

ORIGINAL ARTICLE

Feminist post-structural analysis of obesity management: A relational experience

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Received: March 12, 2015

Accepted: April 12, 2015

Online Published: April 27, 2015

DOI: 10.5430/cns.v3n3p76

URL: <http://dx.doi.org/10.5430/cns.v3n3p76>

ABSTRACT

Objective: The aim of this study was to examine the experiences of overweight and obese individuals and nurses, physicians and dietitians who cared for them in the assessment and management of obesity.

Methods: Design and Methods: A feminist post-structural methodology and semi structured face to face interviews were used to examine personal, social and institutional aspects of obesity management. Setting: Rural and urban settings across a province in eastern Canada. Sample: Participants included 22 clients living with obesity and 16 health care professionals (nurses, physicians and dietitians).

Results: Marginalization, oppression, bias and stigma continued to affect obesity management. Participants discussed the importance of supportive relationships between clients and health care providers.

Conclusions: Individuals living with obesity require greater levels and duration of support, given the multiple barriers they face at the individual, social and institutional levels. Implications: Health care professionals need to understand the social construction and relational context of obesity in order to minimize stigma and enhance the provision of supportive and non-judgmental care.

Key Words: Obesity, Interpersonal relationship, Feminist post-structuralism, Nurses, Physicians, Dietitians

1. INTRODUCTION

Obesity is cited by many health care professionals and organizations as an emerging health problem globally and recognized by the World Health Organization^[1] to be one of the most neglected public health issues. There are several factors that impede the management of obesity, including the fact that care has primarily focused on individual behaviour with little attention to social, cultural and environmental influences.^[2,3] Individuals are faced with significant challenges in maintaining a healthy body weight due to external factors such as a general reduction in physical activity within daily lifestyles, the availability of energy-dense, nutrient-

poor foods and the absence of healthy public policies.^[2,4,5] All of these factors create significant barriers to maintaining a healthy body weight that is often referred to as an obesogenic environment.^[5]

In addition to the challenges of living in an obesogenic environment, obese or overweight individuals are often marginalized and highly stigmatized in society which can further present barriers to achieving a healthier lifestyle and weight.^[6] Western beliefs and values about weight have socially constructed obesity to be a sensitive topic to address where much value is placed on aesthetic beauty. Not only is there an overwhelming focus on aesthetic beauty in West-

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ern culture^[7] but psychological labels such as laziness and an assumption of lack of knowledge have also been used to describe those experiencing obesity.^[8] Because obesity is both a physical reality and a socially constructed experience^[9] based on relations of power^[10,11] it is imperative that we carefully examine how the experience of weight management is affected by interactions between people as well as their beliefs, values and practices associated with obesity. Individuals living with obesity also experience criticism and a lack of understanding from the health professionals from which they seek support, which further impedes weight management.^[11] Specifically, interpersonal relationships between health care providers and clients are integral to the successful management of obesity.^[8,10] Given the social and relational context in which weight management occurs, there is a need to better understand the role of relationships in obesity management. There currently is a gap in our understanding of how obesity is experienced relationally between clients and health professionals. This qualitative study employed a feminist poststructuralist framework to understand the complex meanings of obesity within the social, cultural and relational context in which it occurs.

1.1 Background and literature review

Obesity is recognized as the second most modifiable cause of illness and is a significant public health concern globally.^[12] Rates of obesity among adults and children are rapidly increasing and have doubled since 1980.^[13] Over 60% of the population in Canada are considered to be overweight or obese.^[14] Alongside the growing prevalence of obesity, there has been a wealth of research in this area. However, the majority of this research has focused on the behavioural and/or personal factors related to weight gain, with less attention on the broader social, environmental, and cultural contexts in which obesity develops. Within this individualistic framing of obesity, the individual may be blamed for their ill health. Research suggests that health professionals might share these individualistic views on obesity, which in turn can reinforce stigmatization and negative stereotypes,^[3,15] and interfere with the provision of support for weight management. Campos^[16] has challenged the dominant discourse that constructs and drives the obesity epidemic and questions some of the invasive scientific methods that are used to help individuals lose weight. Exploring the individual, social, institutional, and political aspects of obesity is therefore essential in order to ensure individuals seeking support from within the health system receive the appropriate care and support they deserve.

