SUFFERING, HOPING, RESISTING AND ACCEPTING: PERCEPTIONS OF OVERWEIGHT WOMEN ABOUT PERSONAL IDENTITY AND MEDICAL CARE

A Dissertation

by

BONNIE R. CREEL

Submitted to the Office of Graduate Studies of
Texas A&M University
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

December 2010

Major Subject: Communication

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Approved by:

Chair of Committee,	Barbara F. Sharf
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ABSTRACT

Suffering, Hoping, Resisting and Accepting: Perceptions of Overweight Women about Personal Identity and Medical Care. (December 2010)

Bonnie R. Creel, B.F.A., Texas Christian University;

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Chair of Advisory Committee: Dr. Barbara F. Sharf

Obesity has been linked to a wide range of health problems. Evidence suggests that overweight and obese (OW/O) women avoid or delay seeking medical care and routine health screenings, a choice that may result in poorer overall health. The objective of this study is to explore how an OW/O woman's self-identity and her experiences in past medical encounters may affect her health-seeking behaviors. Twenty-three women who self-identified as being overweight (currently or in the past) were recruited using a flyer placed in a women's exercise facility and through the snowball method. Each agreed to an audio-taped, in-depth, semi-structured interview. Interviews were transcribed and analyzed.

This study employs multiple methods of analysis and multiple genres of representation of the data, an approach recently termed "crystallization." Analysis of an autoethnographic narrative served as a guide for the generation of the research questions, which focused on how OW/O women conceptualize their identities in relation to their bodies, how their attitudes about their bodies may have impacted choices about seeking

healthcare and their perception of their experiences within medical encounters, and what OW/O women believe to be potentially effective strategies for clinicians to adopt in caring for overweight patients.

Interviews were scrutinized to identify story types using Arthur Frank's well-established framework for the analysis of narratives of sudden life-threatening illness. Two additional story types, Reorientation and Acceptance, are proposed as potentially useful in analyzing stories of chronic health conditions. Grounded theory analysis was used to identify the factors that OW/O women perceive to contribute to their weight struggles, as well as to determine clinician attitudes and practices that OW/O women regard as effective and ineffective. Two emergent themes—othering and control—were discerned in the data and are discussed in terms of both how OW/O women are impacted by their weight and how practitioners can work to provide more effective care. An explanatory model linking social bias, personal identity, and medical interactions is proposed. Finally, a performance script is presented as a means of synthesizing and disseminating research findings.

DEDICATION

This work is dedicated to the memory of my mother, Irene Pelsue, whose steadfast support of all my endeavors still encourages me. It is also dedicated to the memory of Dr. George Thomas Tade, my first academic and professional mentor, whose faith in me made my teaching career possible.

I also dedicate this work to the twenty-three women who so graciously agreed to participate in this project. A simple acknowledgement of their contributions is not sufficient, as their sharing of their lives and their examples of courage go far beyond the provision of "data." They inspire me to want to do something beyond this work to encourage other women and the medical practitioners they rely on to find a better path in the quest for more compassionate care and healthier lives.

ACKNOWLEDGEMENTS

I would like to thank my committee chair, Dr. Barbara Sharf, for supporting my vision for this project, for introducing me to the type of research that constantly engages and challenges me, and for her patience and guidance over the many years it has taken to accomplish this goal. I also thank the other members of my committee—Dr. Richard Street, Dr. Katherine Miller, and Dr. Carolyn Clark—for their encouragement and for the inspiration I received in their classes. I thank all of my doctoral professors for the rigor they demanded of me and for their examples of what it means to be a scholar.

I am grateful for the encouragement of my teaching colleague, Dr. Cheryl Hamilton, whose insistence that I should pursue the goal of a Ph.D. was one of the catalysts for my undertaking this challenge. I am also grateful to my department chair, Lisa Benedetti, who made numerous accommodations in my teaching schedule and who put me in touch with other people who could be helpful in countless ways.

I am forever in debt to the twenty-three women who agreed to participate in my interviews. I am especially grateful for Sharon Kenna's and Jeanine Novotny's kindness in allowing me to recruit at their exercise facility, and for the interest of friends who referred me to potential respondents. I also wish to thank Marilyn Rutledge and Pat Nitschke for their work in transcribing the interviews, and to Brooke Thompson for her assistance in the preparation of my final draft.

Finally, I am deeply grateful to my family, especially my husband, Jim, for their patience and support over the many years it has taken me to accomplish this goal.

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CHAPTER I

INTRODUCTION: WEIGHING THE PROBLEM OF OVERWEIGHT/OBESITY

I was dreading it.

For several years I had successfully managed to treat everything from minor maladies to more serious respiratory illnesses by relying on over-the-counter medications and my body's own willingness to heal itself. Had a tetanus vaccine been available on the shelves of my pharmacy, I would not have been sitting there, waiting for my name to be called while pretending to read a three year old copy of *National Geographic*. At that moment my mind was not focused on the beauties of Bali as much as it was on mentally rehearsing what I planned to say. "Bonnie Creel?" I heard my name and got to my feet.

The nurse led me down the hall past the warren of examination rooms to the intake area. "Let's hop up on the scales," she chirped. I resisted the urge to suggest, "You first." Instead, I took a deep breath and asked, "Is there anything about my tetanus shot that will depend on what I weigh?"

She looked at me, puzzled. "No. A tetanus shot is a tetanus shot."

A pause. "Well, then," I said, "I prefer not to be weighed."

A long, awkward pause. "Oh, well," she stammered. "Okay. That's fine."

This dissertation follows the style of *Communication Monographs.*

She led me to one of the examination rooms, took my blood pressure, hastily asked the usual questions, and then, without our eyes ever having met, she announced, "Doctor will be with you in a few minutes," and she closed the door.

My heart was pounding and I sensed the flush in my face. Had there been disapproval when she closed the door? Would she be in trouble for not having a number recorded in the "Wt___" space? Would she report me to the doctor as a "bad" patient?

A few days later, my friend Peggy's eyes widened as I recounted the story of My Visit to the Doctor. "You really did that? I didn't know you *could* do that!" she exclaimed. I tried to join her in her obvious celebration of my insurrection. But I was filled with self-loathing. How could I have done that? Hadn't I made the nurse anxious? What a coward I was to act as though a simple metal platform was some sort of fearsome ogre. I felt undeserving of my friend's frank admiration. I was ashamed.

Almost two decades have passed, but I have never been able to summon the nerve to repeat my little act of resistance. In the intervening years I have often observed myself postponing health screenings, even delaying medical treatment for acute illness until it becomes essential to see the doctor for a prescription. "The body heals itself," I have rationalized. But in the periphery of my mind, I have always known the truth: I won't see the doctor because I am fat.

From Me-search to Research

I have often wondered if my thought processes in making decisions about whether and when to seek healthcare were shared by others who contend with issues of

weight. For a time, I struggled with the idea of entering into a research project that explored this question, concerned that my own position as an overweight woman would jeopardize my ability to maintain any semblance of objectivity. However, I was struck by something that a graduate school colleague of mine told me about Dr. David Rosen, a professor of analytical psychology, whose research team's motto—"Research is me-search"—guides them as they study "personal suffering (passion) and meaning" (D. Rosen, personal correspondence, June 23, 2009). Personal suffering? Yes, I have suffered. There is hardly any aspect of my life that has not been affected, in one way or another, by my struggle with my weight. Meaning? Yes, the search for meaning in my experience with overweight and obesity—for some grasp of the transcendent and multiple "whys" that surround that experience—has been a dominant theme in the story of my life.

For that reason, I decided to use my own experience as a point of departure in focusing my dissertation on the medical encounter between physicians and their overweight/obese (OW/O) patients. I am curious about how OW/O women conceptualize their weight status with respect to its influence on their identity formation, particularly regarding the intersection of health, appearance, and self-esteem. Further, I wonder how the perceptions that female OW/O patients have about previous communication with physicians and other health professionals during medical encounters may have influenced that identity, either encouraging or discouraging successful weight reduction and other positive health-seeking behaviors. Perhaps an understanding of the perspectives of overweight women will encourage health

professionals to examine their own presuppositions in what, I hope, is their sincere desire to find ways to assist overweight patients to realize their health goals.

The Association of Weight with Health Conditions

The topic of overweight/obesity is significant in light of the overwhelming consensus of experts that obesity is among our nation's most serious health problems. As weight has become more definitively regarded as a health issue, the terms "overweight" and "obese" have been precisely defined. The Centers for Disease Control and Prevention (2009) use a person's body mass index (BMI), a number that is derived from calculations based on weight and height, to classify that individual's weight status. A person with a BMI between 18.5 and 24.9 is regarded as being at a "healthy" weight. A BMI of 25-29.9 places one in the "overweight" category and anything above 30 is considered "obese." The National Institutes of Health (2008) use the term "morbidly obese" to refer to anyone who has a BMI of 40 or greater or who is 100 pounds overweight.

To get some sense of the magnitude of the issue of OW/O, I turned to statistical research to find answers. I found that the National Health and Nutrition Examination Survey conducted in 2003-2004 revealed that 66% of adults aged 20 and above are overweight, and almost half of those (i.e., 32% of the adult population of the US) qualify as obese (Prevalence of Overweight, 2006). Obesity has been found to be an independent risk factor in the development of coronary heart disease (Ghandehari, Le, Kamal-Bahl, Bassin, & Wong, 2009; Klein et al., 2004; Zalesin, Franklin, Miller, Peterson, &

McCullough, 2008). Since cardiovascular disease is the number one cause of death in the United States, (Heron et al., 2009), it seems clear that OW/O merits our concern. It is particularly interesting to note that heart disease has been traditionally considered to be a "man's disease," but since 1985 more women than men die annually from cardiovascular diseases (American Heart Association, 2010).

In my research I found that obesity is also associated with the second leading cause of death: Cancer (Heron et al., 2009). Along with smoking and alcohol use, OW/O was found to be among the three most significant causes of cancer in countries with high income and high standards of living (Danaei, VanderHoorn, Lopez, Murray, & Ezzati, 2005). Obesity has been strongly linked to breast cancer (Calle, Rodriguez, Walker-Thurmond, & Thun, 2003; Weir et al., 2003) and to a poor prognosis for recovery from breast cancer (Carmichael, 2006). Obesity is also associated with cervical cancer (Calle et al., 2003) and with ovarian cancer (Leitzman et al., 2009). Furthermore, overweight and obesity appear to increase the risk of colorectal (Weir et al., 2003), biliary (Grainge, West, Solaymani-Dodaran, Aithal, & Card, 2009), pancreatic (Luo, Margolis, Adami, LaCroix, & Ye, 2008) and prostate cancers (Freedland et al., 2008). Even cutaneous melanoma has been linked to obesity due to the increase in body mass surface of people who are overweight (Dennis, Lowe, Lynch, & Alavanja, 2008).

In addition to confirming what I had been told about the risk of heart disease and various forms of cancer posed by being overweight or obese, I discovered that there are also associations with a number of other physical problems. I learned, for example, that the likelihood of developing chronic diseases is much higher for overweight people than

for their leaner peers (Field et al., 2001; Must et al., 1999)). The relationship between weight and Type II diabetes is incontrovertible (Adeghate, Schattner, & Dunn, 2006; Nguyen, Magno, Lane, Hinojosa, & Lane, 2008). Weight is also implicated in esophageal reflux (Chung et al., 2008), diverticulitis and diverticular bleeding (Strate, Liu, Aldoori, Syngal, & Giovannucci, 2009), hypertension (Nguyen et al., 2008), and kidney stones (Asplin, 2009). One article I read reminded me of my own experience lying on a gurney in an emergency room, in a city distant from my home, with what I would eventually learn was a gallstone attack. The ambulance attendants had already informally diagnosed me, and I overheard them as they stood at the nurses' station in the ER. "You know what they say: Fat, Female, Fertile, and Forty," one of them remarked. That was the first time I had heard this medical axiom borne out of what I have since learned (Ruhl & Everhart, 2001) is a well-known association between weight and gallbladder disease. Obesity has also been associated with poor wound healing (Wilson & Clark, 2003) and has even been found to be a marker for periodontal disease (Ylostalo, Suominen-Taipale, Reunanen & Knuuttila, 2008). There is also data that links a mother's obesity before pregnancy to an increase in various types of birth defects in her child (Oddy, DeKlerk, Miller, Payne, & Bower, 2009; Watkins, Rasmussen, Honein, Botto, & Moore, 2003).

Quality of Life, Mental Health, Mortality, and the Cost of Healthcare

Quality of life issues are certainly complicated by overweight and obesity. Abundant evidence links excessive weight with Obstructive Sleep Apnea (Carter &

Watenpaugh, 2008; Frey & Pilcher, 2003; Hirshkowitz, 2008). In fact, Hirshkowitz (2008) asserts that the most significant risk factor for sleep apnea is obesity, and that 40-70% of obese patients suffer from the condition. However, even overweight and obese people who do not have sleep apnea often experience poor quality of sleep and excessive daytime sleepiness (Resta et al., 2003; Vgontzas, Bixler, & Chrousos, 2006). Older adults who are overweight are more prone to experiencing reduced sleep duration than those of normal weight (Patel et al., 2005). Overweight older adults often face a decline in quality of life due to reduced mobility, particularly when they were also overweight at earlier points in their adulthood rather than only as a consequence of aging (Houston et al., 2009).

I was not surprised to find that overweight and obesity are also linked to psychological problems including a variety of personality disorders (Mather, Cox, Enns, & Sareen, 2008), mood and somatoform disorders (Baumeister & Harter, 2007) and psychiatric conditions such as depression, anxiety disorders, social phobias, and panic attacks (Mather et al., 2009). Women who are obese or overweight are significantly more likely to experience depression or anxiety than are their more normal-weight counterparts (Zhao et al., 2009). Interestingly, one study (Carpenter, Hasin, Allison, & Faith, 2000) found that major depression, as well as suicide ideation and suicide attempts, correlated with higher body mass index (BMI) in women, but with lower BMIs in men. Another study (Dong, Li, Li, & Price, 2006) found that the risk of suicide attempts is 87-122% higher among extremely obese people when compared to the general population.

There is little doubt that being overweight or obese causes or contributes to the development of a wide array of serious physical and mental health problems. However, it appears that OW/O is also significantly related to higher mortality rates from all causes (Reis et al., 2009). Moreover, while it is generally agreed that affluent people—presumably because of their better access to healthcare and the ability to afford more nutritious food—are healthier in general than those in lower socioeconomic groups, being obese appears to erase that advantage; that is, obese people in high-income brackets are no healthier than their less advantaged neighbors (Obesity Cancels Health Advantage, 2008). Sturm and Wells (2001) found that obesity is at least as significant in terms of morbidity as are smoking, alcoholism, and poverty, even after controlling for chronic health conditions.

In addition to the obvious physical and psychological costs of being overweight or obese, there are very real financial costs. It is estimated that in 2000, healthcare expenditures related to morbid obesity exceeded $11 billion (Arterburn, Maciejewski, & Tsevat, 2005). Per capita costs for healthcare increase as degree of obesity increases, with the most severely obese spending as much as 60% more in healthcare costs than their normal-weight cohorts (Wee et al., 2005). Further, healthcare costs in old age are higher when an individual was overweight early in life (Daviglus, 2005). Yang and Hall (2008) found that elderly men and women who are overweight or obese at age 65 spend significantly more on healthcare and have worse health outcomes than those who are not overweight at that age. It is also important to note that the cost to Medicare of providing

healthcare to an obese elderly person is about 34% higher than the cost of healthcare for a normal-weight elderly person (Lakdawalla, Goldman, & Shang, 2005).

