my hydration or my blood pressure.

Similarly, Violet had recommendations for health professionals when discussing weight with their patients:

I would tell them to let their patients know that it's not just about the scale. It's not about what numbers are going to keep coming at them. It's more about making their overall lifestyle better. I think the less you focus on weight itself and the more you focus on the factors that contribute to that would be better for the patients to hear. Because if you're just hearing, well, you need to lose this many pounds, a lot of people will focus on just that and go about it in very unhealthy ways...more than get to this weight and you'll be happy or you'll be healthy.

### *Conclusions*

In this chapter, I provide a description of the experiences participants had when visiting a health professional since the AMA's 2013 re-classification of obesity as a "disease," the language used in discussions of body weight, and how these experiences and language influence participants. Overall, I define two analytical themes that are central to participant experiences: 1) a series of *competing realities* that complicate participants' everyday interactions with others (health professionals and laypersons) and alter how participants see themselves, and 2) lifelong, ongoing ties between participants' body weights and selves that are borne from past and recent interactions with others (health professionals and laypersons). Both competing realities and connections between body weight and selves are central to participants' experiences, including visits to a health professional since the AMA's policy.

Through participants' descriptions of their experiences, some health professionals seem to have adopted the AMA's disease model of obesity while others have not, thereby



influencing their overall approaches towards their “obese” patients. This includes the choice of language used in discussions of body weight with their patients, the degree to which body weight is seen as an urgent health issue, and the choice of diagnosis and treatment plan, if any. Despite major efforts to standardize obesity treatment, participants’ experiences are more influenced by the individual health professional’s approach towards obesity and by participants’ past experiences with body weight, than by the policy change itself. Participants’ interpretations of obesity as a “disease” also varied; while some were understanding of the AMA’s decision, others were highly critical of a disease model of obesity. It is also notable that many participants rejected a diagnosis of “obesity” given by a health professional since 2013. Participants provided feedback as to how health professionals can improve their conversations with their patients about body weight.

Overall, findings suggest that the AMA’s policy has had immediate and meaningful influences on many participants through their experiences with others and by facing popular societal and medical depictions of *obesity the disease*. Therefore, while the current research approach does not aim to represent a pre-post policy model, findings do suggest that extreme acts of medicalizing obesity, like the AMA’s 2013 policy, influence participants’ lives and experiences with body weight in overwhelming and sometimes detrimental ways.

## CHAPTER 5: CONCLUSIONS, IMPLICATIONS, AND DISCUSSION

*We cannot condone injustice under the rubric of standardization and ignorance.*

*--Lucy Aphramor*

In this dissertation, I explored the influences that the American Medical Association's 2013 designation of obesity as a "disease" had over the past three and a half years for those considered "obese" by medical standards. Although quite exploratory, this project was informed by integrating several bodies of literature including clinical, public, and critical perspectives of obesity, sociology of scientific knowledge, sociology of language, the illness experience, social constructionism, and medicalization. Through a symbolic interactionist framework and constructivist grounded theory methodology, I conducted 31 in-depth interviews with 29 participants considered "obese" by medical standards ( $BMI \geq 30 \text{ kg/m}^2$ ). Findings suggest that the AMA's policy has indeed influenced the experiences that participants had when visiting a health professional since 2013. Findings also suggest that body weight is an integral part of the self for participants, and interactions with others (health professionals and lay persons) and had solidified ties between body weight and selves throughout their lifetimes. Lifelong ties influenced participants' current understandings of obesity and of their own bodies, and came to light in conversations with health professionals since the AMA's re-classification of obesity as a disease.

I define two analytical themes that were common to experiences of body weight in light of the AMA's policy. First, participants experienced a series of *competing realities* that complicated their interactions with others (health professionals and lay persons) and that altered how participants saw themselves. Seven common competing realities were central to participants' experiences: 1) contrasts between health professionals' prioritization of body weight and participants' main complaint(s), 2) a variety of approaches towards a disease model of obesity among health professionals, 3) disagreements between health professionals' diagnoses of obesity and participants' self identities regarding their body weight, 4) contrasts between medical definitions of obesity and participants' own definitions of obesity, 5) contrasts between a disease model of obesity and participants' views of weight as a risk to health, 6) contrasts between popular explanations of obesity and participants' narratives of weight status, and 7) a wide variety of weight-loss behaviors among participants, and often, amongst themselves. Competing realities are embedded in the "obesity epidemic" by operating at the individual, or micro level of society, through interaction with others (health professionals and lay persons). Competing realities tend to complicate participants' relationships with their own bodies and confuse understandings of obesity, in general. Until public health promotion scientists and health practitioners in obesity recognize the lived experiences of those considered "obese," these competing realities will continue to generate irrelevant and impractical solutions, and complicate the lives of those considered "obese" by medical standards.