Despite recent research exploring social and environmental influences, obesity remains ineffectively managed within the health care setting.^[17,18] Clients living with obesity often

feel judged and unsupported by the very professionals and health care system that they believe could help them effectively address their weight.^[11] Moreover, the subject of an individual's weight is often deemed a sensitive topic and an issue that health professionals are reluctant to address for a variety of reasons including: fear of offending the client; lack of expert knowledge and time constraints.^[19] Clients often identify that they experience bias and stigmatization within the health care system however the relationship and interaction between individuals living with obesity and health care professionals is not well understood. Having issues of obesity be ignored or overlooked can hinder effective management.^[17]

To better address the complexities of obesity management, it is essential to focus on the relational and contextual aspects of a person's experience. Understanding how obesity is socially constructed, understood and experienced by both those living with obesity or being overweight and the professionals who care for them can provide valuable information as to how weight issues can be addressed in a way that is supportive and respectful of an individual's needs. Furthermore, such an understanding can ensure that the issue is addressed within the social, environmental and cultural environment in which it occurs. Exploring the perspectives and experiences of all stakeholders and understanding the ways in which client and health care professionals interact will provide an in-depth and contextual understanding of obesity management that does not currently exist.

1.2 Purpose and research questions

The aim of this study was to examine the experiences of individuals living with obesity or being overweight, the perceptions of health care providers and the role of social, institutional and political structures, in the assessment and management of weight issues. The research questions were: (1) What are the perceptions and experiences of individuals experiencing overweight or obesity about their weight management as they interact with health professionals (nurses, physicians and dieticians) and the health care system? (2) How do health care professionals, when assisting with weight management, perceive and experience interactions with clients who are experiencing overweight or obesity and the health care system? (3) What are the barriers and enablers within the current healthcare system that inhibit or support the attainment of best practice guidelines for weight management?

This paper presents one theme of findings from a feminist post-structural analysis of the obesity management experience from the perspective of individuals living with obesity or being overweight and the health professionals (nurses,

physicians and dieticians) who care for them.^[20] The findings presented here focus on the relational aspect of care between the client and health care provider and the centrality of this relationship to overweight/obesity management.

1.3 Methodology

Feminist poststructuralism was used to examine how social and institutional discourses, associated with being overweight or obese were personally experienced by clients and the health care providers who cared for them. This methodology is informed by concepts from Foucault^[21] and feminist theories^[22–25] that critically question everyday practices by focusing on the meaning of experience and language through discourse analysis. Feminist poststructuralism focuses on social and institutional constructions of experience and includes but is not limited to constructs of gender, abilities, race, ethnicity, class, socio-economic status, and culture. This methodology also incorporates Foucault's understanding of power as complex and relational that is used to deconstruct moments of binary and oppressive constructions of power. Embedded in this methodological approach is attention to how health care professionals and clients living with obesity or being overweight interact and negotiate relations of power. In other words, it is the experience of the relationship between people that will offer insight into the nuances of how power is shared or contested. Attention to the concepts of subjectivity and agency provided insight into how experiences were negotiated through relationships between the clients and health care providers. Subjectivity framed each participant's personal and social location during the experience of their interactions with their clients or health care provider. This reflexivity about self then offered an understanding of how each person was positioned within society and the health care system based on personal understandings of self in relation to others. This often brought to light "other ways of understanding" that could then be used to challenge normative and stigmatizing stereotypes about obesity and obesity management. Agency was also used to understand how participants had control over their lives and the ability to make changes.^[22,24] Informed by feminist methodology, we accepted each person's story as unique, reliable and trustworthy.

2. METHODS

2.1 Setting

The study took place in an eastern Canadian province. Posters and other recruitment material were distributed across the province in health care facilities where physicians, nurse practitioners and dieticians worked.