Public Awareness of the Issue of Weight and Health

The focus on overweight and obesity, however, is not confined to arcane medical journals; it is widely and repeatedly disseminated through the media to such a degree that it is hard to imagine how anyone in the populace could have failed to hear the message. I remember purchasing the issue when *Time* magazine declared 2004 the "Year of Obesity" (Lemonick, 2004), and I recall that in the summer of that year, *Time* co-hosted a summit on obesity with ABC News (Elmer-DeWitt, 2004) that was funded by the Robert Wood Johnson Foundation and included an impressive array of health experts and researchers specializing in obesity. I have also noticed that articles frequently appear in the popular press reporting on the findings of scholarly studies linking obesity to an array of health risks (see, for example, Barker, 2003; Gupta, 2004a; Gupta, 2004b; Hellmich, 2003; Koplan, 2005; Morrow, 2004; and Stein, 2003, for a tiny fraction of the popular coverage).

Surely we have heard the news. And yet, we are told, Americans are getting fatter and fatter with each passing year. In fact, data from the first National Health Examination Survey and the National Health and Nutrition Examination Survey suggests that by 2020, nearly 78% of men will be classified as overweight and nearly half of those will fall into the category of obese. The projections are that 71% of women will be overweight, and that over 43% of women will fit the criteria to be categorized as obese

(Ruhm, 2007). Furthermore, it is expected that the numbers of people falling at the severe or extreme levels of obesity will rise especially dramatically. In 2000, approximately 2% of the adult population fell into the severe or extreme category of obesity (Sturm, 2003), but Ruhm's (2007) projections suggest that in 2020 we can expect that 3.1% of men and 5.6% of women will fall into that group.

Weight and Patients' Health Decision-Making

Despite the near certainty that overweight people have been exposed to information regarding the relationship between weight and health, there is considerable evidence that they may delay seeking important screenings or routine healthcare (Adams, Smith, Wilbur, & Grady, 1993; Fontaine, Faith, Allison, & Cheskin, 1998; Fontaine, Heo, & Allison, 2001; Olson, Shumaker & Yawn, 1994; Pirisi, 1998; Simoes et al., 1999). This finding was interesting for me to learn, as it answered in a quantitative way one of the questions that occurred to me when I considered my own decision-making: Am I the only person who delays seeking healthcare because of my weight? Apparently not. I learned, though, that when OW/O patients do see their doctors, they are receptive to messages about the dangers of overweight and obesity (Durant, Bartman, Person, Collins, & Austin, 2009) and that effective physician counseling does have a positive effect on patient weight loss (Davis, Emerenini, & Wylie-Rosett, 2006; Loureiro & Nayga, 2006; Potter, Vu, & Croughan-Minihane, 2001; Tan, Zwar, Dennis, & Vagholkar, 2006). However, doctors do not always address the weight issue with patients; in fact, a trend analysis (Abid et al., 2005) demonstrates that there may be a

decline in the frequency with which physicians advise patients to lose weight. Evans (1999) found that 80% of patients in one weight loss program had been advised by their doctors to lose weight, but only 22% received helpful advice on how to go about doing that. In addition, advice to lose weight may be more likely when the patient is already in poor health or suffering from a chronic disease rather than before health issues appear (Ko, Galuska, Zhang, Blanck, & Ainsworth, 2008).

Physician Attitudes about Overweight and Obesity

Unfortunately, evidence points to the possibility that many clinicians are not effective in providing the guidance needed to facilitate weight management. In some cases this may be because doctors or nurses lack knowledge about the use of effective interventions (Block, DeSalvo, and Fisher, 2003; Fleury, Thomas, & Ratledge, 1997; Redland & Stuifbergen, 1993; Strecher et al., 1995). In other cases, physicians may have a pessimistic attitude about the potential for OW/O patients to succeed (Roman-Diaz, 1993). Hayden and colleagues (Hayden, Dixon, Piterman, and O' Brien, 2008) note that "rather than recognize that the treatments in use may be the cause of poor success in treating obesity, many physicians are more likely to blame the patient, citing lack of patient compliance and motivation for the perceived failure of weight loss" (p. 16). Unfortunately, when healthcare professionals blame the patient, they may also tend to think that the patient is solely responsible for the solution (Epstein & Ogden, 2005; Ogden et al., 2001).

Of even greater concern to me is the evidence that healthcare professionals often hold strong negative attitudes toward OW/O patients, ranging from a lack of enjoyment in working with them (Timmerman, Reifsnider & Allan, 2000) to actual anti-fat bias (Adams, et al., 1993; Harvey & Hill, 2001; Hebl & Xu, 2001). I learned that negative attitudes toward overweight patients emerge among medical students during training (Blumberg & Mellis, 1985; Wear, Aultman, Varley, & Zarconi, 2006), and are even found among physicians who are considered specialists in treating obesity (Teachman & Brownell, 2001). One study (Schwartz et al., 2003) found that health professionals—including psychologists—who specialize in treating obese patients use words such as "stupid," "lazy," and "worthless" to describe these patients, revealing significant implicit anti-fat bias. The authors observe that "the stigma of obesity is so strong that even those most knowledgeable about the condition infer that obese people have blameworthy behavioral characteristics that contribute to their problem (i.e., being lazy)" (Schwartz et al., 2003, pp. 1037-1038).

There is ample reason to be concerned that clinicians' negative attitudes may be communicated to patients, resulting in patients delaying medical care and the possibility of practitioners compromising the quality of care that patients receive (Adams, et.al., 1993; Ahmed, Lemkau, & Birt, 2002; Bertakis & Azari, 2005; Harvey & Hill, 2001; Hebl & Xu, 2001; Olson et al., 1994; Wadden et al., 2000). At least one study confirms that the care a patient receives is, in part, related to how the clinician perceives the patient with respect to a number of characteristics, including the extent to which the practitioner believes the patient will adhere to treatment regimens (Street, Gordon, &

Haidet, 2007). It seems logical to assume that the pessimism of doctors about the ability of OW/O people to be successful at weight loss (Roman-Diaz, 1993) could be related to perceptions of poor likelihood of compliance, which might then be linked to their perceptions that people who are overweight are lazy (Schwartz et al., 2003). Schwartz and her colleagues worry that when clinicians believe that OW/O patients are lazy, they will blame them for their obesity, and that this "may influence the professionals' behavior in both overt and subtle ways" including "time spent with patients, empathy, quality of interactions, optimism about improvement, and willingness to provide support" (2003, p. 1038).

Rationale and Research Questions

Given the abundant evidence for the negative health consequences of overweight and obesity, medical clinicians have an obligation to find ways to assist patients in achieving a weight that is healthful to them. In view of that responsibility, the research about physician attitudes toward overweight patients is particularly worrisome. However, while a physician's attitude is important, it is only part of the equation. An often neglected counterpart in the studies cited thus far is an exploration of the lived experience of the overweight patient in medical interactions.

Macdonald (1995) points out that how a woman perceives her body is a central aspect of her identity formation. Studies show that women experience greater body dissatisfaction than men (Aruguete, Yates, & Edman, 2006; Lokken, Ferraro, Kirchner, & Bowling, 2003) and their degree of dissatisfaction seems to be increasing (Feingold &

Mazella, 1998). Freedman (1986) asserts that because body image is so important to a woman, negative attitudes toward her body often express themselves in anorexia, obesity, depression, sexual problems, low self-esteem, and psychosomatic disorders. How an OW/O woman perceives the influence of her weight on her identity may play an important role in how she perceives the messages she receives in communication with health professionals about both weight-related and non-weight related topics. This, in turn, may significantly impact a woman's health decisions and behaviors. Because the evidence suggests that men and women have different attitudes toward the significance of weight on their sense of self (Grover, Keel, & Mitchell, 2003; Pilner, Chaiken, & Flett, 1990), I have chosen to limit my study to an exploration of women's perceptions of the effects of overweight and obesity in identity formation and in interactions with healthcare providers.

My overarching research question, therefore, is: *How is an OW/O woman's weight implicated in her self-identity, how does she make sense of the experience of being overweight, and what role does her identity and her understanding of her weight play in her health-seeking behaviors and in interactions with physicians and other health professionals?*

I have divided my central research question into three sets of sub-questions, each designed to explore the separate but connected lines of inquiry suggested by the overarching question. The first of these is: *How does their weight affect the development of self-identity in OW/O women, especially with respect to their views of their body and its relationship with their sense of "self"? How has the OW/O woman's view of her body*

influenced her sense of self in relationship with others? The second set of sub-questions focuses on how OW/O women make sense of their weight: *What are the factors that OW/O women believe to have contributed to their weight problems? What are their perceptions about how being overweight impacts their lives?* The third set of sub-questions is aimed at exploring what the personal experiences of OW/O women in medical encounters can tell us about how they perceive communication with clinicians: *In what ways have their experiences in medical consultations been beneficial or detrimental in promoting positive health outcomes? What recommendations would OW/O women make to improve medical encounters and practitioner communication with OW/O women?*

My goal in exploring these questions is to provide a basis for understanding how an OW/O woman's attitudes about herself with respect to weight may be a factor in how she communicates with clinicians about weight management. I am interested in how she approaches communication in encounters with health professionals—which may include nurses, primary care physicians, obstetrics-gynecology doctors, or practitioners in any specialty with whom she has consulted about her weight or other relevant health issues. I am interested in how she perceives the messages about her weight that she has both sent and received in her interactions with health professionals. The purpose of this line of investigation is to shed light on the underlying thought processes that influence the OW/O woman's health-seeking behaviors, as well as to reveal the communication practices of health professionals that serve to inhibit or promote positive health decisions.

In Chapter II, I will discuss the methodology used in conducting this study, including an explanation of approaches to the analysis of my data as well as the specifics of data collection. Chapter III will present an autoethnographic narrative that launched my interest in this topic, including a discussion of some of the insights gained from an analysis of that narrative and the ways in which those insights shaped my research questions.

Chapter IV will focus on answering my first sub-question. Using a categorical framework for narrative analysis, I will explore how my respondents' stories reveal the role of weight in the structuring of their personal identities. In Chapter V, I will concentrate on the second sub-question, using a grounded theory approach to examine how my informants have made sense of their weight problems. I will be investigating the factors they believe have contributed to their weight problems and I will discuss their perceptions of the impact that being OW/O has had on their lives.

In Chapter VI, I will apply the implications of my grounded theory analysis in Chapter V to how OW/O women experience medical encounters in order to answer my third set of research sub-questions. I will present material from the accounts my respondents gave of their experiences in medical interactions, focusing especially on those interactions where their status as an overweight woman seems to them to be salient. I will consider how their encounters have affected their attitudes—both positive and negative—about medical practitioners and how those attitudes appear to have affected their health-seeking behaviors. I will also discuss what the OW/O women I talked to would like to experience in medical interactions.

Chapter VII will provide a summary of this work and the conclusions drawn from it, as well as implications of the findings for scholarship in health communication, medical practice, and for OW/O women. In Chapter VIII, I will use material and ideas from the interviews in the development of a performance script. The performance script is designed to serve as a synthesis of ideas explored in the previous chapters, pulling together the answers of all three sub-questions to address the overarching research question. The script also gives voice to the thoughts of my respondents in ways that will illumine their experiences beyond the conventions of the typical academic report.

CHAPTER II

METHODOLOGY

> The language of illness and disease permeates our everyday lives. We routinely talk about living in a "sick" society or about the "disease" of violence infecting our world, offhandedly labeling anyone who behaves in a way we don't understand or don't condone as "sick."
>
> This metaphoric use of language reveals the true nature of illness: behaviors, conditions, or situations that powerful groups find disturbing and believe stem from internal biological or psychological roots. In other times or places, the same behaviors, conditions, or situations might have been ignored, condemned as sin, or labeled crime. In other words, illness is both a social construction and a moral status. (Weitz, 2001, p.145)

There is little doubt that attitudes about weight have changed over time. Sobal (1995) notes that a shift in social values in the United States since the 1950s has led to a reevaluation of fatness from being something that traditional societies once regarded as "good and healthy" to something that is now viewed as "bad, sinful, and ugly . . . providing the basis for the moral model of fatness, which suggests that fat people are responsible for their condition and should be punished as a means of social control for being fat" (Sobal, 1995, p. 69). Sobal also observes that the adoption of the term "obesity" has contributed to a medicalization of overweight, "with language helping to

shift perceptions from badness to sickness" (p. 70). Goode (1969) asserts, "Naming has political implications" (p. 89), and Conrad and Schneider (1992) point out that such transitions in language serve the interests of medical practitioners who are held in higher prestige when seen as uniquely qualified to address the issue. Riessman (1992) contends that medicalizing overweight is a particular concern for women because it "illustrates in a most graphic form how power relations are maintained through medical social control, how women internalize their oppression by desiring to be thin and turning to doctors for help" (p. 136).

These and other critiques of the social construction of weight are, to me, compelling and persuasive. Since critical scholarship aims for the emancipation of people from the pernicious effects of political structures that primarily serve the interests of elites, I believe there is potential for important work to be done in examining the practices of medicine *vis a vis* weight. However, I also believe it is important to address the issue in a more immediately practical way. In the course of this study, I will be addressing some of the ideas discussed above that point to a need for further critical evaluation of the conceptualization of overweight and obesity in our contemporary culture. My primary emphasis, however, will be on the practical concerns of how overweight and obese people can achieve better health.

The focus of this study is to explore the lived experiences of women who identify themselves as overweight or obese (OW/O), especially those experiences that take place within the context of medical encounters. I have entered into this study because of my own history as an overweight woman who has also been obese, a position that has

afforded me an opportunity throughout my life to discuss issues of weight informally with other women who contend with the same problem. From these discussions I have formed the opinion that there is much to be learned from the diverse perspectives of those engaged in the struggle to find a path to health despite/because of/instead of being overweight.

I have several goals in undertaking this study. Like all researchers, I hope to contribute to the body of scholarship in my discipline, the field of health communication, particularly in the area of patient-practitioner communication. However, my primary objective is to go beyond the scholarly audience, to enlarge the understanding of overweight patients and their healthcare providers. My intent is to pursue opportunities to disseminate my findings in publications that are commonly read by medical professionals; the goal in doing so would be to encourage them to examine their own practices as they occupy the role into which they have been thrust because of the prevailing views of weight in our culture today. Just as important to me is to reach the "lay" audience: women who are overweight or obese and the people who are in relationship with them. My hope is that my findings will promote a more empathic understanding of the perspective of overweight women and, at the same time, encourage OW/O women to examine their own thought processes in making health decisions and to assert their rights to humane care.

In this chapter, I will explain the methodological choices I made in exploring my topic and in representing my data. The decisions I made in how to proceed are linked to the goals discussed above: to open a space for critical reflection on the ways in which

weight is regarded in our culture as well as to examine the practices of both OW/O women and their medical practitioners in working toward positive health outcomes. First, though, I will outline the metatheoretical commitments that underlie my approach to this study. It is important to me that I acknowledge these perspectives here because they inform my research methodology and the manner in which I have conducted it.

Metatheoretical Commitments

I approach this topic from a symbolic interactionist perspective (Berger & Luckmann, 1966; Blumer, 1969; Mead, 1962). In this view, people create meaning through interaction with others, interpreting another's symbolic behavior though a stock of knowledge gained through previous interactions with that person and with others, as well as through the ways that the identities of the self and the other are enacted. Further, our responses to others' behaviors are shaped by the meanings we have ascribed to the behaviors, along with how we define the situation in which the interaction occurs.

I proceed from a relativist interpretivist ontology—albeit a fairly conservative form of relativism consistent with Kuhn (1962)—holding that no single perception of reality can be privileged over another. Perhaps a better way to describe my ontological view is that it is a pragmatic relativism: there may be absolute *T*ruths, but my assumption is that the only reality that I (or anyone else) can embrace is the reality I can perceive; therefore, I must respect that another's perspective may differ from my own, and it is entirely possible—indeed probable—that neither of us can fully apprehend the *T*ruth. I am working from a social constructionist epistemology (Berger & Luckmann,

1966), subscribing to the notion that knowledge is created inter-subjectively in interaction with others in the social world. My axiological position conforms to the notion that it is not possible, nor even desirable, to eliminate values from the conduct of research. Indeed, my preferred view is consistent with Miller's (2005) discussion of the perspective of critical theorists who hold that "values are not to be excised and controlled, or even acknowledged and explored. Rather, values should guide scholarship, and theorists should work as change agents in supporting those values" (p. 74). Despite my position as an overweight woman, I have attempted to bracket out my own biases and assumptions in hearing and honoring the ideas of my subjects, while at the same time I acknowledge that I proceed from a particular set of values that are shaped by my experiences and are necessarily implicated in my research.