Second, participants' experiences with body weight were influenced by their lifelong ties between body weight and selves. Body weight was a meaningful part of

participants' every day lives through their interactions with others. Interactions with others, both health professionals and lay persons such as family, friends, co-workers, peers, and strangers, influenced the way participants saw themselves and understood their body weight. For participants, the past could not be separated from the present because of the extent that body weight was deeply embedded in participants' entire lives. Body weight was a paramount feature of participants' interpretations of how others' saw them, and therefore was a paramount feature of participants' selves. Because of the lifelong ties between body weight and selves, body weight influenced everyday activities such as getting dressed, shopping, eating, working, going to school, hanging out with family and friends, dating, trying out for an athletic team, going to the beach, pool, and gym, dining out with others, and visiting a health professional.

Through participants' experiences with health professionals, findings suggest that health-professionals may not be following uniform guidelines in the implementation and practice of *obesity the disease*. However, findings also suggest that the AMA's policy enables health professionals an option to diagnosis obesity as a formal and legitimized disease, and as findings suggest, is certainly being practiced by many health professionals. A formal diagnosis of *obesity the disease* is confusing for participants who do not see themselves as "obese," and for participants who hold significantly different meanings of "obese," "health," and "disease." Some participants who were given a formal diagnosis of obesity since the AMA's policy rejected their new diagnosis. This finding begs the question as to how common it is for patients to outwardly reject a given diagnosis of any kind, and if *obesity the disease* is a unique diagnosis that provides patients more agency to define their own health. Future research is encouraged to explore

the potential differences in the ways patients interpret a diagnosis of obesity compared to other diseases.

Participants' experiences when visiting a health professional since 2013 also suggest that health professionals may not be following the new protocol for obesity released by the AMA and its standard guidelines for treatment. As some participants' received paperwork, referrals to specialists, prescriptions for lab tests, and "obesity" as a marked diagnosis in a computer system, others who were diagnosed with *obesity the disease* left the physician visit empty handed. All participants were encouraged to try to lose weight, however, recommendations to lose weight also varied. Some participants were reminded to diet and exercise, while others were referred to a weight-loss specialist, prescribed lab tests for weight-related conditions, and even recommended weight-loss surgery. Considering the possible variety in health professionals' treatment suggestions regarding obesity, participants' experiences may be more influenced by the individual health professional's approach to obesity treatment than the AMA's standardized guidelines diagnosing and treating obesity. This isn't necessarily a negative influence of the AMA's policy, since some health professionals seem to continue to use their own approaches to body weight that may be more in alignment with their patients' views. However, it is evident throughout the findings that the AMA's policy is detrimental because it enables health professionals to approach body weight in its most medicalized form: a formal disease. Approaching obesity as a formal disease makes obesity the disease appear problematic by nature, or as having an indisputable threat to health. Of serious concern, findings suggest that some health professionals prioritized weight over patients' main complaint(s), and that some participants who suffered from other

physical (i.e. MRSA, mono, diabetes, joint and bone injuries), mental illnesses (i.e. bipolar disorder, depression, anxiety), and histories of drug and alcohol dependencies or eating disorders (i.e. anorexia, bulimia, abuse of laxatives) were inappropriately treated for these concerns because of the overemphasis some health professionals placed on patients' BMI-labeled obesity. First, it is imperative for health professionals to consider their patients' overall health, to be informed about patients' medical histories and biographies, and to ask their patients about concerns regarding their own health. If patients' BMI-labeled obesity is not their (own) primary concern, especially because they are experiencing more life-threatening and health-threatening conditions, health professionals are strongly encouraged to take patients' main concerns as serious and of priority.

This suggests that patients may know, more so than their health professionals, of their own day-to-day experiences and challenges, and therefore, what concerns should be of priority or in need of immediate treatment. In this project, one participant lost custody of her three children, another participant's untreated lesion of MRSA that spread along the entire right side of her neck had to be surgically removed, and one participant lived with untreated mono because of the mistreatment of more immediate concerns that the health professional prioritized as less important than body weight. Further, there were a host of participants who refused to seek medical treatment when experiencing possible signs of illness, and had refused to engage in annual check-ups or physicals solely based on the degree to which health professionals had prioritized their weight as a major health concern, which frequently resulted in severe weight-based stigma and fat-shaming. Participants already are stigmatized and shamed for their body weight by others

throughout their entire lives. When the physician visit is not seen as a safe-space for those who constantly grapple with this kind of discrimination on a daily basis, it is likely that seeking medical treatment of any kind may be outwardly rejected. The formalization of obesity as a disease allows health professionals to prioritize body weight as a primary concern and to justify their emphasis on obesity by citing the AMA's new protocol and the availability of a formal disease diagnosis of obesity.