2.2 Sample and recruitment

The inclusion criteria for this study included: (1) Individuals (men or women), who self-identified as being overweight or obese. All participants were accepted into the study based on self-identification. Although we did not share this with the participants as part of the screening process or during the interview, we also checked their BMI and found that self-identification corresponded with the medical measurement of BMI of 25-30 kg/m² for overweight or BMI of 30 kg/m² and above for obesity. All participants had interacted with at least one health care professional regarding weight management, were 18 years of age or older, and could speak and understand English. (2) Health care professionals, including physicians, nurses and dieticians, who worked in a health care facility and practicing at the time of the study, who had cared for clients who were overweight or obese for the purposes of weight management. They could all speak and understand English.

Purposive sampling was employed to obtain information-rich cases.^[26] Following ethical approval from the affiliated University and all nine District Health Authorities, participants were recruited through a variety of print and media advertisements and through targeted emails via professional organizations. In total, 38 interviews were conducted among the 2 groups and included 22 individuals who were living with obesity or being overweight and 16 health professionals (8 dietitians, 4 family physicians, 4 nurses). The majority of participants were women: 80% of individuals who were overweight or living with obesity ($n = 18$), 100% of dietitians ($n = 8$), 100% of nurses ($n = 4$) and 75% of physicians ($n = 3$). The mean age for individuals who were living with obesity or being overweight was 47 and 44 for health professionals. Health professionals reported a range of years of service from 3 to 30 years. 45% of individuals who were living with obesity or being overweight reported having co-morbid conditions (all cases more than one).

2.3 Data collection

Individual, face-to-face interviews, were conducted by the research coordinator (RC) and took place at either the client's home, their work or the researchers' university depending on the client's choice. The interviews focused on understanding the obesity/overweight management experience, were guided by a semi-structured interview guide and lasted approximately 30-90 minutes. The semi-structured interview guide differed between the 3 groups to capture the unique perspective of the participant cohort. For example clients who were overweight were asked to tell us in their own words their experiences while interacting with a health care provider concerning their weight. The interviewer would respond to

the participants and when appropriate follow up with probing questions in order to obtain as much detail, personal feelings and perspectives as possible. Using a similar interviewing style, the health care professionals were asked to talk about their experiences when counseling and working with clients who were obese or overweight. Interviews were audiotaped and transcribed verbatim and the qualitative software, Atlas TI, was used for data management. Interviewer field notes, used to capture observations and participant reactions, were also included in the analysis. Copies of transcripts were then made available to each respective participant, who were then contacted by phone to seek further comments or clarification as needed.

2.4 Data analysis

Each interview was immediately transcribed and analysis started so that data collection and analysis were being conducted simultaneously. Team members experienced in the use of feminist poststructuralism led the analysis working with the research coordinator. Analysis included attention to the language and practices of participants, focusing on how they perceived their relations with whom they interacted. Discourse analysis began after the first interview so that emerging themes could be identified for each participant and then compared to subsequent participants.^[23] Data collection ended when no new themes emerged. This decision was made by three team members and the RC who had been working together on the analysis to reach consensus. In keeping with the feminist post-structuralist methodology, we employed discourse analysis to examine each participant's experience. We did this by first identifying each participant's beliefs, values and practices around weight management with either a health care professional or client. These beliefs, values and practices were then organized into discourses that were constructed socially and institutionally through relations of power. The moments of tension, conflict and supportive interactions alerted us to the spaces where power was being negotiated between clients and health care professionals. The detailed stories provided the evidence about how social and institutional discourses affect each individual through these relations. Participants were also encouraged to share other aspects about their weight that they felt were important to describe. These included stories about their childhood as well as ongoing experiences in society and at home. These stories provided rich data to understand how participants experienced relations of power that were sometimes empowering and at other times disempowering. For example we examined how language, social marketing and the media influenced participants' experiences.

3. RESULT

The following section will focus on the theme of the relational experiences of obesity management arising from the interviews with individuals who were living with obesity or being overweight and the health care professionals. The four relational subthemes include (1) Obesity management as a relational process, (2) Interpersonal expectations: Emotional support, (3) Feeling judged, (4) Support or dependency, (5) Stigma and blame: Interpersonal tensions.

3.1 Obesity management as a relational process

The interviews provided insight into how clients and health care providers related to each other through different beliefs, values and practices that had been constructed personally and socially. It was evident in the interviews that both the interpersonal connection and power relations between clients and health care providers could either help or hinder effective obesity management. Clients living with obesity or being overweight and health care professionals discussed a variety of experiences about weight management that included positive interactions of support, help and understanding and at other times negative interactions of non-support, judgment and frustration.