The methodology I employed in conducting my research follows logically from my objectives and from my metatheoretical commitments. The purpose of this chapter is to explain my methodology and the specific ways in which it was applied. I will begin by briefly discussing the two methods I used to collect data, and then I will discuss the approach I took to the analysis of that data. Following those two sections, I will explain the specific procedures I followed in developing my interview schedule, recruiting my subjects and collecting the data. Finally, I will summarize the demographics of my subject pool.

Methods of Data Collection

Autoethnography

The first method I used is autoethnography. Ellis and Bochner (2000) define autoethnography as "an autobiographical genre of writing and research that displays multiple layers of consciousness, connecting the personal to the cultural" in which the researcher/writer focuses "outward on social and cultural aspects of their personal experience" as well as "inward, exposing a vulnerable self that is moved by and may move through, refract and resist cultural interpretations" (p. 739). To engage in autoethnographic writing requires reflexivity, which Lincoln and Guba (2000) describe as "a conscious experiencing of the self as both inquirer and respondent, as teacher and learner, as the one coming to know the self within the processes of research itself" (p. 183).

The use of autoethnography seems particularly appropriate in my line of research, dealing as I am with issues of the body. Autoethnography is a form of embodied writing, as Spry (2006) asserts in saying, "The autoethnographic text emerges from the researcher's bodily standpoint as she is continually recognizing and interpreting the residue traces of culture inscribed upon her hide from interacting with others in contexts" (p.189). The reflexivity that is required in both writing and analyzing my own personal narrative has allowed me to challenge my assumptions and interrogate the meanings constructed within the social interactions that are recounted in my story. At the same time, as Chang (2008) observes, "Personal engagement in autoethnographic stories frequently stirs the self-reflection of listeners, a powerful by-product of this research

inquiry" (p. 53). Goodall (1998) argues for the validity of autoethnography as a research method when he asserts, "When it is done well, we can *learn previously unspoken unknown things about culture and communication* from it" (as cited in Spry, 2006, p. 192; italics in secondary source).

My objective in this study is not just to explore my own experience. On the other hand, because of my status as a woman who has dealt with issues of overweight and obesity for the majority of my life, I do have some insight that I believe to be relevant in the exploration of my topic. Moreover, I believe it is important to further acknowledge my positionality by including my own voice in some way. I decided early in the process of developing my dissertation proposal that I would generate an autobiographical story as a sort of launching point for my investigation. I decided to use a strategy I am terming "autoethnographic interviewing," in which I posed a question to myself that I was likely to ask any other respondent. The results of that effort and its usefulness for my study are discussed in detail in Chapter III. I also believe that my positionality as an OW/O woman affected the conduct of my research. Although I cannot be certain of this, I strongly suspect that when I talked with my respondents, my embodiment as a researcher who was herself overweight facilitated the development of rapport and encouraged disclosure. Indeed, at times the inclusive "we" was evoked in my informants' responses as they reflected on the experiences they perceived that all or most OW/O women share—a "we" that clearly was extended to include me. I feel sure that our interviews were intersubjectively created as I responded with affirming head nods and facial

expressions that reflected that I recognized their experiences and could genuinely appreciate their points of view.

Interviews

While my own autoethnographic narrative serves as a starting point for my study, the focus of my project is the perceptions of other women. Schutz (1967) reminds us, though, that we can never fully apprehend another's lived experience.

> I am always interpreting your lived experiences from my own standpoint. Even if I had ideal knowledge of all your meaning-contexts at a given moment and so were able to arrange your whole supply of experience, I should still not be able to determine whether the particular meaning-contexts of yours in which I arranged your lived experiences were the same as those which *you* were using. (p. 106)

Schutz (1967) goes on to observe that in using language as signs to represent another's subjective experience, "the subjective meaning that the interpreter *does* grasp is at best an approximation to the sign-user's intended meaning, but never the meaning itself, for one's knowledge of another person's perspective is always necessarily limited" (p. 129).

In order to gain access to the emic perspective of other women, I chose to conduct in-depth interviews. Schutz affirms the value of the face-to-face conversation when he observes that "I can . . . ask you how you are interpreting your lived experiences, and, in the process, I can correct, expand, and enrich my own understanding of you" (p. 171). The interview, then, can surely serve my research goals.

In the “Procedures” section of this chapter, I will explain in more detail how my interview schedule was constructed and modified. I will also describe how interviewees were recruited and how the interviews were conducted.

Data Analysis and Representation: Crystallizing Perspectives

A variety of qualitative methods for data analysis are amenable to research that proceeds from the perspectives and metatheoretical commitments I have outlined above. My decision was to use multiple methods of analysis and multiple genres of representation of the data, an approach that has been recently termed “crystallization.” The concept of crystallization was introduced by Richardson (1994) in the first edition of Denzin and Lincoln’s *Handbook of Qualitative Research* and revisited by Richardson (2000) and Janesick (2000) in the second edition. Ellingson (2009) has more fully developed the idea as a methodology for doing qualitative research after having used it in her own work, both in a book (2005) and in journal articles (1998; 2002; 2008a; 2008b) that use a variety of approaches from which to examine the same data.

The appeal of the crystallization methodology for research that is generated from interpretivist and social constructionist commitments is captured by Ellingson’s (2009) definition:

> Crystallization combines multiple forms of analysis and multiple genres of representation into a coherent text or series of related texts, building a rich and openly partial account of a phenomenon that problematizes its own construction, highlights researchers’ vulnerabilities and positionality, makes claims about

> socially constructed meanings, and reveals the indeterminacy of knowledge claims even as it makes them. (p. 4)

Janesick (2000) notes that the strength of crystallization lies in what is implied by the metaphor of a crystal: "What we see when we view a crystal . . . depends on how we view it, how we hold it up to the light or not" (p. 392). I take this to mean that the use of crystallization allows us to get at the meaning of a text from multiple entry points, each offering a slightly different perspective from which to view what appears to be happening. Richardson (2000) explains that crystallization replaces the more commonly accepted use of triangulation as a strategy to ensure reliability and validity of research findings, arguing that the use of mixed methods multi-genre research "provides us with a deepened, complex, thoroughly partial, understanding of the topic. Paradoxically, we know more and doubt what we know. Ingeniously, we know there is always more to know" (p. 934).

In Ellingson's explication of crystallization, she offers a "qualitative continuum" (2009, pp. 8-9) on which she places different methods of research and genres of representation from traditional social science to more artistic and creative forms. On the right end, she includes approaches that fall into the "science/realist" category, including methods such as structured interviews, measurement, coding textual data, and the like. She locates semi-structured interviews that are then analyzed as narratives or through the grounded theory method in the "middle-ground" of the continuum. She classifies genres on the left end as "art/impressionist," and it is here that she places autoethnography as well as performance.

In the following sub-sections, I will discuss the three analytic methods I chose to use in my study of the experiences of overweight women and their interactions with healthcare practitioners. Those methods include narrative analysis, grounded theory analysis, and performance.

Narrative Analysis

The first piece of data that commanded my attention was the autoethnographic story, a text that called for narrative analysis. This task required me to function reflexively as analyst of my own story, a position that provided me with an opportunity to examine my own assumptions and interrogate the meanings I attached to being an overweight person, particularly in relationship to the medical system. My approach to that analysis was to investigate the story as a "presentation of the self" (Linde, 1993, p. 81) and to expand that view to understand my narrator's perspective in making sense of the behaviors of practitioners in medical encounters. The story I generated and the analysis I performed are contained in Chapter III.

The analysis of my autoethnographic story was important to this project in significant ways. First, it provided me with the opportunity to hear and understand my own thoughts and to explore the assumptions and beliefs that underlie them. However, there was also a practical use of the analysis, as it helped me to formulate my research questions in order to explore the experiences of other OW/O women. I will discuss more about this process in the "Procedures" section of this chapter.

I also used a narrative approach as one of the lenses through which I analyzed my interviews. In writing about the interview process, Holstein and Gubrium (1995) note

that it is essential to realize that the people we interview "are not so much repositories of knowledge—treasuries of information awaiting excavation—as they are constructors of knowledge in collaboration with interviewers" (p. 4). Although the interview process is a collaborative one, Mishler (1986) argues that "the interviewee-interviewer relationship is marked by a striking asymmetry of power" (p. 117). Mishler advocates empowering respondents by opening up the interview in ways that elicit narratives from them, asserting:

> Through their narratives people may be moved beyond the text to the possibilities of action. That is, to be empowered is not only to speak in one's own voice and to tell one's own story, but to apply the understanding arrived at to action in accord with one's own interests. (p. 119)

Although my primary purpose in choosing to use interviews was to acquire information that would be used as data for my study, I was also hopeful that at least some of my respondents would find that the interview process helped them to reflect on their experiences in ways that would benefit them. For that reason, I kept in mind Mishler's observation about the potential for narrative to empower respondents, and I included questions in my interview schedule that were intended to encourage narratives to emerge.

One question that I almost always asked my informants was "Tell me a little about your history with weight." (This question was not asked in instances where the respondent had already begun to chronicle weight issues in response to another question, but in most cases the question was explicitly asked.) Other questions invited participants

to recount episodes: “Tell me about a time when . . .” As a result, stories did emerge. However, I also found that the interviews taken as a whole could be viewed as presenting a kind of story arc; episodes might not have been recalled in chronological order, for example, but the way respondents worked to present themselves and others did have elements that produced a story which, when pieced together, could be seen as having a certain unity.

For my analysis of the interviews, then, I decided to explore story types that were represented in the interview texts. I used a theoretical framework posited by Arthur W. Frank in his highly-regarded book *The Wounded Storyteller* (1995). In this book, Frank identifies three primary types found in illness stories. In my analysis, I worked to locate my respondents’ interviews within Frank’s typology. I found it to be both useful and illuminating. However, I also learned that the story arcs in my interviews did not all find a home in Frank’s framework, which focuses on the experience of acute and life-threatening illnesses. Therefore, I have proposed an extension of his typology that might be useful in studying the stories of people whose physical conditions are not acute but are, instead, chronic in nature. The result of the narrative analysis of my interviews is found in Chapter IV.

Grounded Theory Analysis

The second of the analytical methods I chose to use is grounded theory. I was interested in discovering commonalities among my respondents, not only in the encounters they had in medical settings, but also in their ideas about how they experience being overweight or obese. Grounded theory (Glaser & Strauss, 1967;

Glaser, 1998; Strauss & Corbin, 1990) is an inductive method that begins with the collection of data. The researcher looks at the initial data, interrogating it to determine, as Glaser and Strauss (1967) say, “What is this data a study of?” (as cited by Charmaz, 2006, p. 47). The tentative answers to that question are the basis for creating initial or “open” codes. As research progresses and more data are gathered, a process of “constant comparison” ensues, whereby data is compared to data, and codes are compared to codes. Eventually coding becomes more “focused,” meaning that “the most significant and/or frequent earlier codes” are used to make “decisions about which initial codes make the most analytic sense to categorize your data incisively and completely” (Charmaz, 2006, p. 57). The grounded theory researcher then moves to “axial coding” in which categories are examined and subcategories developed. Charmaz (2006) asserts that axial coding is a “strategy for bringing data back together again in a coherent whole” (p. 60). Eventually the researcher will refine categories to such a degree that they may be interpreted as theoretical constructions.

In recent years, critique of the grounded theory method has focused on what is viewed as essentially objectivist assumptions and procedures in the way grounded theory is traditionally engaged. Charmaz (2006), who was a student of Glaser and Strauss, traces the evolution of the grounded theory method, including the ways in which Glaser and Strauss eventually diverged in their approaches. She notes that while the method was originally developed as an alternative to positivistic quantitative approaches, “Ironically, by 1990 grounded theory not only became known for its rigor and usefulness, but also for *its* positivistic assumptions” (Charmaz, 2006, p. 9). She prefers a

more “constructivist” approach that eschews the notion “that we can gather our data unfettered by bias or biography” (Charmaz, 2000, p. 522), and she rejects the idea that findings can be regarded as evidence pointing to *T*he *T*ruth. Instead, she says, “we can claim only to have interpreted *a* reality, as we understood both our own experience and our subjects’ portrayals of theirs” (Charmaz, 2000, p. 523). Charmaz’s approach (2006) maintains the rigor of the traditional practice of grounded theory while highlighting a more interpretivist perspective. As I worked though my interviews and proceeded through stages of coding, I consciously thought of Charmaz’s conception of the grounded theory method, recognizing that my findings were only partial understandings but that, when taken as one facet of the crystallized approach, they could be useful. The results of my grounded theory analysis are contained in Chapters V and VI.

Performance

In Chapter VIII, I present a performance script that serves as a synthesis of much of the work done in this study. Performance has always been important in the discipline of communication, from its roots as an essential aspect of effective oratory, though the oral interpretation of literature, to the development of performance studies as an area of academic interest in recent years. Conquergood (2002) argues for the validity of performance as a means of scholarly enterprise when he asserts that there are three ways in which performance functions:

> We can think of performance (1) as a work of *imagination*, as an object of study; (2) as a pragmatics of *inquiry* (both as model and method), as an optic and

> operation of research; (3) as a tactic of *intervention*, an alternative space of struggle. (p. 152)

In my view, Conquergood's conception of the uses of performance provides a rationale for its inclusion as a methodology for my work.

In the context of my project, the value of creating a performance piece as an *imaginative* work is bolstered by the recognition that the object of my study is bodies—specifically large bodies and the women embodied within them—and the effects of that embodiment on their identities and their relationships with the social world. Performance is quite clearly an act of embodiment. As Langellier (1999) notes, the performance of personal narrative "is situated, embodied, and material—stories of the body told through the body which make cultural conflict concrete and accessible" (p. 129). Albright (1997) observes that "in performance . . . the audience is forced to deal directly with the history of that body in conjunction with the history of their own bodies" (p. 121). A text that is performed, then, can be a way to engage an audience, not only for the purpose of creating a pleasurable aesthetic experience, but also for the purpose of co-constructing meaning. "The audience is there with the performer, and the performer is present bodily and in dialogue with the audience" (Ellis, 2004, p. 208). The audience is also provided an opportunity to "enter beyond the self and reach respectfully into another's world" (Madison & Hamera, 2006, p. xv).

Conquergood's assertion that performance can also be seen as both a model and method of *inquiry* is further reinforcement of the value of this process. The development of the script for a performance piece required me to further interrogate my data,

reexamining certain elements within each interview that had the potential to be both aesthetically and intellectually stimulating. Denzin (2000) points out that performance can function to elucidate cultural practices, noting that texts, "when performed or read, become symbolic representations of what the culture and the person values. In their performances, performers embody these values" (p. 906). Madison (1999) concurs with Conquergood's conception of performance functioning as an "optic" when she suggests:

> We see the familiar for the very first time, and after that we can no longer speak or reason about what we thought we knew in the exact same way, lest we forget the performance. . . . Performance helps me see. It illumines like a good theory. It orders the world and it lets the world loose. (p. 108)

The development of a performance script can also encourage the researcher/author to think in different ways about taken-for-granted assumptions, especially those that shape theoretical interpretations about the meanings of the actions of other human beings.