Further, health professionals' approaches to dealing with their "obese" patients, and the language used in discussions of obesity had important consequences for participants. For some participants, these consequences were considered more harmful and threatening to their overall health and well-being than excess fat alone. Participants felt stigmatized and fat-shamed, de-humanized, frustrated, sad, and confused by conversations about body weight with health professionals. Health professionals are encouraged to take into account the importance and meaning of body weight in participants' every day lives. For most participants, this was related to experiences they had with body weight throughout their entire lives. Further fat-shaming and stigmatization in the health-care setting evoked a range of emotions and memories from the past, and further influenced participants' views of themselves. Some participants became discouraged from visiting a health professional after they had been fat-shamed or stigmatized during a visit to the physician's office. If health professionals' concerns for those considered "obese" is truly their patients' health, health professionals' approaches and use of language in discussing body weight with their patients are key areas of much needed reflexivity and improvement.

Decisions made by health professionals on behalf of their “obese” patients can have serious, long term consequences. As previously mentioned, a participant suffering from bipolar disorder was ineffectively treated because she was given a drug for anxiety since the recommended drug for bipolar disorder was known for its side effects of rapid weight gain. For this participant, being ineffectively treated led to manic episodes which then led to a child custody battle that she lost. Now living in Florida and being effectively treated for bipolar disorder, this participant is trying to make sense of what happened and how one health professional’s decision changed life entirely for herself and her three children. I urge health professionals to be mindful of the priority they place on a patient’s weight and how this compares to the other health conditions at hand.

Diagnoses of obesity were given to participants without any other concern for related issues such as Type II diabetes, cardio-vascular disease, abnormal thyroid, arthritis, high blood pressure, and sleep apnea. Additionally, diagnoses of obesity were given to participants without any knowledge of the participants’ lifestyle, diet, and physical activity. Assumptions that participants were not already engaged in health-conscious behaviors is ignorant, and health professionals are encouraged to ask their patients about other signs of weight-related conditions and about their behaviors that might clarify whether weight is seen as problematic for the patient or not. Most participants considered themselves healthy, and define health in a variety of ways. Health professionals are encouraged to take part in a broader understanding of their “obese” patients, and at the very least, understand that a particular BMI does not suggest anything about the person or his or her health or behaviors. In this project, one participant was suffering from an eating disorder although she was considered “obese” by her BMI. Her



case alone suggests that assumptions made on behalf of health professionals and others about one's behaviors based on their weight can be extremely inaccurate.

Assumptions of over-eating, leading a sedentary lifestyle, a lack of self-control, and laziness may be inaccurate depictions of how patients have come to their current weight status and body. Considering that some participants had multiple jobs, were pursuing a college or graduate education, and were primary or sole caregivers for family members, these stereotypes and assumptions of "obese" people were not relevant. Further, some participants' financial situations influenced decisions about food and exercise, whether it was affording only certain foods for themselves (and for some, their families), or picking up a second job that severely influenced the amount of sleep they were getting and time to cook, shop for groceries, and exercise.

It is important to note that *obesity the disease* does not account for multiple pathologies that are actually reflective of experience. Participants gave multiple reasons for their weight status, including rapid weight-gain from injectable birth control, treatment for rheumatoid arthritis and shingles, and ineffective physical therapy for a knee-injury that led to months of complete inactivity since the participant could barely move. Sometimes, weight gain is a consequence of previous behaviors that are often seen as more harmful to one's health than excess body fat. Participants also saw themselves as overall healthy, and saw their current behaviors as healthier alternatives to past behaviors. To them, eating more was a "healthier choice" compared to drinking alcohol, smoking, abusing laxatives and weight-loss supplements, or depriving themselves of eating at all. In providing health care to a patient that meets the requirements of "obese," health

professionals should take into account the patient's overall health, and behaviors in comparison to past ones.

Through this project, it is evident that many participants' behaviors are at odds with popular assumptions of "obese" people. Research and clinical practice should avoid assumptions about the behaviors, lifestyles, and priorities of those considered "obese." Seeking to know and understand participants and patients requires a constant process of reflexivity on behalf of the theorist, researcher, and health professional. Remaining in tune with one's own attitudes and beliefs and how these may differ from those of whom one is studying or evaluating is critical.

It is important to note that visuals of what the "obese" person looks like mirror extreme representations of obesity in the media. Medically-defined "obesity," based on the BMI, probably does not look "obese" to most people. Participants themselves did not know that they were considered "obese" until they were told because of the meanings participants hold of "obesity" that have been influenced by these extreme representations of obesity in the media, such as "My 600-lb. Life" and "What's Killing Gilbert Grape?" Through these findings, I encourage health professionals to be aware of the differences in meaning some have of "obesity" and how these meanings are similar to or different from medically-defined "obesity." I wonder how health professionals deal with patients who are medically-defined as "obese" yet do not look "obese" to the health professional, such as a person with a high-level of muscle mass or someone who "carries" weight in certain ways. Do health professionals, through their own perceptions of what "obese" looks like, decide when medically-defined obesity is relevant for a patient? What does this mean in light of *obesity the disease*? Future research in this area could address these questions.