Descriptions of their perceptions and expectations of each other (client and health care provider) revealed points of tensions and support and also emphasized the importance of the interprofessional relationship. At times health care providers spoke with understanding towards their clients' struggles and recognition for the greater societal influence on weight. Yet as the following quote depicts, there is a tension between acknowledging societal influences and the tendency to blame the individual. As one health professional states:

“Not everybody, but the majority of people that you see are concerned about their weight because we are a weight obsessed society . . . And, they want the quick fix . . . They don't want to come and hear it's all about them, it's all their fault. They want someone to fix it. Well, nobody can fix it but you.”

The clients struggled with the lack of care they received for their obesity and recognized that there was a lack of understanding among health professionals about the complexity of obesity and a lack of significance given to this issue in relation to other health conditions. As one client shares:

“If I went into a doctor's office and I was really underweight, they wouldn't just send me away and say just go eat . . . and, if you're a person who has an eating disorder, you know who's

obese, there's no help. And people don't think they should help you almost, like ... that's your problem, I just, I don't see it that way ... I think that people who are severely obese there's things going on, it's not just that you need an extra serving of fruit in your diet."

It was within the description of both moments of tension and periods of support that provided the greatest insight into how obesity could be managed more successfully. Although health care professionals in this study sought to offer supportive weight management to clients, they also expressed their frustrations about not having the resources or knowledge to help their clients. Institutional discourses around weight management affected their practices. Conflicting beliefs and values about weight management between clients and health care professionals often created moments where clients felt marginalized in their relationships with care providers. The following subthemes describe the interpersonal values, beliefs, practices and discourses that impacted both the experience and management of obesity or being overweight in the context of relationships.

3.2 Interpersonal expectations: Emotional support

A positive relationship between clients and health professionals was seen as critical for successful weight management particularly from the perspective of the client living with obesity or being overweight. All of these participants reported feeling that due to the sensitive nature of the topic of weight, the existence of a trusting, supportive and mutually respectful relationship was essential. Some participants talked about the experience of receiving the understanding, compassion and support they needed, while others shared experiences of feeling judged, dismissed, ignored, intimidated and offended by their interactions with health professionals. Whether describing positive or negative moments, emotional support was always identified as an essential component of building a trusting relationship. Emotional support was what individuals living with obesity or being overweight valued most in their interactions with health professionals and this often preceded success with weight loss. While many of the health care professionals spoke about the importance of offering support, others spoke about their frustrations of not being able to provide it due to time constraints or lack of other resources. All of the client participants spoke of needing to have a connection, a "fit" with their health professionals to effectively address their weight issues. One individual whom had successfully lost weight over a period of two years said that the emotional support and understanding of her health professional was what had allowed her to make the changes necessary to succeed where she had failed previously. As

one client shared, being a good health care professional took care and concern and involved the provision of emotional support:

"If you don't want to help people then you shouldn't be a doctor. It's not just about writing a prescription and shoveling you out the door as quick as you can. I'm sure there are some good doctors out there, that actually take the time [to connect with you ... you don't have to sit there for an hour to show some care or concern, make some kind of effort. That's all we're asking for really."

This client described the importance of having health care professionals express care and concern. This highlights the importance of going beyond simply accessing information and guidance about weight management. Similar to all other client participants in the study, the "fit" or relational aspect between client and health care provider was pivotal to success. Other participants described being emotionally supported by their health professionals and the narratives conveyed the importance of sympathy in these interactions. As one client shared:

"My previous doctor was pretty understanding. There were times, I was more comfortable with him. I'd been going to him for a few years. I would go in and I would cry to him. I mean, he would say obviously this is really affecting you, and I understand it's hard ... there wasn't a lot else. I felt that he was more understanding and more sympathetic, but I don't know if he didn't know of anything else to offer, or if there is anything else to offer."