Finally, as Conquergood's words suggest, performance can function as a mechanism for *intervention* in order to facilitate change. It is one of my objectives for my study to encourage a reexamination of cultural attitudes and practices that serve to suppress the development of positive self-identity among OW/O women and, as a result, inhibit their agency in seeking humane healthcare. To do this, I must first find avenues for the dissemination of my research findings. Performance opens a space for awareness among people who are unlikely to ever read an article in a scholarly journal. As Gergen and Gergen (2000) affirm, performance "expands the range of communities in which the work can stimulate dialogue" (p. 1029). Viewing a performance elicits a different

response than reading an essay because, as Ellis (2004) believes, “Performance is immediate, passionate and emotional, and evokes empathy” (p. 208). Ellingson (2009) builds on Ellis’ assertion when she insists, “At its best, art engages our hearts and minds, sparking compassion and inspiring people to change themselves, their communities, and the world” (p. 62). In performance, human actions are “re-presented, re-located and re-materialized for the possibility of a substantial re-consideration and re-examination” (Madison & Hamera, 2006, p. xix). Langellier (1999) holds that the capacity for performance to reach broader audiences in ways that foster a reconsideration of cultural practices is why “performance is especially crucial to those communities left out of the privilege of dominant culture, those bodies without voice in the political sense” (p. 129).

To this point in this chapter, I have followed a discussion of my metatheoretical commitments with a presentation of the methods I chose for collecting and analyzing my data. For the remainder of this chapter, I will outline the specific procedures I used in preparing for my interviews and in recruiting participants. Then I will summarize the demographics of my sample, providing an overview of several characteristics of my informants.

Procedures for Data Collection

Since the impetus for this study was provided by the generation of my autoethnographic narrative and subsequent analysis, I began to prepare for my interviews by identifying salient themes in my own narrative. From those themes, I

developed a number of questions that I would ask my respondents, seeking to determine if there might be commonalities among our experiences.

First, I formulated the central research question and the three sets of sub-questions that I am seeking to answer in this study. The central question arose from my curiosity about the extent to which my experience might be similar to the experiences of other OW/O women, so I wanted to know: *How is an OW/O woman's weight implicated in her self-identity, how does she make sense of the experience of being overweight, and what role does her identity and her understanding of her weight play in her health-seeking behaviors and in interactions with physicians and other health professionals?*

Since one of the most salient issues raised in my analysis of my story was the way I presented myself, my first set of sub-questions was formulated to address the matter of self-identity: *How does their weight affect the development of self-identity in OW/O women, especially with respect to their views of their body and its relationship with their sense of "self"? How has the OW/O woman's view of her body influenced her sense of self in relationship with others?* These questions became the focus of Chapter IV, and I explored them through the use of narrative analysis.

Tied into an OW/O woman's identity is how she makes sense of her weight. For that reason, I have posed a second set of sub-questions: *What are the factors that OW/O women believe to have contributed to their weight problems? What are their perceptions about how being overweight impacts their lives?* I addressed these questions using grounded thematic analysis in Chapter V.

Because of the way I presented the actions of the clinicians in my story, I was also concerned to learn about the perceptions of other OW/O women about their own past medical encounters, and so I wondered: *In what ways have their experiences in medical consultations been beneficial or detrimental in promoting positive health outcomes? What recommendations would OW/O women make to improve medical encounters and practitioner communication with OW/O women?* This, then, is my third set of sub-questions, the subject matter of Chapter VI.

The major research questions provided the broad outline of the specific questions that would be included in my interview schedule. I worked to develop other questions that were not necessarily implicated in my narrative but might serve to elicit insights and experiences of my respondents that extend beyond mine. As my data collection progressed and I employed the grounded theory method, I refined my research questions to reflect concepts and categories that seemed to be emerging. My refined interview schedule appears in Appendix A.

I turned my attention then to the problem of recruiting participants. I began by contacting the owners of the exercise facility that I have used for several years. This facility is part of a national chain of exercise studios that cater to women only, attracting members from all age groups, though my own informal observation suggests that the majority of members at the location I attend are aged 40 and above. I presented my study to the owners and asked if I might be able to place flyers at various locations in the facility that would briefly explain the nature of the study and provide a means by which

interested persons could contact me. They graciously agreed, and eight women responded and were interviewed. The recruitment flyer is found in Appendix B.

I also hoped to enlist participants from other organizations. I contacted a major internationally-known commercial weight-loss program, beginning by making personal contact with a leader of a local "class" and proceeding to communicate via telephone and email with executives at the international headquarters. I was denied permission to recruit from their membership due to what they perceived to be a conflict with their policies related to confidentiality. I supplied copies of my consent form and the approval letter from the Institutional Review Board, but these documents were not persuasive. I had similar experiences when I approached two other nonprofit organizations, both well-known for establishing support groups for overweight women. Again, I started at the local level and proceeded to communicate with regional and national coordinators and directors. The concerns were the same and the results were the same.

My next recruitment approach was to employ the snowball technique. I was very fortunate that several of my respondents had friends to whom they referred me. In addition, I had many social occasions in which a discussion of my work generated considerable interest from colleagues, friends and acquaintances—in some cases people I had just met for the first time—and offers to put me in contact with people they knew. I found this method to be very effective; fifteen of my twenty-three informants were referred to me by other respondents or through my professional and social contacts.

Interviews were conducted in a variety of settings, often in the respondent's home. Those homes ranged from a cozy stationary mobile home in a decidedly blue-

collar neighborhood to a large and comfortably decorated home in a well-established and prestigious neighborhood in a large city. Other interviews were conducted in respondents' offices or in rooms at their places of business, in the classroom of the exercise facility from which several respondents were enlisted, and in a hotel room where the participant and I were attending a professional meeting. Two interviews were conducted in my office and seven in my home.

The duration of the interviews ranged from just under an hour to nearly two hours, though the latter was an anomaly. Most interviews averaged less than one hour and fifteen minutes for a total of over 27 hours of recorded conversation. The interviews generated 926 pages of typed double-spaced pages, ranging from almost 24 pages to 63 pages in length. The consent form, approved by the Institutional Review Board, stated that the respondent was being asked to allow me to audiotape-record the interview and that it was, in fact, a requirement of participation in order to insure accuracy in reporting their responses; none of the participants expressed concern, either verbally or nonverbally, about being tape recorded. The transcriptions of the interviews were prepared by two women, both highly experienced legal secretaries who are trained in the necessity of confidentiality in all their work.

Initially I had been concerned about socioeconomic and ethnic diversity in my interview pool. This, however, did not prove to be the problem I had expected it to be. Although the exercise facility from which I recruited is located in a suburban area, the people who are members there are more socioeconomically diverse than I had realized. I had not considered that the membership fee at this facility is quite inexpensive when

compared to the other gyms in our area (for many of the long-time members less than $29 per month), and I learned by being invited to conduct the interviews in their homes that many of the members live in very modest circumstances. In addition, people I met through the snowball strategy added to diversity in both socioeconomic and ethnic characteristics.

By the end of my study, I had interviewed twenty-three women, ranging in age from 21-70. Of these, fifteen are Caucasian, four are Hispanic, and four are African-American. Most were employed at the time of the interview; three were retired and one was unemployed due to a serious health issue. Several of my participants were teachers, representing all levels of education from pre-school to graduate school. Others were involved in sales, some in clerical occupations, and one was a housekeeper. In terms of level of education attained, three had completed high-school with some additional training in a trade or special interest, three were currently in college, seventeen had completed a college degree ranging from Associate's (2), Bachelor's (9), and Master's (5, plus one nearing completion) degrees, and one woman had a Ph.D. One woman had been working on her Bachelor's degree but had not been able to complete it due to her husband's and her own illnesses.

Eleven identified themselves as married, a few having also been previously divorced. Three were living with a partner and four were divorced at the time of the interview. Seven were never-married singles (including one who was living with a partner in a committed relationship). Fifteen were parents, with children ranging from toddlers to adults-with-children of their own, and a few were great-grandmothers.

In response to questions about their health status, respondents reported that they considered themselves to have been overweight for as few as four years of their life to as long as their "whole life" or "as long as I can remember." All except one considered themselves to be overweight at the time of the interview. They recalled that at their heaviest they would have needed to lose anywhere from 20 to 170+ pounds to be at what they considered to be a normal weight for them. Many commented that they were at their heaviest at the time of the interview.

Many of my respondents reported that they had been diagnosed with a health problem for which they had been told that their weight was a contributing or complicating factor. Those conditions included diabetes, high blood pressure, high cholesterol, joint and orthopedic problems, sleep apnea, and a number of gynecological problems. However, eighteen regarded their overall health status to be generally good (ranging from "okay" and "decent" to "great or "fabulous!" Almost all of the participants had attempted to lose weight on multiple occasions. They identified a variety of means they had used, including pills, commercial weight-loss programs, diets promoted in books, weight-loss programs conducted by wellness clinics, exercise programs, "fad" diets, and "just watching what I eat." Only one respondent claimed never to have made a serious effort to lose weight. Five of the women had undergone some type of bariatric surgery, including three gastric bypasses and two gastric banding procedures. Two were in the process of planning for surgery, and several admitted to thinking about the possibility.

Table 1 summarizes five categories of demographic information, three of which (age, ethnicity, and education) are typically of interest in research reports, and two of which (number of years overweight and number of pounds over desired weight at heaviest) are of specific interest to this study. The other demographic information discussed above is difficult to capture in table form. However, in Appendix C, I have provided brief profiles of each of my respondents and, where germane, some of those details are included there. The profiles are designed to give the reader a sense of who these women are beyond the numbers attached to categories of age, ethnicity and weight contained in a table. They are located as the last appendix to make it easier for the reader to refer to this information, if desired, when reading the chapters to come.

In this chapter I have discussed the methodology I used in accomplishing this study. I outlined the metatheoretical commitments that provide the foundation for the approaches I elected to use. I presented the two methods of data collection I employed, and I explained the decision I made to use multiple genres of analysis and representation of my data. I described the procedures I utilized in the collection of my data and in preparing it for my use, and I summarized some of the demographic characteristics of my respondents. In the next chapters I will present the results of my efforts, beginning with my autoethnographic story and my analysis of it. I will then move to chapters related to narrative analysis of the interview texts, grounded theory analysis, and a chapter that draws conclusions and makes recommendations for the use of the material in this study by the various audiences for whom it is intended. Finally, I will present a performance script that synthesizes the work done in this study.

Table 1 Participant Demographics

Name	Age	Ethnicity	Education (highest level completed)	How long OW	Pounds OW (at heaviest)
Angel	52	Caucasian	12th grade + trade school	30 years	170 +
Ann	57	Caucasian	Bachelor's Degree	44 years	100
AnnaMarie	41	African-American	Master's Degree	"all my life"	70
Charlotte	56	Caucasian	Bachelor's Degree	"90% of my life"	110
Diana	42	Hispanic	Master's Degree	"all my life"	90 +
Gabby	50	Caucasian	Bachelor's Degree	25 years	44
GiGi	55	Caucasian	Master's Degree	"my entire life"	170
Grace	43	Caucasian	Senior in college	16 years	100
Lisa	41	African-American	Bachelor's Degree	15 years	40-60
Mae	56	Caucasian	Senior in college	"my entire life"	60
Maggie	58	Caucasian	Bachelor's Degree	10 + years	20
Marianne	56	Caucasian	Bachelor's Degree	25-30 years	100 +
Mary Frances	64	Caucasian	Ph.D.	30 + years	140
Mary Lou	70	Caucasian	Bachelor's Degree	15 years	35
Megan	38	Hispanic	Associate's Degree	16 years	80
Naomi	51	Caucasian	12th grade + continuing education	"always"	40
Raquel	39	Hispanic	Master's in progress	"90% of my life"	70
Ruth	52	Caucasian	Associate's Degree	"most of my life"	150
Sasha	49	African-American	Bachelor's Degree	20 years	50
Sherry	55	Caucasian	12th grade + trade school	"last 4 years"	30
Susan	52	Caucasian	Master's Degree	"last 6 years"	60
Vanessa	21	Hispanic	Junior in college	9-10 years	100
Victoria	30	African-American	Master's Degree	"at least 16 years"	130

CHAPTER III

AN AUTOETHNOGRAPHIC EXPLORATION

I have a genuine respect for quantitative research. I like reading studies about matters that interest me in which *t*ruth is found using detached methods and then reported in tidy statistics. It is reassuring to know that correlations do or do not exist, have or have not been found. Quantitative research almost invariably leads me to new and interesting questions. And for me, it is qualitative research that often gets at answers to those questions, providing a space for studying what has been termed the "lived experience" (Schutz, 1967; Van Maanen, 1990) behind the statistics.

Narrative studies are of particular interest to me, especially since some of the finest exemplars of the application of narrative methods are found in work related to health communication. Books by Adelman and Frey (1997), Brody (1987), Charon and Montello (2002), Fadiman (1997), Frank (1995), Geist-Martin, Ray and Sharf (2002), Harter, Japp, and Beck (2005), Kleinman (1988) and Vanderford and Smith (1996), as well as numerous journal articles (Cahill & Eggleston, 1995; Charmaz, 1994; Charmaz, 1999; Sharf, 1990; Sharf, 2001; Vanderford, Jenks, & Sharf, 1997, among many others) have allowed me to see how people enact their identities in the stories they tell, how people narrate to make sense of disruptions in their life caused by sudden or chronic illness, and the potential for empowerment that is inherent in the act of an individual (re)presenting their experience through narrative discourse.

Moreover, I have seen that narrative plays a crucial role within healthcare beyond the patient. Steiner (2005) demonstrates that narratives are useful to those in clinical practice, in medical research, and in healthcare policy, and he asserts, “None of these disciplines can do without stories, and none should underestimate their value” (p. 2903). The use of narrative contributes, as well, to better understanding of the relationships between the elderly or the ill and their caregivers (see Brannen & Petite, 2008; Dobbins, 2007; Miller, Shoemaker, Willyard, & Addison, 2008, for example).

My introduction to the notion of personal narrative as scholarship came relatively late in my life. For years I had accepted post-positivist methodology as the one correct way of doing research. It was challenging, though refreshing, to orient myself to another perspective on what “counts” as valid social science and to see that there are alternative pathways to knowing. Scholarship involving the narrative accounts of others was easier than other forms of qualitative research for me to accept; it is a little subversive, but it still feels like scholarly research because it retains some (though certainly not total) separation of the subject from the investigator. But autoethnography? That seemed to be pushing the quantitative-qualitative continuum a little too far. Paul Atkinson’s (1997) concerns about the “misuse” of narrative when it “transcends the realm of analytic methodology and becomes a surrogate form of liberal humanism and a romantic celebration of the individual subject” (p. 335) seemed to me to be worthy of concern, as was his warning that the “danger of substituting a psychotherapeutic for a sociological view of the person” (p. 342) is even greater when working with personal narratives and

autoethnographies. I was concerned about the potential for self-indulgence on the part of the researcher, as well as the seeming voyeurism on the part of the reader.

It wasn't at all difficult, however, for me to recognize the benefits of autoethnography to the writer. Clearly the process of writing a personal narrative demands a certain reflexivity, the value of which is reinforced when Bruner (1990) refers to it as "our capacity to turn around on the past and alter the present in its light, or to alter the past in the light of the present" (p.109). Reading Ellis' (1995) remarkably revealing account of her complex relationship with her mentor/husband, culminating in her role as caregiver at the end of his life, clearly illustrated to me the use of autoethnography as sense-making. It also didn't take too much imagination to see how reading another's autoethnographic work could be useful to a reader. As Schutz (1967) observed, "When I become aware of a segment of your lived experience, I arrange what I see within my own meaning-context" (p. 106). I take this to mean that my reading of another's personal narrative allows me to gain insight into my own meaning-making processes, which strikes me as a worthy objective.