Findings suggest that interactions with others are extremely meaningful to participants. Interactions with parents, other family members, friends, peers, co-workers, and strangers, suggest to participants how others think and see them, which in turn, influences how they think and see themselves. Parents, whether considered “obese” or not, significantly influence participants through their language and behaviors about weight. It is critical that parents understand the severity and influences of their words and what they mean for participants. Some participants have or currently starve themselves because of the amount of pressure they feel from others, including their parents, to maintain a certain weight or body. One participant never felt beautiful and had jaded views on all men because of her father’s words and actions growing up. Comments about eating and clothes, in addition to name-calling have severe consequences for participants. Romantic partners or “hook-ups,” through their language and behaviors, shaped how participants saw their own worthiness and attractiveness, not only to that individual but to all potential partners or hook-ups. Participants already experience enough fat-shaming, stigma, and bullying from others, and from societal pressures to fit beauty and body ideals. Loved ones, such as parents, siblings, children, extended family members, friends, and romantic partners should be aware of the “weight” of their words and the meanings they hold.

With an extensive amount of theoretical contributions from multiple areas such as critical works of obesity, medicalization, social constructionism, symbolic interaction, language studies, and the like, a solid framework is created for those who are interested in conducting similar work. The lack of empirical studies that aim to address lived experiences of body weight, and the influences of the medicalization of obesity for

individuals, serves as a starting point for researchers moving forward in obesity studies. Further, this project is exploratory in the sense that it is the first to understand the experiences “obese” people have since the AMA’s 2013 designation of obesity as a “disease.” Future research can assist in a more narrowed focus on the following issues within *obesity the disease*: physician-patient relationship, treatment, and patient compliance.

Obesity, understood and treated as a disease with assumptions of a singular view of the body and overweightness misses the experiences, self-identities, and meanings people labeled “obese” actually have. Further, lived experiences of body weight challenge the appropriateness of a “disease” category for obesity because of the vast differences in pathologies, mobility, and behaviors of participants. Findings bring to light multiple issues that physicians and patients may face within the newly established *disease of obesity*, and further research in this area is needed.

In conclusion, unless the issues and implications discussed here are adequately addressed, all funding, policies, efforts, and attempts on behalf of the medical profession, public health sector, and concerned organizations to “tackle America’s obesity problem” will remain ineffective. Potentially, this can lead to a future of continuous increase in these efforts without any observable or meaningful solution to the said problem. After all, understanding obesity cannot be understood without the willingness to understand those who are considered “obese” in the first place, and the findings from this project suggest just some of the many reasons why.

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## APPENDIX A

### PHYSICIAN GUIDELINES-AMA



## Talking about weight with your patients

### **The importance of having a conversation**

Broaching the topic of body weight and obesity is very difficult for many physicians. Part of the difficulty lies in the time constraints a busy practice faces, lack of effective treatment options, inadequate reimbursement, and low confidence or insufficient training in weight management counseling. However, many physicians simply do not discuss body weight because they don't know how to raise this sensitive issue, they fear they will insult the patient, or they have attitudes or biases that are particular to obesity.

There are few other conditions in medical practice and in our society that are as stigmatized and shunned as obesity. Some view obesity as a personal moral failure while others believe it is solely due to sloth and gluttony. Still others feel that it is a personal responsibility to be solved by the patient alone. Regardless of the reason, discussions about body weight infrequently occur in the physician's office, a situation analogous to a "don't ask, don't tell" policy. In reality, obesity is a complex disease with genetic, biological, economic, environmental, psychosocial and behavioral determinants. Rather than blaming patients for their weight, recognizing obesity as a medical condition will pave the way for a frank, open and respectful dialogue.

### **Broaching the topic of obesity**

There is no clearly established method for telling patients they are overweight or obese. However, initiating talk about body weight is an interactive process—information should be shared between patient and physician. The initial goals of the conversation are to inform the patient of his/her body weight related to health standards, clearly convey the health risks associated with excess weight, explore the patient's motivation and readiness to engage in weight control, elicit barriers to behavioral change, and establish practical lifestyle changes and short-term goals.

When first raising the topic of body weight, words matter. The approach physicians use to broach this potentially sensitive topic may influence how patients react emotionally and cognitively to the discussion and advice provided. Language used by the physician sets the stage for the interaction. It is up to the physician to decide which words will be most constructive and therapeutic. The reason for the concern is that the word "obesity" is a highly-charged, emotive term. It has a significant pejorative meaning with many patients, leaving them feeling judged and blamed when labeled as such. Therefore, it is common practice to use euphemisms for the word obesity when initially broaching the topic, or at least placing the term in a clinical context, such as "medically obese."



According to one study, when asked which word(s) patients prefer, they selected “weight,” “excess weight,” “BMI” or “weight problem.” For many patients, the word obesity has an offensive and derogatory association and may influence how they feel about themselves and their problem. On the other hand, it is important not to sugarcoat the diagnosis. For some patients, using the term “obese” may convey that the problem is serious and has consequences. The bottom line is the physician and patient must use shared terminology that is agreeable, inoffensive and understandable to both individuals. The conversation should be mutually respectful, express concern rather than judgment, be sensitive to the patient and lessen stigma.