This quotation demonstrates a positive and meaningful interaction for the client who was very appreciative that the doctor was able to provide understanding and sympathy. From the perspective of the client, being understanding and sympathetic was very powerful and allowed this client to feel comfortable. Other clients also spoke about the importance of understanding that was part of a positive and supportive relationship. There were many other examples of where health care professionals were unable to provide any more information or referrals to help with weight loss; however when there was understanding and support the clients felt they could go on and not be disheartened with their attempts at weight loss. In this instance, this doctor was able to move away from the dominant role of knowledge expert that has been socially constructed in the health care system and provide a more empathetic relationship. What is important to

note is that in our study, the majority of individuals who were living with obesity or being overweight revealed that when health professionals tried to understand their struggle, took an interest in their personal stories and had ample time to spend with them, they felt most supported. They also indicated that they felt supported when health providers gave personalized advice and took a flexible approach towards weight loss. Health professionals' knowledge and expertise of the intricacies of obesity were also recognized as having a positive impact on the outcomes for clients. Individuals shared that they needed their health care providers to provide a comprehensive approach to weight loss and help them be accountable to their goals.

3.3 Feeling judged

All of the participants living with obesity or being overweight spoke about the impact of being judged. This included critiquing the skills of their health care providers to see if they were going to be judgmental or not. Embedded within the dominant social construction of obesity is the assumption that those experiencing it should be blamed and therefore negatively judged about their weight. This social discourse created moments of tension for these individuals that often led to self blame, feelings of stigma and weight bias from the wider society and feeling taken advantage of by the weight loss industry. There were many examples given by participants in our study that demonstrated the importance of challenging and eliminating judgment. Because all participants expected to be judged, it was often a surprise and/or relief to find a health care professional who was non-judgmental. As one participant shared:

[Dietician] would say: "It's okay, your body fluctuates. It could just be anything." But she never tried to [judge] ... Because as soon as you say that, all it takes is that statement could send that big person, could send them home and all they are going to do is open the freezer and pull out a tub of ice cream, and it's toast from there. So I think she realized how important her support or how important being subtle is. Like she just realized that what she says is very, very important, and how she says it and how she looks at me.

As evident above, it was the meaning the participants placed on the interaction that was most important. Being non-judgmental created a relationship that shifted the power relations between the dietician and client so that there was a feeling of support. As evidenced from this quote, it was both the language used by the health provider and the tone/delivery that impacted the practitioner-client relationship. This client

appreciated how the dietician was subtle and how she looked at her. There is meaning, both implied and received in all communication and as evidenced in the narratives, and the interpretation of meaning has implications for developing a therapeutic relationship. In this case interpreting whether judgment was present in the interaction was very important. Expecting judgment from health care professionals is based on historical institutionally created binary relationships between health care professionals and clients. When this binary is disrupted by health care professionals by shifting the power relations through respect and non-judgment, clients may feel supported and more confident.

Many individuals living with obesity or being overweight described instances of receiving both positive and negative feedback from health professionals. As evidenced in the narratives, even though clients experienced discrimination in society, negative feedback from health professionals was especially demoralizing. Some of the participants shared that their interactions with health professionals left them with feelings of condescension. They described experiences of having their concerns dismissed as well as feeling intimidated and judged. Both verbal and non-verbal communications impacted the participants' experience of support. One woman shared the impact of receiving a negative look from her physician after gaining a significant amount of weight:

"And I lost a lot of weight, and I was maintaining it. And then I had a hysterectomy, and 6 weeks later, my mother died very suddenly. And I just absolutely lost 10 months of my life. I just ... I was emotionally a wreck. The doctor put me on antidepressants. I took them for one day and slept all day, and threw them away the next day because that wasn't the answer. When I went back to see the gynaecologist after my 6 week visit, I knew I had put on weight. But when I went into his office and saw the look of absolute disgust on his face when I walked in. I mean I'm feeling bad myself because I know I put on weight. You know, I had just buried my mother for heaven's sakes. And I'll never forget that look on his face. I mean he tried to hide it but it didn't work. It didn't work. And of course that made me feel even worse."