I still struggled, however, with whether this form of study truly accomplishes the goals of social science scholarship. Ultimately, I found answers to this question in several places. The first was in reading Ellis and Bochner's (2000) chapter in the *Handbook of Qualitative Research*. They identify the goal of personal narrative as a means "to encourage compassion and promote dialogue" (p. 748), and they assert their commitment "to introduce personal ethnography into the practical contexts of everyday life, to people whose work would be enhanced by it, like doctors, nurses, social workers,

administrators, and teachers" (p. 760) It struck me that Ellis' (1995) book certainly did have the potential to illumine social processes in a way that could contribute to understanding. The second affirmation of the validity of approaching research from the standpoint of the researcher came to me in David Rosen's idea (discussed in Chapter I) that "research is me-search." This notion seems to be saying that no research is truly value-free, that the researcher's perspective is always implicated in some way, and that it is appropriate to recognize and account for the researcher's position in any scholarly enterprise. Whether or not Professor Rosen would endorse the foregrounding of the researcher's experience as it is accomplished in autoethnography, I find myself drawn to the honesty of an approach that makes no pretense whatsoever of attempting to obliterate the presence of the researcher engaged in the investigation of phenomena in the social world. Then, too, Ellis and Bochner (2000) point out that sometimes reflexive ethnography is used as a starting point for a research project (p. 740).

I was also influenced by Dorothy Smith's important essay (Smith, 1979) discussing the "standpoint" approach to feminist research. Smith points out the importance of viewing research as inquiry into "problematics," in which attention is directed to a possible set of questions about phenomena which may, on the surface, seem mundane or obvious, but, below the surface, are more complex than supposed. She proposes that such inquiry "can begin from the position of any member of the society, explicating the problematic of her/his experience as a sociological problematic" (p. 183). The notion that the experience of one individual may have relevance beyond the particular case is further reinforced in *Women's Ways of Knowing* (Belenky, Clinchy,

Goldberger, & Tarule, 1997) with the authors' insistence that subjective knowledge—"the inner expert"—is "the hallmark of women's emergent sense of self and sense of agency and control" (p. 68). Further, they affirm the value of researching "inductively, opening our ears to the voices and perspectives of women so that we might begin to hear the unheard and unimagined" (p. 11).

And so I wondered: What unimagined truths might my previously unheard story/stories reveal? I wanted to *hear* my story, unalloyed by any editing that writing the tale might allow. Perhaps an analysis of my story would enable me to answer some of my questions, draw some conclusions, and find their implications.

I decided to approach the task of generating my story as if I were interviewing any other informant from whom I hoped to elicit a narrative. This methodology, which I have termed "autoethnographic interviewing," requires me to enact the roles of both interviewer and interviewee. As the interviewer, I provide some structure to the "conversation" by the phrasing of my question. As the interviewee, my response to the question allows me to access thoughts that had previously resided in a realm of amorphous unarticulated experience. I decided to audiotape my interview to allow me, in my third role as researcher/analyst, to examine the story thoughtfully.

So, I asked myself this question to elicit my narrative: "Can you tell me about a medical encounter in which weight became an issue that affected how you experienced that encounter?" The following is my transcription of my story.[1]

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[1] Idiosyncratic punctuation in the transcription is used to provide the reader with a sense of pauses and emphasis. No attempt is made to conform to conventions of any formal notation system of discourse analysis.

Performing Narrative

-I , suppose , , I suspect I could , think of *several* , but one that stands out in my mind , was about , mmm , perhaps , spring of , maybe 1995? Somewhere around there. And I *realized* that I had been *procrastinating* , in getting a well-woman check,[2] for *several* years. I don't know how long it had been since I'd had one , *several* years. And we had , uh , had a , *change* in our *insurance* coverage , at work so , I had to find a new ob-gyn. And I'd been thinking for some time that it might be , something that I would *like* , to have a , *female* ob-gyn. I'm not exactly sure , why I thought that would be , an *improvement*. I think I , was *expecting* that perhaps a *woman* , would understand a *professional* woman , and the *stresses* and , *challenges* of *being* a professional woman and , balancing family and *career* and all that sort of thing. And somehow that seemed important to me that my doctor be someone who could empathize with those kinds of issues. So I got a referral to a , *woman* , *ob-gyn* , from my general practitioner , and she was , *very* highly regarded by the medical community in our city , and by other patients that I talked to later.

And I was *really excited*. I was looking forward to the appointment , I was feeling good about *finally* getting this done and , feeling good about having a *new* doctor and , and thinking that maybe there would be some *change* that would , *happen* , you know after I talked to her that I would somehow get some sort of help that I needed.

[2] "Well-woman check" is a term that is commonly used to refer to a woman's annual gynecological exam.

So I went to the appointment and , of course *first* the nurse comes in and takes your history and does your blood pressure and all of that sort of preliminary thing. And when she was taking my blood pressure she came up with a higher *reading* than , was *typical* for me. And I was *kind of surprised* by that so she took it another time or two and then , the *whole* time she was , *acting very frustrated* , kind of , "hhhh" , making little , *sounds* , that made me think that she was really kind of , *distressed*. And she left the room for a few minutes and then she came back and she said, "Well, we're just going to have to go with the reading that we've got , because , I *can't* find the blood pressure cuff that we have , we don't use it very often so I'm not sure where it is , but it's , *especially* designed for , *large* women. So I think maybe the reading is because this blood pressure cuff that we're using for you is really , *too small* , and *maybe* it's because you're nervous since you haven't seen a doctor in some time."

And I remember thinking , , , that I felt like a *freak*. , Uh , and ah I was I was *heavy* , there's no question about *that*. But I had never felt *freakishly* heavy. But I did at that moment. (spoken in mock awe) *I was so big , that a normal blood pressure cuff would not fit around my arm*.

So then the doctor came into the room and she was performing the exam. And , the whole time she was performing it she was , kind of , , hh , I don't know how to describe it. She wasn't *rude*. But , there came a *point* during the exam where , I had the *sense* from the kind of *sounds* she was making , the kind of sounds that people make when they're , *doing* something *physical* that requires a lot of *effort* so , they have these little kind of , "unhhh, unhhh," , little *exhaled breath* , that you do when you're , exerting

a lot of effort on something? And then she said , "I'm *afraid* I'm not going to be able to do a very good exam on *you* , because it's very difficult to palpate *fat*."

, , , And I remember when she said that, that I felt (spoken in intense whisper) ***so terribly sorry*** , that I was putting her *through* that. I *realized* , that *touching* me , was *disgusting* to her. I felt like , , I was , an *unpleasant* , *object* that she had to *deal* with. And that she was *doing her best* to be (voice quavers) nice about it but , *really deep down* she was just *terribly disgusted* to have to be touching me. , , And I don't really know that it was anything that , she *did*. I-I-I couldn't even say that I think , *now* , that she necessarily *was*. But that's how I felt at the time. I felt like she was *disgusted* with me. Or not disgusted with *me* but *disgusted* , with having to *touch* me.

So , , , (sigh) the next time I had a well-woman check , was , five years later in the summer of 2000. Uhm. My general practitioner's *nurse practitioner* did my well-woman check , and *she was very good*. *But* it came back with a *suspicious* result on my Pap smear. So I had to take some medication for several months and then go back for a *follow-up* Pap smear, and *this* time I had to have *another* doctor because of insurance carrier issues. And I *really* couldn't stand *him*. And I had a *very definite* impression when I left his office that *he* was very worried. There were things that he said and things that he *didn't* say that made it *sound* like he was , *very* deeply concerned.

So for *several* weeks while I waited for the results of that Pap smear , that *follow-up* Pap smear , I remember thinking , , "It's my *own* fault. I didn't get a well-woman check for ***so*** many years , and if this Pap smear comes back bad , it's my *own fault* ,

because I didn't go to the doctor." But then I thought , , , "It's so *hard* to go to the doctor. Because you feel like you're so , , *disgusting*."

But the Pap smear came back okay.

Performing Analysis

In *The Call of Stories*, Robert Coles (1989) describes his growing awareness during his medical school residency that a patient's story becomes a "text" that, along with the formal abstractions that are part of the technical practice of medicine, is significant because it enables the physician to "understand the palpable pain and suffering of another human being" (p. 8). The narrative featured here is not a story told *to* a physician, but the story *about* a physician that is embedded in the narrative seems to me to be capable of that same sort of enlightenment. This narrative, however, is also about a patient, and its potential to illumine the motives of that patient is another concern of this study. It is to that concern that I now turn.

I occupy an unusual position relative to this narrative. It is a position that offers the opportunity for—indeed, demands—reflexivity. Linde (1993) defines reflexivity as "the ability to relate to oneself externally, as an object or as an other" (p. 120). She goes on to note that a certain amount of reflexivity is inherent in narrative because a narrative "creates a split between the narrator and the protagonist. It allows the narrator to stand apart from and comment on the actions of the protagonist" (p.123). In this case, however, I am not only the protagonist and the narrator; I am also the analyst. Lindlof (1995) advocates separation of ethnographic narrative and analysis because such a

strategy “provides the reader with two perspectives: one that experiences through the eyes (and other senses) of the author, and one that tries to critique through the disciplinary knowledge of the author” (p. 261). The narrative under examination is autoethnographic. Moreover, it recounts an obviously painful memory. It seems reasonable—perhaps even necessary—to achieve some degree of emotional distance if I am to analyze my own story with rigor and a fresh perspective. It would be difficult to challenge my own perceptions without some detachment. To some extent, the methodology I used to generate my narrative may have encouraged some distancing, but it seems clear to me that my examination of the resulting text must move me yet another step away. To that end, my analysis of the narrative will adopt the third person omniscient perspective.

The transcription of the narrative, as has been noted, includes indicators of the use of pauses, emphasis, and other paralinguistic features of the oral narration. The value of capturing such moments within a transcription has been affirmed by Riessman (1993) and Linde (1993). The evaluative elements of a narrative, in which the narrator conveys her/his assessments of the characters and events being described as well as the response s/he desires from the listener, are, according to Linde, “socially the most important part of the narrative” (p. 72). While evaluation is often revealed directly within the language of the text, Linde asserts that paralinguistic aspects of the performed narrative are important to note because they are a significant means by which narrators accomplish evaluation (p. 72). For that reason, my analysis relies heavily, although not exclusively, on those paralinguistic acts that seem to provide keys to understanding meanings.

Analysis of the Text

Linde (1993) points out that narrative is always essentially "a presentation of the self" and that "the evaluative component in particular establishes the kind of self that is presented" (p.81). She asserts that "part of the hidden point of any narrative is to show that the narrator knows what the norms are and agrees with them" (p. 123), and that the narrator is always making a "claim" that s/he is "a good person, a proper person, a competent person" who "did what any good person or what any extraordinarily good person would do in this situation, or as much as a good person could do when blocked by extraordinarily difficult circumstances" (p. 81). Bloom (1996) posits that narrators use "simultaneous unconscious and conscious strategic representations of one's self" (p. 193) in the telling of their stories.

Presenting the Self Positively

The narrator of this story seems eager to present herself in a positive light. She refers to herself twice as a "*professional woman*," suggesting that this is her preferred identity. She refers to the medical examination at four points in the story as a "well-woman check." While this may be nothing more than a reflection of her familiarity with common medical parlance, there are other terms by which such medical procedures are referred, such as "pelvic exam" or "annual gynecologic screening." Her choice of terms suggests that she identifies with the population of "well" women, and she wants her listener to perceive her that way.

She paints herself as a person who has endured repeated disruptions in her insurance coverage that require her to change healthcare providers each time she seeks

her screening exam; but she accepts this, as she accepts the importance of the exams, her admitted procrastination notwithstanding. In fact, her recognition that she repeatedly delays in getting her check-ups indicates that she agrees with and respects the medical norms that make sacred the annual screening. She also wants her listener to know that, despite the fact that she has had to deal with constraints imposed by insurance coverage, she was "*really excited*" about the possibilities offered by being required to see a new doctor. In this way she presents herself as an optimistic person. She wants us to understand that she was not going into the medical encounter looking for some reason to be dissatisfied. Her hopefulness makes the pain she recounts later all the more difficult to bear.

Presenting the Topic of Weight

It is interesting to note that the narrator does not refer at all to her overweight status until she is deep into the story. Although the question she is responding to asks her to tell a story about a medical encounter where weight becomes an issue, there is no requirement implied in the question that the story should relate to being overweight or obese; a tale about a normal-weight person's distorted body image could just as easily result from the question. She alludes, but rather vaguely, to some "*change*" that she is hoping will "*happen*," and to "some sort of help" that she thinks she needs. She speaks of the "*stresses*" and "*challenges*" of "balancing family and *career* and all that sort of thing," but this could as easily imply that the help she needs might be with depression or insomnia or some other condition generally regarded as attributable to stress.

When she does acknowledge that she was "*heavy*," and admits that "there's no question about *that*," she chooses the euphemistic term rather than the term "*fat*" that only appears later in the story, and then in reference to the doctor's observation of her body composition rather than as a self-representation. Perhaps this strategy is used to accomplish one of the functions of evaluation posited by Labov and Waletzky (1997), to present the narrator in the most favorable light possible, or "self-aggrandizement" (p. 30). We have no way of knowing just how overweight the narrator is at the time of this medical encounter. Certainly her language attempts to minimize it, which may serve to make her portrayal of the doctor and, to some extent, the nurse even more unfavorable to the listener than their actions and words already warrant. Further, by avoiding any hint of concerns about being overweight until she is well into the story, she heightens the sense that she was an innocent actor, blind-sided by the apparent insensitivity of the practitioners' remarks.

Presenting the Self Negatively

The narrator, however, is willing to acknowledge some aspects of her self that are less than positive. She admits that she "*realized*" that she had been "*procrastinating*" in scheduling her screening exam, though, again, her self-definition as a "well" woman may function to blunt this self-criticism. She clearly implies that she has a problem of some sort, and it would seem that this problem is socio-emotional since she mentions the "*stresses*" and "*challenges*" rather than some acute physical ailment.

She presents herself as a victim in her references to her changing insurance carriers, but, as noted above, this ultimately can be seen as a strategy to portray herself

as someone who perseveres in the face of obstacles, nullifying the negativity inherent in presenting oneself as a victim. Perhaps the most interesting negative characterization of her self comes in the narrator's plaintive hope that "some *change* would , *happen* , you know after I talked to her that I would somehow get some sort of help that I needed." In this statement, the narrator suggests that she does not see herself as an agent of change; it is a portrayal of a person who hopes to remain passive, allowing change to be effected by something the physician can presumably do.

Presenting the Others

The other key agents in this narrative are the representatives of the world of medicine. The narrator initially presents the medical establishment in a negative light. She chooses a female ob-gyn because she "thought that would be , an *improvement*," which suggests that previous practitioners had failed her in some way. And yet, her faith in medicine seems secure; she has expectations that her new doctor will be someone who can "empathize" with her and give her the help she needs. She is impressed by the fact that her chosen physician was "*very* highly regarded by the medical community" and "by other patients." This last statement, however, may be part of the narrator's strategy to ask the listener to question whether any medical practitioner can be trusted when one that is so highly regarded can fail her patient in such an egregious manner as will be revealed later in the story.

As the story progresses, it is hard to find much to admire in the conduct of the medical personnel. The nurse practitioner introduced briefly at the end of the story is the only one who emerges as laudable, though why she is singled out for such positive

treatment ("*she was very good*") is not made clear. Even less clear is why the second doctor is denounced so thoroughly ("I *really* couldn't stand *him*") when he is described as conveying that he was "*very* deeply concerned" about the narrator's health. Perhaps the narrator felt that the concern was directed at her medical condition rather than to her as a person.

The picture we have of the first ob-gyn and her nurse, however, is of two medical professionals who, at the very least, lack sensitivity in their language choice. Perhaps the nurse's statements could be seen as making an attempt at sensitivity since she does use the euphemistic phrase "*large* women," though it is reasonable to wonder why she felt compelled to offer her explanation of the differences in the blood pressure cuffs in the first place. She may be acknowledging and trying to repair her indiscretion, however, when she offers an alternative explanation for the higher-than-expected blood pressure reading.