### Putting the conversation into words

The following phrases are suggested approaches to introduce the topic of body weight with the patient:

- I would like to talk to you about your weight. Is that ok? *Asking permission demonstrates respect for the patient and should foster a more therapeutic patient-physician relationship.*
  - I am concerned about your weight and would like to talk with you about it. Is that ok?
  - Monitoring your weight is as important as measuring your blood pressure and heart rate. I’ve noticed that your weight is up from last year. Has anything been going on that may have contributed to the weight gain? *Identifying body weight as a clinical marker similar to other familiar and routine measurements places weight in a medical context.*
  - What do you know about the risks of being overweight? *Good opening remark to initiate a discussion about the patient’s medical problems that are obesity-related.*
  - Your excess weight is contributing to your [elevated blood pressure, diabetes, high fats in the blood, GERD, obstructive sleep apnea]. As little as a 5 percent weight loss has been shown to improve these conditions. Are you interested in taking better control of your weight? Is this a good time? *Begins the evaluation for readiness to change and motivation.*
  - Based on your height, your weight today places you in a category we medically call obesity. It puts you at a higher risk of developing [diabetes, heart disease, hypertension, some forms of cancer].
  - We medically define obesity by using a term called body mass index, or BMI. This is a calculation based on a person’s height and weight. Plugging your height and weight into this equation, your BMI is [32]. Obesity is any BMI over 30. *Explains what BMI means and expresses patient’s weight in a medical context.*
  - We define a healthy weight according to body mass index, or BMI. BMI is based on your height and weight. A healthy BMI is under 25; overweight is between 25 and 30, and obesity is defined as a BMI over 30. Based on your height and weight, your BMI is [34]. This is called class 1 obesity.
  - I’ve looked over your chart and am concerned about your increasing weight. According to my records, you have gained [5] pounds over the past [3] years. Although you are still in the healthy body weight range, you’re on a path to become overweight in the near future. Do you have a sense of what is causing this? *It is important to review the trajectory of weight change over time, regardless of the patient’s BMI category.*
  - Looking at your chart, I have noticed that you have maintained a healthy weight over the past [5] years. That is great. Is this something that you need to work at? [If yes] What do you do to successfully maintain a healthy weight? *It is important to discuss body weight as part of the medical history, regardless of the patient’s BMI category.*
- Follow up with open-ended questions to assess motivation, readiness and barriers to lifestyle change, using principles of motivational interviewing to express empathy and autonomy.
- What aspect of your weight would you like to talk about?
  - On a scale from 1 to 10, how interested are you in taking control of your weight?
  - On a scale from 1 to 10, how confident are you in taking control of your weight?
  - How do you see the benefits of weight loss?
  - How do you see the drawbacks of weight loss?
  - How might things be different if you successfully lose weight?
  - What is hard about managing your weight? *This open-ended empathetic question readily acknowledges that weight control is difficult and conveys an interest for further understanding.*
  - How does being overweight affect you? *This question probes the burden of obesity. Common answers refer to appearance, self-esteem and image, physical ailments and quality-of-life issues.*
  - What can’t you do now that you would like to do if you weighed less? *This question provides useful information regarding expectations and benchmarks for assessing progress.*

- Is your weight an issue in your marriage (or with your significant other, partner or family)? *This question addresses the social importance of a shared environment and emotional significance of a relationship.*

### Common questions from patients

Physicians should be prepared to respond to the following possible questions from their patients:

- How do I start getting control of my weight?
- How do you recommend I deal with my weight?
- Why is it so hard to control my weight?
- Is there something wrong with my metabolism?
- Why is weight a challenge for me, but for my friends and family it isn't?
- Why is it important to address my weight issues now, rather than later in the future?

### Referring for additional weight loss services

Referral to a specialist in obesity management or a program should be considered for patients who are ready to make changes in their behavior. They should at least be in the contemplation or preparation stage of change. A referral may be prompted by the patient or physician. If the patient is interested and ready to engage in weight control, asking specific questions will help guide the direction of additional care.

- What do you expect from this visit? Or, how can I best help you control your weight? *These questions directly address the patient's expectations of how you can assist them in weight management.*
- What kind of help do you think you need to control your weight? *Many patients have specific ideas about where they need additional assistance.*
- What would make the most sense to you about taking control of your weight?
- Based on what we just discussed, I would like to refer you to a [dietitian, colleague, weight management program] to help you with your weight. What do you think about that?

### When should a patient be considered for medication therapy?

According to the Food and Drug Administration (FDA) and the National Heart, Lung, and Blood Institute (NHLBI) Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, medication therapy, or pharmacotherapy, is indicated for:

- Obese patients with a BMI  $\geq 30$
- Overweight patients with a BMI  $\geq 27$  and concomitant obesity-related risk factors or diseases such as hypertension, diabetes or dyslipidemia

However, the BMI threshold is only one part of the criteria for medication treatment. For patients who meet BMI criteria, pharmacotherapy should be considered for the patient who:

- Will be taking the medication in conjunction with an overall weight management program, including a reduced-calorie diet and increased physical activity
- Has realistic expectations of medication therapy
- Is unable to achieve weight loss despite using lifestyle approaches of diet, physical activity and behavioral changes to the best of their ability

### Discussing drug therapy

Initiation of treatment includes telling patients how the medication works, what side effects they may experience and what weight loss benefits to expect. The sample script below highlights the importance of dietary behavior in achieving success.