Evidenced by the above quote, the participant's perception of the physician's disgust compounded how bad she was already feeling about herself and her weight gain. Several of the participants indicated that it was the "little" or "simple" acts that could make a big difference in how they felt supported by others. Their stories convey how devastating, and

life-threatening, it can be to receive negative feedback from a professional who was supposed to be helping them. As one participant shared, *“It’s almost like you have somebody who is suicidal, and you put them in a room with someone who just drops a hint that life is not worth living.”*

Although health professionals might not have understood the impact of their language, individuals living with obesity or being overweight described being keenly aware of and sensitive to judgments in relation to their weight. The clients also described that the situation of not having their weight addressed openly by health professionals was also a form of judgment and stigmatization. One woman explained that the impersonal nature of her interactions with health providers and the rigidity of treatment plans, developed without her input, left her feeling like a child and judged:

They [dietetics] were very sort of rigid but not just in the meal plan but it was also about “if you don’t keep a diary, I won’t see you again”. It was one of those things that I felt like a little child. I felt like I was being judged. And this is the last person that I want to judge me. I’m already judged by everyone else out there. Even strangers who don’t know me assume that all I do in my life is sit there and eat. They don’t know anything about me. And it’s not the case at all ... And I thought this is horrible that she would judge me and just treat me like a little kid. You know, there are much more subtle ways of explaining to the patient that your food diary is very important than simply telling me, “If you don’t keep a food diary, I am not going to see you again ...” So I didn’t go back.

As described by this participant, the relationship that transpired between herself and this dietician made her feel like a little child. This clearly indicates the type of power relationship that had been created through the language used by the dietician and the meaning the client attached to it. The client had been given an ultimatum whereby she would be dismissed if she didn’t follow the dietician’s orders to keep a diary. It appears that a medical discourse that situates health care professionals with more power than clients through a binary relationship had influenced the dietician’s interaction with the participant. Similar to the example given previously by another participant, this participant used the term “subtle” to describe a more appropriate way for health professionals to communicate. In other words, although it is important to talk about weight management it is the way people talk about it that has the biggest impact either positively or negatively. The way health care professionals talk to clients experiencing

overweight or obesity is a critical moment where relations of power are formed in positive or negative ways. In the previous quotation, the participant demonstrates her keen awareness of the situation and her ability to assert her agency by deciding not to return to this dietician.

Many other participants in the study who were living with obesity or being overweight described feeling discouraged when the health professional appeared dismissive or was not able to work with them to try to find a solution to their weight issues. They also described how discouraging it was to be judged by someone whose role was to provide professional support. Despite demonstrated agency the participants’ stories tell of how vulnerable and dejected they could feel as a result of negative interactions with professionals.

3.4 Support or dependency?

Many health professionals believed clients had unrealistic expectations about weight loss and the lifestyle changes required to sustain a healthy weight. Health professionals often described feeling frustrated that clients played into the weight-loss industry “gimmicks” promising quick fixes. It was evident in the interviews that the fad diet discourse was powerful within society; a discourse rejected and criticized by many health professionals that created further tension in the client-health professional relationship. The health professionals shared their frustrations in regards to their inability to adequately address obesity in clinical practice and the subsequent impact this had on their relationships with clients. As one health professional shared:

“I think it’s after years of being frustrated as a clinical practitioner, where you think what is wrong here? I’m doing everything I was shown to do but yet it’s not enough or it’s not working. Or again, you have people that are taking the word of some other fad. People are still on fad diets. Like we can’t seem to convince people that what we say in terms of food, it will work if you just stick with it”.

Not unlike the clients living with obesity or being overweight, health care professionals also acknowledged the benefit of building a trusting and supportive relationship with one another. One health care professional described struggling to demonstrate their knowledge and expertise to patients with so many competing discourses in relation to weight loss:

“It’s always extremist, I find in our ways we think of managing weight. I always found it was a real struggle to try and persuade people otherwise. I also found that you really didn’t have enough time to build a relationship with some-

body to really develop a level of trust where they would take your word over the person they saw down at the health food store or something of that nature”.

The interviews revealed that most health professionals believed that fad diets were “quick fixes” and competed with the “healthy eating lifestyle” that they prescribed. This doctor recognized that the tension between the two discourses on weight management was “extremist” or constructed in opposition and therefore fad diets were labeled as “bad”. This polarization of weight loss styles puts the health professional in a challenging position. Several health professionals recognized that patients would not follow weight loss regimes unless trusting relationships were developed.