The narrator's performance of the text at this point is interesting. It is not possible to capture in the transcript all of the paralinguistic elements that emerge when listening to the tape recording of the narrative. The passage about the missing blood pressure cuff seems almost incidental to the story when it is read. However, the speaker's tempo and inflection in the recording reveal much more. The narrator's tempo as she remembers the nurse's statements achieves an almost throwaway quality, suggesting that the narrator recognizes that the alternative explanation is not really what the nurse believes to be the true explanation of the atypical blood pressure reading. At the same time, the inflection in the narrator's voice suggests irony, making it clear that

she perceives the nurse as blithely unaware of the effect her words might have on her patient. The narrator, however, clearly understands the effect, as is illustrated both by her inflection and by the next lines of her story. She interprets the nurse as saying that she was an aberration, one of the very few in their practice who would require a different cuff. This, of course, contributes to the narrator's final evaluation of herself as a "***freak***."

Perhaps the most striking feature of the narrative is the storyteller's treatment of the first ob-gyn. While the narrator seems to recognize the insensitivity of the nurse's comments, she is quite charitable toward the doctor. It is hard to deny the shocking effect of the doctor's statement, "I'm *afraid* I'm not going to be able to do a very good exam on *you*, because it's very difficult to palpate *fat*." Indeed, the narrator's pause at this point is one of the longest in the narrative, suggesting that she, too, appreciates how almost inconceivable it is that a doctor would ever say such a thing to a patient. And yet, the narrator repeatedly defends the doctor. "She wasn't ***rude***," the narrator insists, when the doctor's behaviors seem, at the very least, artless.

The narrator is keenly attuned to the nonverbal behaviors of her physician, particularly the sounds she makes as she performs the examination. It may be that the narrator is by nature inclined to be unusually conscious of nonverbal aspects of communication. It is also possible that her hyper-awareness is due to some insecurity that manifests itself in excessive concern for how others are responding to her. Whatever the underlying factors may be, it seems clear—if we are to believe that the narrator's account is reasonably accurate—that this physician is seriously deficient in her ability to monitor her own communication behaviors, both verbal and nonverbal. The narrator

claims that the doctor was "*doing her best* to be nice," and her voice quavers as she says this. But her most sincere expression of sympathy for the doctor occurs when, following the long pause after the doctor's statement about the difficulty of palpating fat, the narrator says, "And I remember when she said that, that I felt (spoken in intense whisper) ***so terribly sorry*** , that I was putting her *through* that." Indeed, this is the most heartfelt utterance in the entire narrative.

It is difficult to know what to make of the narrator's defense of the doctor. She tells us that the encounter was one that made her feel like she was "*disgusting*" to the doctor. It is possible that this perception was one that the narrator held about herself and brought with her to the examination, filtering her interpretations through that perception. The narrator even seems willing to amend her initial perceptions when she says, "I-I-I couldn't even say that I think , *now* , that she necessarily *was*." It is plausible, though, that the verbal and nonverbal behaviors of the doctor were significant moments that contributed to the formation—or at least reinforced—what Goffman (1963) terms a "spoiled identity." The narrator claims that she "felt like , , I was , an *unpleasant* , *object* that she had to *deal* with." This reflects a dehumanization of the patient—a sense that she felt regarded as a body rather than as a person. She uses a form of the word "disgust" six times in the story, suggesting that this is the dominant message that she internalized about herself and her physician's response to her. In the story that opens this paper, this same narrator admits to avoiding medical care because she is "fat," but at the end of the narrative featured in this chapter, the reason she gives is "because you feel like you're so , , *disgusting*." It seems clear that the two concepts are linked in her self-image.

One clue to the significance of the narrator's experience with the female ob-gyn to her perception that she is disgusting and to her subsequent choices in seeking health care can be found in a simple word: So. The word "so" is used five times in the story to emphasize the magnitude of some phenomenon (e.g., "so big," "so terribly sorry"); however, it is used nine times as a marker that justifies an action taken as a consequence of the preceding action. The most striking example of this is when the narrator says, "So , , , (sigh) the next time I had a well-woman check , was , five years later in the summer of 2000." She accepts responsibility for the potentially dire consequences of failing to get regular gynecologic screenings when she reports her anxiety while awaiting the results of a follow-up to a suspicious Pap smear: "It's my *own* fault. I didn't get a well-woman check for ***so*** many years, and if this Pap smear comes back bad , it's my *own fault* , because I didn't go to the doctor." But then she explains her reason: "It's so *hard* to go to the doctor. Because you feel like you're so, , *disgusting*." It is reasonable to infer that the experiences in the first ob-gyn's office were consequential to her subsequent delay in attending to her health.

We have no reason to assume that the purposes of the medical practitioners were anything other than to provide health care according to the accepted standards and protocols of their professions. The narrator's purposes, however, are both clearly stated and vague; we know she was seeking some sort of "help," but we do not know what she felt her specific needs were. We also do not know whether her objectives were met, as she does not report any of the conversation with the doctor beyond the performance of the physical examination. It is hard to imagine that the remainder of the appointment was

managed in silence. We might wonder if the doctor's remark about palpating fat was intended as an opening to discuss the advisability of weight loss; if it was, it certainly seems to have been, at best, a clumsy attempt. As far as can be determined from the story, the narrator did not choose to see this physician again. Her decision to have the nurse practitioner perform her next screening may have been because of yet another unmentioned change in insurance coverage. Or it may have been because of the treatment she received in the female ob-gyn's office. Certainly it is logical to assume that her goal after the painful experience recounted in this narrative is to find a way to maintain her health in a manner that is consistent with humane treatment. This assertion, of course, assumes that she believes she deserves such treatment.

Application of Analysis

As I had suspected, the reflexivity that Linde (1993) described as inherent in narrating one's own story was amplified by the process of then analyzing my own text. Certainly there were significant rewards in doing so. The insights gained were personally beneficial to me, allowing me to acquire a level of self-awareness that was not possible by merely reflecting on my experience. I was also surprised at the degree of emotional detachment I was able to achieve in relating to myself as an "other."

However, the purpose of presenting my personal narrative in the body of this work is not therapeutic. The reason it is included here is because it serves as a point of departure for my study of the processes at work when OW/O women make health

decisions and negotiate medical encounters. The analysis of my autoethnographic work suggests three key areas that seem to need further exploration.

One question that is raised by my analysis is the role of weight in shaping a woman's personal identity. Women enter medical encounters the same way they enter into any other interactions—with a body that presents their "self" to the social world. It seems pertinent, then, to understand how OW/O women see their selves in relationship to their bodies, and how that perception shapes how they see themselves in relationship with others.

A second question I see linked to the issue of identity is how OW/O women make sense of their weight. The attributions women make in explaining how their problems with overweight and obesity have developed, as well as their perceptions of how their lives are impacted by being overweight, may help us to understand more about how women view their health. The way an OW/O woman defines her health status may provide insights into the thought processes that lead to decisions about seeking healthcare in the first place. There may be, for example, differences in health-seeking behaviors between those women who see themselves as "well" though overweight and those women who regard their weight as an "illness" that requires medical intervention.

The third issue that seems to require investigation is how OW/O women have experienced medical encounters in the past, and whether those encounters have had beneficial or detrimental consequences to achieving desirable health outcomes. The analysis of my story does not portray all clinicians in a negative light. However, it does point to the possibility that experiences that reinforce already spoiled identities may have

the potential to discourage positive health behaviors. Furthermore, the extent to which an OW/O woman's self-image affects the way she interprets the verbal and nonverbal messages received from health practitioners may influence the way she exercises her agency in health matters. A woman who regards her body as "disgusting," for example, may be more sensitive to messages that suggest that her practitioner sees her the same way, which may reduce her expectations for empathic care and prevent her from asserting her right to such care. Identifying specific features of the medical encounter that play a role in undermining an OW/O woman's belief that she can achieve good health should serve to enlighten clinicians and promote an examination of medical practices.

By revealing these ideas, the analysis of my personal narrative sets the course for the remainder of this study. In the following three chapters, these and related issues will be explored through the presentation of the thoughts and experiences of some remarkably articulate and resilient women. Chapter IV will explore the issue of self-identity through the examination of my interviews using a theoretical framework for narrative analysis. In Chapter V, I will focus on the perceptions my respondents have about how being overweight or obese affects their lives. I will examine their thoughts about the factors that have led to their weight struggles as well as their motivations for continuing to try to lose weight despite the fact that almost all have experienced a disheartening lack of success in past efforts. In chapter VI, I will discuss my respondents' thoughts about how their weight has affected their experiences in medical

interactions and their ideas about how those encounters could be altered in ways that would be beneficial in encouraging positive health outcomes.

CHAPTER IV

STORYING WEIGHT: NARRATIVE ANALYSIS

"When you're fat . . . well, you're just not yourself."

This statement was made by Angel, one of the twenty-three women who graciously consented to participate in my study. It reflects a struggle described by almost all of the women I interviewed: the problem of reconciling her sense of who she is—her self-identity—with the reflection of the self she sees in her mirror.

From the symbolic interactionist perspective, the reading of one's "looking-glass self" (Cooley, 1922) is conditioned by three factors: "the imagination of our appearance to the other person; the imagination of his judgment of that appearance; and some sort of self-feeling, such as pride or mortification" (p. 184).

Waskul and Vannini (2006) point out that "when we gaze upon bodies of others we necessarily interpret what we observe" (p. 5). Similarly, when we gaze upon the reflection of our own bodies, we also make interpretations. When a person views her own body in a mirror, the body in the mirror obviously does not make judgments about the person; but the person/self is making judgments about the self based on judgments about the body in the mirror. As Charmaz and Rosenfeld (2006) note, "Just as the other may give primacy to our surface appearance as a marker of our essential value and standing, so might we" (p. 45).

Our bodies and our selves are reflexively related. The body is not merely a container of the organ systems that sustain life; it is a significant feature of the self that

we think about, and in thinking about it, we make judgments that alter or confirm our self-identity. Our selves, then, are embodied, and the only way the self can interact with the social world is through the body. It is not surprising, therefore, that the body itself is the site of so many of the judgments we make about others and about ourselves.

The body is a "vessel of meaning" (Waskul & Vannini, 2006, p. 3), and the meanings we derive from bodies are messages that are inscribed on that body by culture. Our culture tells us what body types are considered attractive and what body types are repugnant. The relationship between body and self-identity, therefore, is particularly relevant when exploring the lived experience of people whose bodies deviate from what is considered normative in a culture. Those people, by virtue of their deviance, are often stigmatized and must develop strategies for coping with their spoiled identities (Goffman, 1963). In contemporary Western culture, for example, although multitudes of people are dealing with disability or illness, the healthy and fit body is presumed to be the norm. Oddly, despite the statistics that tell us that nearly 70% of the American population is overweight and that half of those qualify as obese (Prevalence of Overweight, 2006), the thin body is presumed to be the norm.

Indeed, the slender body is "our contemporary aesthetic ideal for women, an ideal whose obsessive pursuit has become the central torment of many women's lives" (Bordo, 1993, p. 167). The word "torment" may seem hyperbolic to someone who has never lived as an overweight/obese (OW/O) person. However, the stories told to me by my respondents—along with my own experience—lead me to believe that the word is

well chosen. I would wager that, if asked, nearly all of my twenty-three respondents would concur.

My interviews generated a wealth of stories of varying lengths. My informants told stories of how their weight had affected their ability to develop or maintain relationships with others. Many stories were told to illustrate how their weight had altered their life choices. Other stories told of how their weight had affected their health, and I heard stories about how their feelings about their weight had influenced health-seeking behaviors. In short, their stories were accounts of how weight has had a profound effect on the choices in their lives—choices that can be viewed as reflections of their embodied selves.

As discussed in Chapter I, I have divided my central research question into three sets of sub-questions, the first of which is: *How does their weight affect the development of self-identity in OW/O women, especially with respect to their views of their body and its relationship with their sense of "self"? How has the OW/O woman's view of her body influenced her sense of self in relationship with others*? To answer these questions, I turn to my respondents' stories. Bruner (2002) notes that "selfhood rests upon a good story, a plot with Self as the agent that heads somewhere and gives continuity" (p. 7). Each of the stories I heard from my informants depicts emplotted agency, but the continuity of the respondent's stories is achieved within the interview as a whole. The interview, in my mind, is a meta-narrative that enables me to contextualize the briefer stories and story-fragments.

I have chosen to approach the task of analyzing my interviews *qua* narratives by placing them within a theoretical framework suggested by Arthur Frank (1995) in which he looks at narrative types. Although the interviews dealt with a number of topics beyond the specific concept of self-identity, I will focus this chapter on issues of identity. I will be looking at how each respondent has incorporated conceptions of her body into her self-identity and how that identity has been embodied in interactions with the social world, particularly the world of medicine.

In the next section, I will lay out those key ideas contained within Frank's framework that I find useful to the analysis of my informants' narratives. Following that, I will apply those ideas by illustrating how my informants' narratives fit within Frank's scheme. For each narrative type, I will focus on the story of one of my informants as an exemplar, and I will comment on salient aspects of the stories of other women who fall into that category. In the chapters that follow, I will use other methods of representation to answer the second and third parts of my research question and to explore the implications of my research. I will conclude with recommendations for how the totality of this project may inform the efforts of healthcare practitioners to find effective ways of assisting OW/O women to reach health goals.

Arthur Frank's *The Wounded Storyteller*

In his book *At the Will of the Body* (1991), Arthur Frank begins an exploration of the emotional and physical struggles of a person who is confronted with sudden and life-threatening illness by reflecting on his own experiences with heart attack and cancer. In

The Wounded Storyteller (1995), Frank continues that exploration, positing that people tell stories "to give voice to the body" (p. 3) and that listening to them, though often hard, is "a fundamental moral act" (p. 25). Frank then goes on to erect a framework of typologies, suggesting that illness stories can be conceptualized as adhering to three basic plotlines: Restitution, Chaos, and Quest. Frank acknowledges that "no actual telling conforms exclusively to any of the three narratives" (p. 76), but he asserts that the construction of such a schema may "encourage closer attention to the stories ill persons tell" (p. 76).