- Phentermine is absorbed into the body and travels to the appetite center in the brain. It works by helping you feel less hungry. So, if you respond, you'll feel less hungry than you are used to. You'll need to slow down your eating and pay attention to when you feel full. Phentermine helps you lose weight only if you stop eating when you feel full. Side effects may include headache, dry mouth, insomnia and constipation.
- Prescription orlistat blocks one-third of the fat in your food. So if you eat 30 grams of fat with lunch, orlistat will block 10 grams, and your body will only absorb 20 grams. You may see the blocked fat floating in the toilet bowl when you go to the bathroom. In order to tolerate orlistat, you need to eat less fatty foods, meaning less oils, margarine, butter, dressings, gravy, chips, fries, pizza and so forth. In general, no more than 30 percent of the calories in your diet should come from fat. The side effects of the medication are directly related to the amount of fat you consume.

## When should a patient be considered for weight-loss surgery?

According to NHLBI guidelines, surgical intervention is an option for carefully selected patients:

- With clinically severe obesity (a BMI  $\geq$  40, or BMI  $\geq$  35 with comorbid conditions such as type 2 diabetes, cardiovascular disease, obstructive sleep apnea)
- Who are at high risk for obesity-associated morbidity or mortality
- For whom less invasive methods of weight loss have failed—for these patients, the benefits of a more invasive intervention should outweigh the risks

In addition to the selection criteria named above, the following patient factors should be taken into account when considering surgery:

- Realistic expectations about what the surgical procedure entails
- Ability/desire to follow the surgically-imposed dietary changes
- Good social support system
- No active substance abuse or clinically significant and unstable psychopathology, such as untreated psychosis, uncontrolled depression, borderline personality disorder or bulimia nervosa
- Demonstrated adherence to medical recommendations (e.g., medication taking, follow-up appointments, laboratory testing)

### Discussing bariatric surgery

Weight loss surgery may be brought up by the patient or physician. The physician should be informed of the options available in the community. This is an example of an initial dialogue:

Weight loss surgery, also called bariatric surgery, can be very helpful for individuals with severe obesity who are struggling with their weight. Depending on the procedure, it reduces how much food you can eat at one time and, therefore, reduces the amount of calories you consume in a day. Other procedures actually change the hormonal signals that come from the gut, so you are less hungry. However, surgery carries risks, and we need to talk about whether it is right for you.

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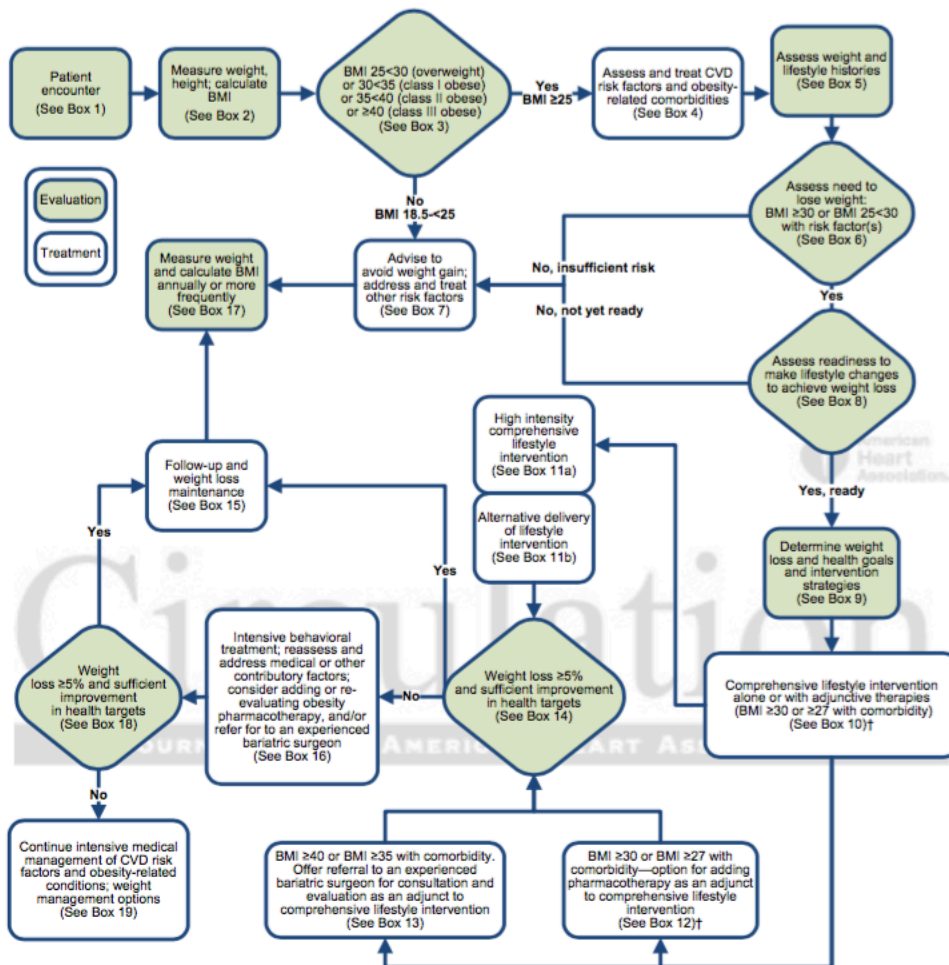
### Additional information