Although health professionals acknowledged the need to establish trust, several health professionals described being fearful of individuals becoming “dependent” upon them to obtain and sustain weight loss. Some health professionals struggled with their role in “supporting” versus fostering a dependency on their support. It was evident from the interviews that there were limits to the level and length of care the health professionals believed they could or should provide. As one participant shared:

“But we don’t allow them to hang on forever because then you create that dependency. And that dependency is not healthy. The person really needs to get to know the basics, learn the basics, and try it on their own. So it’s not that we create that dependency of we need to see you every week for that weigh-in. You know, we need to go over your food journals with you. We are not a Weight Watchers or any of the other programs”.

In the above quotations, while the health care professionals rejected the diet industry in many respects, they also acknowledged that the same private weight loss programs offered a level of support they were unable to provide. While both clients and health care professionals agreed that “support” was needed, it appears that the meaning attached to support shifted and changed depending on the relationship between the health care professional and the client. This highlights the need to pay attention to the words, nuances, facial expressions and information that are offered and exchanged between health care professionals and clients as they develop individualized supportive relationships.

3.5 Stigma and blame: Interpersonal tensions

Focusing on obesity primarily as a disease also led to the use of certain language by some health professionals. Language

used to describe and reference individuals living with obesity or being overweight reflects the tendency to treat the patient as an object: as a disease, a weight; a cost to the system. As one health professional stated:

“I’ve met patients whose digestive tracts can handle a gallon of ice cream. But normal people can’t ... That’s super obese. There’s the morbidly obese and then there’s the extremely morbidly obese. And that’s luckily relatively uncommon. Although we have several in the community. And they run into health problems. In fact, we just had a death of a 500 pounder recently. Thirteen weeks in ICU. That is not cheap for the province is it?”

Within this quote it can be seen that an individual living with morbid obesity was referenced as a “500 pounder”. Focus on cost was pitted against the loss of this person’s life. We can see how the beliefs and values of measuring, costing, and objectifying obesity leads to certain practices by health care professionals within the health care system that then manifest into practices that are interpreted as uncaring and abrupt and most likely interfere with building supportive relationships with clients. Several of the health professionals also made the distinction between patients who were trying to lose weight and those who they believed were not, which sets up damaging dichotomies. As evidenced in the quote below, supportive, non-judgmental and empathetic care was provided based on the perception of whether or not a patient was “trying”.

The ones who are trying, literally trying to lose weight, and they are trying, I just try and keep a positive atmosphere, positive feedback. I try and not let them feel bad about themselves because that is another side of the ones who in fact do want to be thinner ... They are sick and tired of finding it hard to bend over to tie their shoes. Those people, you have to be compassionate ... the attitude I try to foster with them, is “look, you don’t have to lose 80 pounds just as long as you are not gaining pounds and as long as each time you come in, it’s a couple of pounds lighter ... that is okay”.

Labeling and compartmentalizing clients into different groups based on perceived attitudes and practices affected the care that some health care professionals provided to their clients. This particular health care provider decided to provide support to clients who presented as “trying” to lose weight. This perception clearly affected relationship development as well as exuded judgment (positive or negative).

This type of frustration with individuals' lack of commitment to weight loss/management was expressed across the health professional interviews in different ways. Words such as "trying" and "attitude" highlight a focus on individual behavior that clearly led to a judgment about their commitment. This belief in a negative attitude and lack of desire to "try" was not evident in discussions with the individuals living with obesity, all of whom expressed a desire to obtain/maintain a healthy weight. This difference in perceptions created tensions and frustrations between health care professionals and clients. If clients were not seen to be "trying" then some health care professionals might believe they should limit support, which was contrary to what individuals living with obesity identified as essential care (physical and psychological).

All participants recognized the complexity of obesity and the importance of developing "supportive" relationships. It was clear that many of the socially and institutionally constructed discourses about obesity management continued to impede effective relationship building and supportive interactions. Health care professionals and clients identified many conflicts to providing comprehensive care to individuals living with obesity or being overweight. Interpersonal communication practices, including language, can have a significant impact on establishing a trusting, caring relationship. It is clear from the narratives that health care providers need to reflect upon their practice, inclusive of beliefs and values that may be personal, social or institutionally constructed, to best understand how to effectively work with patients towards attaining a healthy body weight. In addition, there is a need to identify, critically analyze and address competing discourses that impede care to this population.