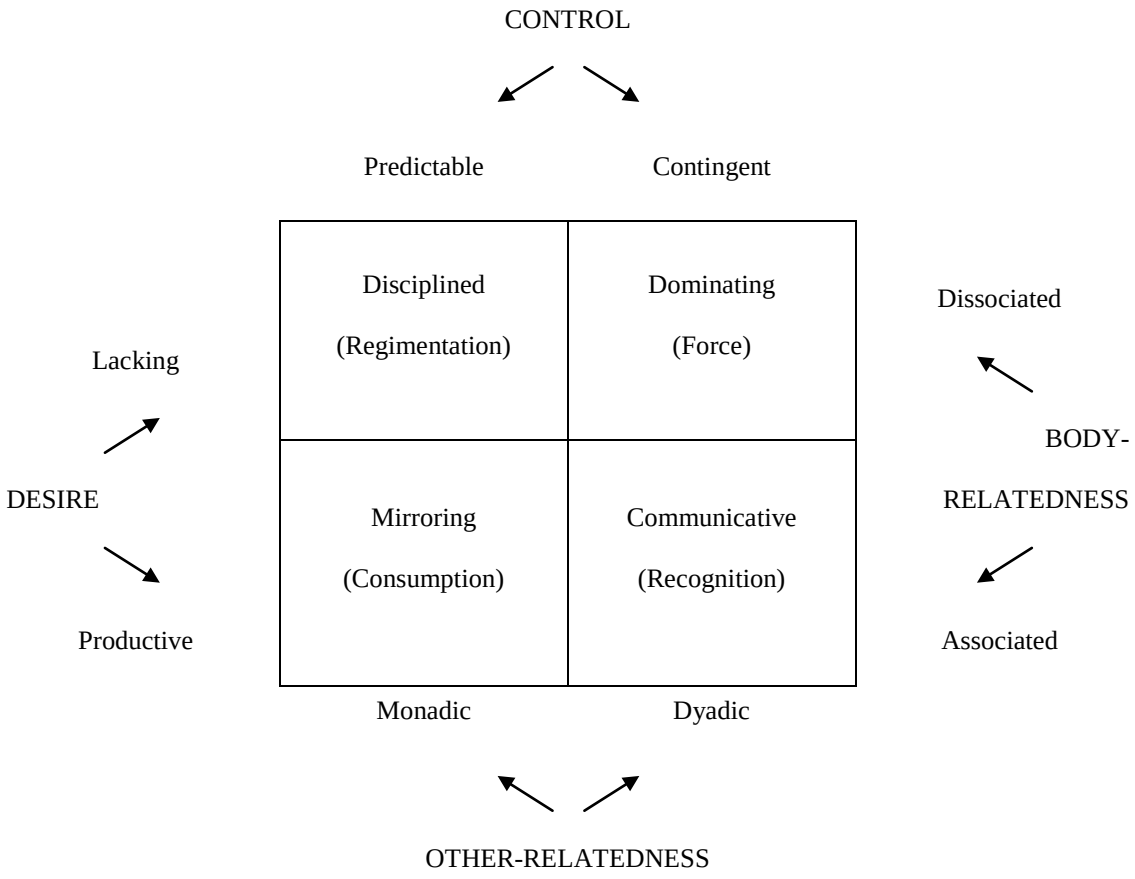

Figure 1 Arthur W. Frank's typology: Body problems, body types, and body actions. (Reproduced from Frank, 1995, p. 30.)

Four Body Problems

In order to distinguish among the three plot types, Frank examines how they differ with respect to the body problems, body types, and body actions found in each. (These are represented in Figure 1.) He begins by outlining "four general problems of embodiment: control, body-relatedness, other-relatedness, and desire" (p. 29).[3] Control of the body involves the capacity to reliably predict how the body will function, while contingency "is the body's condition of being subject to forces that cannot be controlled" (p. 31). The way an individual responds to the body problem of control, then, is conceptualized as falling somewhere along a continuum ranging from *predictability* to *contingency*. Frank uses the concept of the continuum in explicating all four of the body problems.

Frank asks: "Do I *have* a body, or *am* I a body?" (p.33) as a way to introduce the notion of body-relatedness. Individuals who see themselves as "having" a body relate to their bodies as an "it." Such an individual, then, is *dissociated* from her/his body. At the other end of the body-relatedness continuum is the person who is *associated* with her/his body, who sees the body as inextricably bound up in the "I." In other words, the self is an embodied self; the body is not just the container in which the self is carried—it is how the self expresses itself in the social world.

[3] All references to quotations or ideas attributable to A.W. Frank from this point forward in this chapter refer to *The Wounded Storyteller* unless otherwise noted. To facilitate reading, the publication date will not be routinely inserted. Page numbers of direct quotations, however, will be supplied.

Other-relatedness refers to "how the shared condition of being bodies becomes a basis of empathic relations among living beings" (p. 35). The *dyadic* body sees itself relating to others with "the recognition that even though the other is a body outside of mine, 'over against me,' this other *has to do with me, as I with it*" (p. 35). By contrast, the *monadic* body "understands itself as existentially separate and alone" (p. 36).

Frank's explanation of the body problem of desire begins with the observation that all bodies have needs, that a body expresses its needs through the body, and that "the need is fully corporeal and can be satisfied at that level" (p. 37). Desire is distinguished from need in that desire is the body's "demand . . . for more than the need it seeks to express" (p. 37). Some bodies are *productive* of desire while others are *lacking* desire. At first glance, the notion of desiring more than one needs may seem to be an indictment of the desiring body. But as Frank makes clear, the body that lacks desire—at least with respect to the stories of illness—is the body that sees diminished possibilities for the self. "Falling out of love with yourself," Frank says, "means ceasing to consider yourself desirable to yourself" (p. 39). (In my view, rewriting this statement with strategically placed spaces makes clearer the tragedy of this condition. Such a revision might look this way: Falling out of love with your Self means ceasing to consider your Self desirable to yourself.")

Four Body Types and Their Actions

Frank asserts that each of the body problems outlined above requires an action in order to "achieve some working resolution" (p.29) of the problem. These actions are the province of a particular ideal body type that is expressed by—indeed, defined by—the

actions it typically chooses. The **disciplined body** defines itself in the action of *self-regimentation*. It responds to the problem of control by working to "reassert *predictability* through therapeutic regimens" seeking to "compensate for contingencies it cannot accept" (p. 41). In doing so, the self solves the problem of self-relatedness by treating the body as an "it," *dissociating* the self from the body and, at the same time, distancing itself from others to express other-relatedness as a *monadic* body. As I understand Frank, whether the disciplined body is productive of or lacking desire varies. If the individual derives pleasure from the regimens, engaging in them as expressions of love and caring for the body, there is a sense of being *productive* of desire in wanting more of all that is good for the self. It seems to me, however, that the more strongly the individual dissociates self from the body—the more the body is seen as an antagonistic "it"—the greater the likelihood that the disciplined body's only desire will be to *lack* desire.

The **mirroring body** solves the body's problems through *consumption*. The self "attempts to recreate the body in the image of other bodies" (p. 43) by consuming goods and services that hold the promise to accomplish that objective. The mirroring body contends with the problem of control by striving for *predictability*—especially predictability in appearance. In terms of its self-relatedness, it is, as Frank says, "almost compulsively *associated* with its body, but the body is now a surface; again, the visual is primary" (p. 44). *Monadic* in its other-relatedness, the mirroring body is related to others only insofar as they are audience for its performance, and all of its desires are *produced* for the purpose of acquiring the commodities to maintain its self-image.

The **dominating body** enacts its narrative through *force*. This body type is most likely to find expression in the context of serious illness or disability that precludes control; it "assumes the *contingency* of disease but never accepts it" (p. 47). It is not surprising that a body that is unable to be controlled would engender an orientation toward self-relatedness that results in *dissociation* of self and body. To a large degree, an individual living with such an illness would regard the body as an "it" that had profoundly betrayed the self. Frank asserts, however, that the dominating body does not just turn against itself—it turns against others as well. Consequently, its other-relatedness is *dyadic* because it is linked to other bodies, albeit in relationships marked by bitterness and rage. Frank hypothesizes that the bitterness and rage may be the result of the ill person's *lacking* of desire, a lack that is felt as loss. To lack desire is a rational response in the context of life-threatening illness because, as Frank notes, "Contingency militates against desire" (p. 48).

Frank proposes that the **communicative body** is defined by the action of *recognition*. It is fully aware that life is often uncertain, that bodies do break down, that there is much that is beyond our control. The communicative body, therefore, is able to accept the *contingency* that marks most of human existence. By accepting contingency, the communicative body experiences self-relatedness as a fully *associated* body-self. The body does not seem to be an "it" against which the self must do battle; the body is part of the "I." Because it recognizes contingency and embraces the association of the body and the self, the communicative body's other-relatedness is *dyadic* as "it sees reflections of its own suffering in the bodies of others" and "wants and needs to relieve

the suffering of others" (p. 49). This impulse to be fully engaged in sharing itself with others is the principal way in which Frank sees the communicative body as *productive* of desire.

Frank emphasizes that no person fits any one body type, that "the condition of any actual body represents a layering of types . . . a shifting foreground and background of types" (p. 51). Nevertheless, he finds that particular combinations of body problems, body types and body actions are observable within each of his narrative categories (Restitution, Chaos, and Quest). He does not offer his narrative typology and its constituent elements as an effort to construct a sort of grand unifying view from which all narratives can be analyzed. His purpose is to facilitate the hearing of illness stories.

In thinking about how to analyze the interviews I conducted with OW/O women, I wondered if Frank's theoretical framework might be useful. I had one major concern, based on the fact that Frank and I were not hearing exactly the same sorts of stories. Frank was looking at stories of acute illness: one minute the protagonist was among the community of people who thought they were in the "kingdom of the well" and the next minute they entered the "kingdom of the sick" (Sontag, 1978, p. 3). They experienced "narrative wreckage" and their stories served as a way "to *repair* the damage that illness has done to the ill person's sense of where she is in life, and where she may be going" (Frank, 1995, p. 53). The OW/O women who spoke to me, by contrast, were living with a condition that would more accurately be characterized as chronic. There is no moment where the OW/O woman crosses the threshold to enter the kingdom of the fat.

I believe that the distinction between acute illness and chronic conditions did affect the extent to which Frank's typologies can be applied to my informants' stories. However, the approach to identifying narrative types seems to work well, and Frank's categories can be found in my data. There are some variances, and in the analysis that follows those will be remarked upon. In my discussion of each of the narrative types, I will identify the body problems and body types that Frank posits as most frequently depicted in that narrative category. I will also outline the criteria I established in deciding which narrative type each of my respondents' stories represented. The criteria are of my own invention, but I believe they are consistent with Frank's explanation of each typology. They are the result of early stages of my data analysis when I used grounded theory techniques to discover common themes in my interviews. The criteria were useful to me in making decisions about how to assign each informant's story to one of the categories. Finally, I will propose two additional narrative types that account for a significant number of my respondents' stories. That these stories did not fit well with Frank's framework is possibly a consequence of the differences in the lived experiences of people dealing with acute illness versus those dealing with a chronic health condition.

The Restitution Narrative

The basic plot of the restitution narrative is simply stated by Frank: "'Yesterday I was healthy, today I'm sick, but tomorrow I'll be healthy again'" (p. 77). Because "contemporary culture treats health as the normal condition that people ought to have restored" (p. 77), the restitution story is the preferred narrative. Frank points out that

"phrases like 'good as new' are the core of the restitution narrative" (p. 77). If a person tells a story that essentially says, "I'm sick now, but I know I'm going to be fine," he is telling that story prospectively, assuring the listener that there is every reason to be optimistic. A restitution narrative told retrospectively tells of a cure achieved: "Now I am fine!" Frank asserts that the restitution narrative suits well the modernist belief that "for every suffering there is a remedy" (p. 80).

According to Frank, people who tell restitution tales are people who are more likely to require *predictability* in how their bodies function. Because the ill body is not fully controllable, the body is seen as *dissociated* from the self; it is an "it" that is the object of efforts to bring about a cure. Moreover, it is typically *monadic* in that it is occupied with "having" its own disease. It is certainly *productive* of desire, focused as it is on a cure—and willing as it is to acquire whatever commodity will help it achieve that objective. Frank suggests that the teller of the restitution narrative falls somewhere between the disciplined body and the mirroring body: the disciplined body because of its adherence to regimens in the attempt to achieve cure, but mirroring because of its emphasis on the consumption of commodities in that process.

As I analyzed my respondents' interviews and the stories within them, I looked for certain elements that would seem to me to be necessary for a story of an OW/O woman to fit into the restitution category. From that, I developed four criteria. First, since "restitution" implies restoration, I looked for an indication that the woman was at one time at a weight that she regarded as ideal or acceptable, even if that weight was not as low as the Metropolitan Life Insurance Company tables (or her doctor, or her

husband, or some weight loss organization) would regard as ideal. Eighteen of the women in my study had at one time been at a weight they considered acceptable. However, several of these indicated that the only time they could have been regarded as having been at normal weight was in very early childhood. For one, the fact that she had been of normal weight in childhood seemed to affect her sense of what her "true self" was; most, however, discounted their early childhood weight and identified more with what their bodies were like beginning in elementary school or from puberty onward.

Second, I looked for women who were actively involved in some regimen for the purpose of losing weight. It seems to me that a story could not be regarded as a restitution narrative if there were no efforts at restoration either in process (allowing the possibility of a prospective restitution story) or accomplished (permitting a retrospective restitution tale). All but three of the women I interviewed claimed to be doing something in an effort to lose weight, though for many that effort was rather vaguely described as "watching what I eat" or "trying to get in exercise when I can." One woman reported that she was on an 800 calorie daily diet and one was on a very strict regimen dictated by another serious health concern. No woman made reference to currently being on one of the commercial weight loss programs or on any of the many diets that are popularized in magazines or books. Two women had concrete plans to undergo bariatric surgery, and several others were considering it or had not entirely dismissed it as an option. Five had undergone the surgery and were working the post-surgical phase with varying levels of intensity; of these five, four had met my first criterion, so they remained in my pool of possible restitution stories at this point. I also retained those who claimed any sort of

current effort, no matter how vaguely they described it, since I did not feel it was my right to impose my definition of "effort" onto them.

Since restitution implies restoration, my third criterion for being placed in the restitution category was that the woman should be someone whose ultimate goal was to be restored to what she had previously felt was her ideal or acceptable weight, or at least to a weight with which she would now be fully happy. This is the criterion that resulted in the loss of all but three of my respondents. Indeed, it was the criterion that caused me to realize that I would eventually need at least one category beyond Frank's typology. I will develop my rationale for this further when I propose additional categories.

My fourth criterion was that for a woman to be regarded as a teller of a restitution narrative, she had to be optimistic about her chances to succeed. None of my remaining three women in this category were at their goal weight, so none could tell a retrospective tale. However, to tell a prospective restitution story necessitates a certain level of positive expectation of success. One of my remaining three women was very near her goal. Another was not, but she had a plan, was about to embark on it, and was convinced without reservation that she would succeed. The third expressed significant doubt about her ability to achieve her goal. As a result, only two women met the criteria for considering their story to be a restitution tale.[4]

[4] All names of persons, medical facilities, businesses, or other references that might be used to identify a respondent have been changed to protect confidentiality.

A Restitution Narrative: Marianne

Marianne began to gain weight in her 20s, a gradual process that accelerated when her 18-year marriage failed. She describes her life after her divorce as being marked by serious depression. Ultimately, her weight status reached the level of obesity; she states that at her heaviest she was 100 pounds overweight. She has now been in a nine-year relationship with a man ("Mitch") and has recently become the primary caregiver for a pre-school aged grandchild. It was Mitch's concern for her health and his statement that "I cannot live here watching you kill yourself" that finally motivated Marianne to take serious measures to lose weight. She decided to opt for a gastric bypass. She has now lost 89 pounds and states proudly and confidently that she is only 15 pounds "from what I want to be."

The thing that bothered Marianne most about her weight was the anger she felt with herself because she "didn't have the self-discipline to lose this weight and be healthy for my children and be able to live a good life." Although she tried to remain active in the lives of her children, she felt her activity level diminish after her divorce as "it was just a depressing time." She found that she did "not want to get out of bed, not want to do things, not want to get up and go to work," and this "led to eating and going straight to sleep and not caring for myself and not having enough self-confidence." Eventually her weight led to seriously high blood pressure, high cholesterol, and diabetes, necessitating a number of medications that were often adjusted in the effort to control those conditions. Her body was no longer *predictable*, and she felt out of control—of her eating, of her weight, of her body, and of her life. Her weight loss after

surgery has meant that she is now taking only one medication once daily. She is also working out with a trainer four times a week. On the whole, the eating and exercise regimens she has put in place for herself are restoring a sense of control over her life.

Marianne admits that she never did have an accurate view of her body. She "used to say, 'Only God and I know my weight.'" In reality, though, even she did not know it:

> I was embarrassed to go to the doctor because I didn't want to get on the scale. I didn't want to actually see what the pounds were. I'd still say, "Oh, I'm not over 300 pounds," but of course [I was]! I'd still think, "I'm 150."

When she saw in the medical chart that she was labeled "morbidly obese," she thought, "they're not telling the truth!" Her *dissociation* from her body was such that when she was told that one of the criteria to be approved for the surgery was that she needed to be at least 100 pounds overweight (which she clearly was), she found herself worried because she thought she surely didn't meet that criterion.