This online guide was prepared by Robert F. Kushner, MD, professor of medicine, Northwestern University Feinberg School of Medicine, Chicago, IL. June, 2011. For more detailed guidance on talking about weight with your patients, view the "[The assessment and management of adult obesity](#)," part of the *AMA Roadmaps for Clinical Practice* series.

## PHYSICIAN GUIDELINES- AHA/ACC/TOS

Jensen MD, et al.  
2013 AHA/ACC/TOS Obesity Guideline

**Figure 1. Treatment Algorithm—The Chronic Disease Management Model for Primary Care of Patients with Overweight and Obesity\***



\*This algorithm applies to the assessment of overweight and obesity and subsequent decisions based on that assessment. Each step (designated by a box) in this process is reviewed in this section and expanded upon in subsequent sections.

†BMI cutpoint determined by the FDA and listed on the package inserts of FDA-approved obesity medications.

BMI indicates body mass index; CVD, cardiovascular disease; and FDA, Food and Drug Administration.

### Box 1: Patient Encounter for Obesity Prevention and Management

A patient encounter for obesity prevention and management is defined as an interaction with a PCP who assesses a patient's weight status in order to determine presence of overweight or obesity and need for further assessment and

APPENDIX B  
RECRUITMENT FLYER

# Have You Had Some Weighty Conversations Lately?

Participants needed for a  
research study on body  
weight!

**Eligibility Requirements:**

- at least 18 years of age
- have talked to a physician about your body weight at least once in the past 3 years
- Body Mass Index (BMI) is 30 or higher  
- OR
- Have been told you are obese

If you meet the eligibility requirements and are interested in participating, please contact Brittany at [bharder@ut.edu](mailto:bharder@ut.edu) or (954)-632-0310 for more information

## APPENDIX C

### VERBAL CONSENT SCRIPTS

*THE UNIVERSITY OF MIAMI*

#### **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 American Medical Association's Designation of Obesity as a Disease and its Influences on Experiences of Body Weight***

Hi, my name is Brittany Harder and I am involved in a research study called ***The American Medical Association's Designation of Obesity as a Disease and its Influences on Experiences of Body Weight*** with Dr. Linda-Liska Belgrave, Dr. Crystal Adams, Dr. John Murphy, and Dr. Pamela Geller 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 experiences people have when discussing body weight with their physicians since June 2013, when obesity was designated a "disease". 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 experiences you've had when visiting a physician and discussing weight over the past three years and to learn about your experiences with body weight in general. They are also designed to ask your opinion regarding specific clinical practices around obesity. 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 \$20.00. 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.

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.

THE UNIVERSITY OF TAMPA

***The American Medical Association's Designation of Obesity as a Disease and its Influences on Experiences of Body Weight***

Hi, my name is Brittany Harder. I am a Visiting Assistant Professor of Sociology at The University of Tampa and I am involved in a research study called ***The American Medical Association's Designation of Obesity as a Disease and its Influences on Experiences of Body Weight***.

**PURPOSE OF STUDY:**

I am asking you to take part in a research study because I am trying to learn more about experiences people have when discussing body weight with their physicians since June 2013. 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 experiences you've had when visiting a physician and discussing weight over the past three years and to learn about your experiences with body weight in general. They are also designed to ask your opinion regarding specific clinical practices around obesity. The interview will be audio-recorded. I 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 \$20.00. You will be given this gift directly following the interview.

All participants will be given a pseudonym, as well as pseudonyms for any other name or place that may be considered identifying, such as a child's name or a place of employment. 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. In addition, I 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, in a paper submitted for publication, and/or a research presentation at The University of Tampa.

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, [bharder@ut.edu](mailto:bharder@ut.edu).

If you have questions regarding your rights as a research participant, contact The University of Tampa, Institutional Review Board at [irb@ut.edu](mailto:irb@ut.edu).