4. DISCUSSION AND IMPLICATIONS

The findings highlight the importance of building a supportive health professional-client relationship within obesity management that pays attention to the meaning of language, and experience. Details such as facial expressions, tone of voice and subtleties all play a part in how clients and health care professionals negotiate relations of power leading to the feeling of being either supported or judged. The quotations provided in this paper are evidence of the ways in which participants who were living with obesity or being overweight either continued to feel oppressed or marginalized during interactions with health care professionals or supported and surprisingly not judged. This clearly indicates the continued presence of the prevailing and dominant social discourse around obesity that focuses on negativity and blame towards those experiencing obesity or being overweight. This type of hegemonic discourse combined with

the reality that obesity continues to be viewed as a sensitive topic and difficult to discuss openly^[10,27] clearly contributed to the creation of a stigma consciousness where participants in this study anticipated negative comments and perceptions from their health care professionals.^[28] As participants had learned from previous negative experiences, the need for a supportive relationship with their health care professionals was evident to them. Furthermore, the narratives provided insight into how power differentials were created, maintained, and sustained. Most often differences about the meaning of obesity and being overweight were not confronted, discussed or challenged within client-health professional encounters. Similar to other research studies, we found that many health professionals continued to focus on blaming clients for not "trying" and that obesity was an individual problem that reinforces negative social stigma and stereotypes.^[3,15] This is in contrast to the emerging evidence on how broader societal factors influence weight.^[2]

The findings have several implications for practice, education and research to ultimately improve relationships between health professionals and individuals living with obesity or being overweight, and enhance overall obesity management. There is a need to continue to examine the prevalent discourses that emerged in this obesity management study and explore how moments of stigmatization and oppression can be addressed and changed to empowering moments for both clients and health care professionals through a focus on developing effective relationships that pays attention to how power is negotiated through beliefs, values and practices around weight management.^[10] Health care professionals, clients, policy makers, and stakeholders all need to understand the role they play in challenging or perpetuating the social and institutional construction of obesity. Participants in our study offered examples of how they challenged dominant social stereotypes around obesity by being non-judgmental or refusing to continue to participate in judgmental relationships. This shows the importance of understanding the nuances that contribute to relations of power within the client-health care professional relationships. Focusing on values, beliefs and practices, associated with obesity will provide an understanding of how tensions and support are created. This information will then enable an in-depth critique of the more dominant discourses of obesity. There is considerable discrepancy in the perceptions of health professionals and individuals living with obesity or being overweight in relation to both the experience of obesity and expectations of obesity management, which create tensions in the therapeutic relationship. These differences need to be explored and understood within the context of a therapeutic relationship.^[29,30]

A key recommendation arising from these findings is that

we need to move beyond acknowledging the importance of establishing a mutually trusting and supportive relationship with individuals living with obesity. There is a need to ensure that health professionals are adequately trained to address and discuss weight status with patients in a sensitive, non-judgmental and respectful manner.^[31] There are high rates of attrition in weight management and improving relationships between clients and practitioners may help address this issue. In addition, educators and practitioners need to challenge the notion that the health care system needs to be an objective entity, especially with relation to obesity management, which requires sensitivity and understanding. For example, instead of considering the patient's body as an object for assessment and measurement to be categorized with respect to normative standards, the clinician should recognize it as an integral part of the individual's identity within a social context marked by judgment, stigma and rejection. These findings also support the need to question and challenge the notion of "de-

pendence" in obesity management. Individuals living with obesity require greater levels and duration of assistance given the multiple barriers they face at the individual, social and institutional levels. Clients and health professionals need to co-construct and define "supportive" relationships as well as goals.^[32] Interpersonal skills are an important aspect of obesity management and health care providers need to be trained in this capacity during their educational programs. Building supportive and trusting relationships takes time, therefore attention to system and institutional level constructs is also needed to support these important relationships in clinical practice.

ACKNOWLEDGEMENTS

This research was supported by the Nova Scotia Health Research Foundation.

CONFLICTS OF INTEREST DISCLOSURE

The authors declare no competing interest.

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