## APPENDIX D

### INTERVIEW GUIDE

#### *Interview Guide*

- 1) Can you tell me about your experiences with body weight?
- 2) You mentioned that you were told you were “obese” by at least one other person. Could you tell me more about that?
  - How did it make you feel?
- 3) You said that you visited a physician at least once since July 2013 and during that visit, discussed your weight. Could you please tell me about that visit?
  - who brought up the conversation about weight?
  - How was the topic of weight brought up?
  - How did the conversation go?
- 4) Was the visit regarding issues about body weight? If not, what was the sole purpose of the visit?
- 5) Were you expecting the conversation to occur? What did you think about the conversation?
- 6) Did the physician recommend any changes on your behalf regarding your weight? If so, could you please tell me what they were? How were they talked about? What do you think about these recommendations?
- 7) What, if any, treatment options were discussed? If so, could you please tell me what they were? How were they talked about? What do you think about these options?
- 8) Have you been diagnosed with obesity? If so, can you tell me about how the diagnosis was given to you? How do you feel about the diagnosis?

- 9) How did your physician talk about body weight and obesity? Were there any names or labels used for describing or defining these terms? If so, what were they?
- 10) Have you been treated for a diagnosis of obesity? If so, can you tell me about how the treatment was or has been?
- 11) How do you view body weight and obesity? Are there any names or labels you use to describe or define these terms? If so, what are they?
- 12) How would you describe the relationship you have with your physician? Do you trust your physician? Do you feel as if you are involved in decisions related to your health? If so, how?
- 13) How many physicians have you talked to about your weight since July 2013? If you have discussed weight with more than one physician, how were these conversations similar and different from one another? Can you tell me more about the other experiences you've had?
- 14) How many times have you talked to the same physician about your weight since July 2013? Can you tell me more about the other conversations you've had?
- 15) How do you see yourself in terms of your weight? Can you tell me about any experiences with your weight, either similar or different from those you've shared so far?
- 16) Is your weight something that you see as a problem? If so, why do you think it's a problem?
- 17) Can you please share any other information or experiences that you find important or think would be helpful for me to know?

APPENDIX E

**DEFINITIONS OF DISEASE AND ILLNESS**

| <b>Source</b>      | <b>Definition of “disease”</b>  |
|--------------------|---|
| Merriam-Webster    | An illness that affects a person, animal, or plant: a condition that prevents the body or mind from working normally; A problem that a person, group, organization, or society has and cannot stop  |
| Dictionary.com     | A disordered or incorrectly functioning organ, part, structure, or system of the body resulting from the effect of genetic or developmental errors, infection, poisons, nutritional deficiency or imbalance, toxicity, or unfavorable environmental factors, illness; sickness; ailment; Any abnormal condition in a plant that interferes with its vital physiological processes, caused by pathogenic microorganisms, parasites, unfavorable environmental, genetic, or nutritional factors, etc.; Any harmful, depraved, or morbid condition, as of the mind or society; Decomposition of a material under special circumstances |
| English Oxford     | A disorder of structure or function in a human, animal, or plant, especially one that produces specific symptoms or that affects a specific location and is not simply a direct result of physical injury; A particular quality or disposition regarded as adversely affecting a person or group of people  |
| Wikipedia          | A particular abnormal condition, a disorder of a structure or function, that affects part or all of an organism   |
| YourDictionary.com | An illness or sickness with specific, well-defined symptoms that affects a person, plant or animal; Any departure from health; Illness in general; A particular destructive process in an organ or organism, with a specific cause and characteristic symptoms; specif., an illness; ailment; Any harmful or destructive condition, as of society   |
| Reference.com      | An identifiable condition affecting an organ or organism  |

| <b>Source</b>            | <b>Defining Differences Between Disease and Illness</b>   |
|--------------------------|---|
| Reference.com            | A disease is an identifiable condition affecting an organ or organism whereas illness is the subjective negative experience that comes with ill health. Specifically, in this case, illness is a product of disease although one can be made ill through psychosomatic processes without a disease  |
| Eric Cassell (1976)      | Disease is something an organ has; illness is something a man has   |
| Leon Eisenberg (1977)    | Patients suffer illnesses, doctors diagnosis and treat diseases; Illnesses are experiences of discontinuities in states of being and perceived role performances; Diseases, in the scientific paradigm of modern medicine, are abnormalities in the function and/or structure of body organs and systems  |
| Arthur Cott (1986)       | Disease is a physical or organic cause or determinant; Illness is the effect or response. Disease is an observable or inferred physical condition resulting from any sort of lesion, insult, infection, or other homeostatic dysfunction; Illness is the whole array of reported subjective states and other overt responses which are presented by individuals as in some way being disabling or disruptive of their normal lives and which they attribute to a disease determinant. |
| Phil Brown (1995)        | Disease is a more biomedical phenomenon, though strongly affected by social forces; Illness reflects a more subjective phenomenon   |
| Conrad and Barker (2010) | Disease is the biological condition and Illness is the social meaning of the condition  |
| Arthur Kleinman (1988)   | Disease is the practitioners' creation, based on their training and theoretical lenses of their field, that recasts illness in terms of theories of disorder and reconfigures illness problems as narrow, technical issues. Illness is how the person and their networks perceive, live with, and respond to symptoms and disability  |