In terms of other-relatedness, Marianne sees herself as a loving and giving person, and she demonstrates her empathic understanding of others who suffer from obesity by commenting that she would not push surgery as an option for others. She vows that "when I get down to my ideal weight . . . I am never going to say anything to somebody who is fat or obese . . . because I didn't like that done to me." However, in other ways she expresses a *monadic* theme that is one of the most prevalent in all of my interviews: othering. In my view, the sense of being "other" is the clearest expression of the monadic orientation. Marianne, like nearly all of my subjects, has felt the alienation that comes from comparing yourself to others only to find yourself wanting in some

important regard—in this case, her bodily appearance. In talking of her very negative self-image and her self-imposed isolation from people and activities, Marianne recounts that "I had to think people didn't like me . . . because I'm so ugly, because I'm so fat." She even felt judgment from a sister "who herself is not svelte." She acknowledges later in the interview that she can "look back now and I think, 'Well you know, people didn't not love you because you were fat.'" However, this faith in the charity of others still does not extend to people other than her family and her partner, Mitch. She still perceives that others tend to think that if you are overweight you are "disgusting." Moreover, she even acknowledges that she was judgmental of other overweight people when she was overweight; she would "look at somebody . . . eating ice cream and think, 'Well, *they* shouldn't be eating that ice cream!' Well, I just came back from the store buying a pint of ice cream and ate the whole thing!"

Marianne made an interesting point—one that I heard from other women who had undergone weight loss surgery—that one of the things that made the experience of medical consultations with bariatric surgeons so positive was that they and their facilities were oriented toward people of size. Furthermore, the other patients were not thin people. Marianne recounts: "It was real interesting because I walked into the waiting room [and] I thought, 'My Lord! The whole world is fat!'" This observation would suggest that it was reassuring to Marianne to experience kinship with others, allowing a more dyadic relationship with them. Paradoxically, however, Marianne's greatest reassurance came from her next thought, which was, "I am not as big as these people!" We see in this comment both a variant form of othering and another example of a

monadic orientation, albeit one that she is moving away from as she now acknowledges, "Well, apparently I was too!"

Frank's category of desire is difficult to address in analyzing the stories of people who contend with overweight or obesity. He talks of desire as being the expression of the demand for more than one needs. Looked at in that light, most OW/O women would never be lacking in desire. Many of the women I interviewed—Marianne included—admitted to a genuine love of food; many admitted to habitually eating more than they needed in order to sustain life. Even those who insisted that they could not relate at all to compulsive overeaters acknowledged that they often ate more than they should, and they confessed to eating foods that were not wise choices for someone who is attempting to lose weight or maintain a healthy body. For these women, their bodies are always *productive* of desire, including the desire *not* to desire. Their desires are expressed in ways other than appetite. They take part in what Frank labels as the consumption of commodities in the attempt to "recreate the body in the image of other bodies" (p. 43). Marianne recalls attempts to lose with commercial weight loss programs and exercise facilities, as well as acquiring diet pills that "[made] me feel like I was trying to do something about my weight." Of course, her decision to undergo surgery is a prime example of a body that has produced desire, as this commodity is difficult to acquire, expensive, and not without significant risk.

Marianne's story fits Frank's assertion that the restitution narrative depicts a body that falls between the **disciplined body** and the **mirroring body**, engaging as Marianne does in both *self-regimentation* and *consumption*. Her story is also an

exemplar that meets the criteria I established in determining which of my respondents were telling a restitution narrative. Marianne estimates that she was at normal weight for the first half of her life. She is clearly following a regimen with her post-surgical process, including sessions with a personal trainer four times a week along with dietary caution. She expresses no doubt that she will be able to reach her ultimate weight-loss goal.

Another Restitution Narrative: Sasha

I selected Marianne's story as the exemplar for the restitution narrative because she is the woman closest to having achieved restoration of her body. Hers is a story that will soon be able to be told retrospectively. Sasha is only beginning her process of restitution, but her story is worth hearing; I will summarize it here.

Sasha has been overweight for the last 20 years, starting with the birth of her first son. She estimates that she is 50 pounds above her ideal weight. She has made many attempts to lose, but none have been long-lasting. She thinks that part of the problem is that she has been acting in "rebellion against my husband" who told her when she moved from a size 8 to a size 10 that "he wasn't going to touch me until I lost weight. . . . And I was still hot at size 10!" She is now determined to lose weight because her marriage "has fallen apart" and she will soon re-enter the dating scene. Her plan of action is to redouble her efforts to limit portion control, balance her diet, and increase her physical activity, a plan that is aided by an associate in her professional network who is a personal trainer and who has begun to text her every Monday for an update on what she has done in the way of exercise for the week. She is inspired by a program she attended the week prior

to our interview that suggested that she should set small attainable goals and aim for the achievement of her overall goal in three years. Interestingly, she told me that she had been thinking of getting started on this approach for about a week, and had decided that our interview would be the "first step," the official marker of the start of her new program. She is "absolutely" sure she will succeed. "I can do anything I want to."

Sasha expresses a high need for control in her life, and she acknowledges as much, noting that "I am rebellious when it's not my idea." She says that "it makes me angry that this is a part of my life that is not under my control." However, she has recently changed physicians, and her new doctor has emphasized that she is going to approach weight loss with Sasha in a manner that puts Sasha in control. Sasha was particularly taken with the doctor's analogy to the oxygen masks on airplanes, pointing out that the instructions are to put on your own mask before helping someone else. This resonates with Sasha because she views herself as someone who takes care of others in her life without attending to her own needs. She sees this as a metaphor for the necessity of regaining control of her life instead of being at the mercy of the contingencies that face her every day.

Sasha's *dissociation* from her body can be seen as linked to her need for control. She spoke of her body as something that she needed to "camouflage" and that she had to "gird." She referred to her body as a "temple" and as a "house" that she needed "to get ready for the market." Always there was the use of the word "it" to refer to her body, and the word "this" was used to refer to her weight. She spoke of managing the impressions she made on others by the way she would "carry" herself, as though she

sees her body as a means of transportation for the self. She had always felt that by carrying her body in a certain way, she could disguise her weight.

It is difficult to think of Sasha as *monadic* in her other-relatedness, as Frank postulates is true of restitution narrators. She seems to enjoy a wide array of friends and associates and is obviously a person who relates to others empathically. Other than her husband's rejection of her, Sasha's only expression of having ever felt othered was because of comments her grandmother made to her about her weight. However, Frank does talk about the monadic position being one in which the individual sees herself as an "autonomous entity" (p. 85), and Sasha seems to embrace that concept when she opines that her weight loss is "all up to me." Further, she asserts that in her new determination to lose weight, "It's all about me right now—take care of me first. . . . I need to help me first. Charity starts at home."

Sasha can be seen as *productive* of desire when she talks about her determination to get her body ready to explore new relationships. She asserts that she thinks of her plan for weight loss as a new phase of her life, and that "it needs to be a lifestyle change for me because I do want the second half of my life to be the better half. And I can't do that if I'm not healthy."

Sasha's planned program for weight loss is consistent with Frank's notion that the restitution narrator falls somewhere between the *self-regimentation* of the **disciplined body** and the *consumption* of the **mirroring body**. Her current focus is an example of what Frank describes as the attempt to "recreate the body in the images of other bodies: more stylish and healthier bodies" (p. 43).

These, then, were the restitution narratives. Although there are some elements of Frank's framework that are not seen as strongly in these stories as they might be in some of the exemplars he used in his book to develop his theory, it is also important to remember that Frank himself insists that "real people are not ideal types . . . Actual body-selves represent distinctive mixtures of ideal types" (p. 29).

The Chaos Narrative

Frank says, "Chaos is the opposite of restitution: its plot imagines life never getting better" (p. 97). In the chaos story, "the body is imprisoned in the frustrated needs of the moment" (p. 98). The chaotic body is out of control; it is defined by *contingency*. "Efforts to reassert predictability have failed repeatedly, and each failure has had its costs" (p.102). The body's self-relatedness is expressed in *dissociation*, because "association with one's own body is . . . dangerous" (p. 103). The body in the chaos narrative is *monadic* in its other-relatedness, as "relationships also have a history of failure" (p. 102). Frank notes that the chaotic narrator tends to erect a wall that "prevents her from being assisted or comforted" (p. 102-103.) He also asserts that desire is *lacking* because the desires the self once had "have been too frequently frustrated" so that "desire is not only pointless but dangerous, just as relationships with others have become dangerous" (p. 103). Frank does not assign an ideal body type to the chaos narrator, but notes that the chaotic body is often "victim to **dominating bodies**, which make it the object of their force" (p. 104; emphasis added).

In keeping with Frank's framework, I created four criteria for the interviews to be included in the category of chaos narrative. First, I selected only those women who had made multiple attempts at weight loss and had experienced multiple failures. Second, I looked for women whose desires for weight loss had been so frustrated that they were currently in a sort of limbo, with no clear direction for future efforts. This seemed appropriate since Frank asserts that desire in the chaotic body is pointless. A third criterion reinforces the second, and that was that the chaos narrator would be someone who expresses clear lack of optimism about the possibility of ever succeeding. Finally, because of Frank's theory that the chaos teller often erects a wall that prevents assistance and comfort, I looked for women whose stories reflected a sense of anguish that they were having to bear the struggle on their own, that there was little in the way of help for them. Not surprisingly, the stories that emerged from the interviews that met all of these criteria were among the most wrenching of my study. Anger was directed at specific significant others, medical practitioners, culture and the media, and—regrettably in my view—their selves. Selecting one exemplar from this group of six was difficult, as all the stories were extremely compelling.

A Chaos Narrative: Ann

Ann traces the beginning of her weight issues to the point when she was taken at age 13 by her mother to a doctor to get diet pills. She notes that her mother was "heavy by the standards of the day," but she also feels that, in retrospect, neither she nor her mother were really all that fat, though both were the target of critical remarks from Ann's father. Since that time, her weight has been a central struggle in her life. She

believes that she is probably about 100 pounds over her ideal weight. She managed to lose a great deal of weight as a young single woman starting life out of college. For a brief period in her life she was not heavy. “And it was very freeing, it was *very* freeing.” Since then her weight has been up and down, up and down, as she has made “hundreds” of attempts to lose, trying “every imaginable program—I mean, you name it, I’ve done it,” some of them multiple times, in the quest to lose and keep the weight off. She has had therapy and has tried journaling. At several points in our interview she pointed to a large drawer in the corner of her room, full of books, notebooks, journals and other materials that were evidence of all the methods she had tried over the years. As she told her story, she repeatedly said, “I have beat this horse to death” or “I’ve whipped this dog and whipped this dog.” Her final conclusion: “We’re all crazy.” Other words she uses to express this idea are “nuts” and “insane.”

Clearly, Ann feels out of control. There is no predictability about her body; it is all *contingent* on where she is on her weight loss roller coaster. Ann asserts that she thinks that “wanting to be in control” is a cause of her being overweight, a desire that, at the moment, seems to spring from a feeling of being trapped in a job that she dislikes a great deal. In the past, there appear to have been periods of stress in her marriage as well, but she acknowledges that at this time her marriage is in as good a place as it has ever been. At the same time that she says that wanting to be in control is a cause of her weight problems, she also recognizes that although food is “the only thing you think you have control of . . . really the food’s controlling you.” She sees food as an addiction, that she has merely chosen food instead of alcohol or gambling. Another significant insight is

that she believes that being overweight when she was younger "was a sexual thing." She felt protected by knowing that she would not receive attention from males if she were fat. Later she refers to a "scary time" in her marriage when her "safety net was 'keep fat and nobody's going to pay attention to you.' You know? You're very safe." In one sense, it seems that this was not only a way to control how men interacted with her, but also to control how she feared she might be tempted to interact with men.

With respect to self-relatedness, Ann demonstrates a significant degree of *dissociation* from her body. She reveals this in several ways. She separates her mind and her body, for example, when she says several times some version of "you have the knowledge and you know what you need to do, but there's something in the head" that prevents the body from acting as it should. The "something in the head," she suggests, is "something deep-rooted emotionally." In this case, not only is her mind separated from her body, her mind itself is separated into emotions and intellect, neither of which is connected with what her body does. Another indicator of her dissociation from her body is her statement that "I've probably lived in denial about how large I am, because I sure don't see myself as large as I am." She refers to this dysmorphia several times in the interview, telling me that she still sees in the mirror the woman she was when she got married, and she bitterly jokes that her struggle to find some sort of motivation to lose is apparently not influence by concerns about her appearance because "I evidently must think I'm pretty cute!"

In one sense, Ann does not seem to embody the characteristics of someone who is *monadic* in her other-relatedness, as Frank proposes for the chaos narrator. She has a

very wide circle of friends. She is active in her community. She reports that she has never felt any discrimination because of her weight. When she sees other heavy people, she is "empathetic, because I'm sitting there thinking, 'It's a bitch; It's not fun.'" On the other hand, she has felt othered by several important people in her life. Both her husband's mother and her husband's stepmother made derisive comments about her weight. One of them told Ann that in her marriage, gaining five pounds (as Ann had just done on vacation) would be "grounds for divorce." The other simultaneously "obsessed" about Ann's weight and brought her chocolate because it is "good for your heart." Ann does feel othered, though, especially in comparison to her thinner friends. She does not identify with their orientations toward food. One of her sisters, for example, has maintained her lifelong eating regimen despite recently undergoing a very difficult divorce. Ann describes it by saying that her sister cooks for herself every night and sits down at the table, "and she is eating . . . one pork chop and two sprigs of broccoli and a half a potato. . . . I'd be eating out of the refrigerator!"

To Ann, her sister's approach to eating is normal and she—with her disordered eating—cannot relate to it at all. One of her objections to attending Weight Watchers® is that the people there are disciplined. "You have the one idiot that [says], 'Well, I ate one cookie,' and . . . I'm going, 'Oh, my God! I ate the whole package!'" She favors a prestigious nationally recognized private weight loss program—which she has gone through at least twice—because everyone who participates is heavy. She has another sister who has battled weight, but at present she is not able to find comfort from her because that sister has undergone successful bariatric surgery. Her sister's success would

seem to suggest that Ann might get some encouragement for considering this option for herself; however, Ann has ruled it out. At one point Ann expresses some happiness for how well her sister has done, but later she admits she is "a little jealous." She goes on to reject the idea of surgery by referring to it as an "easy fix" and saying, "I think the gastric bypass and Lap Band® are both crutches."

Ann's attitude about her sister and her surgery seems consistent with Frank's description of the monadic body erecting a wall that precludes assistance and comfort. It extends, as well, to her relationships with medical practitioners. Her history with physicians around the issue of weight led one of them to respond to her questions about gastric band surgery by saying, "'You are so non-compliant, you would figure out a way around the Lap Band®. Don't waste your time on that!'" She explains her reticence to discuss weight with her current doctor by lamenting,

> This poor doctor. I mean, we've talked about my weight, we've talked about my weight, talked about my weight. I'm to the point where I think, "God, I'm not gonna bore her another minute." Because I'm sure she's sitting there going, "Just shut up and do it!"

Ann, like several of the women I interviewed, is frustrated by her <u>desire</u> for food. In this regard, her chaotic body can surely be seen as *productive* of desire. In fact, one of the reasons she is reluctant to consider surgery is that "you'd just have to eat less. You'd have to tell food 'Goodbye.' Detach. That's the truth." When asked how that would make her feel, she said she suspected she would feel sad because she found comfort in food. So, like many OW/O women, her greatest desire is to have no desire. In one sense,

however, Ann does illustrate the point Frank makes about lacking desire when he says that the desires the self once had "have been too frequently frustrated" so that "desire is not only pointless but dangerous" (p. 103). In this case, I am referring to the desire to make an effort to lose. Ann is not currently making a clear effort to lose weight. She repeatedly bemoans what feels like the loss of any motivation at all, at one point saying, "If I acted like I had any brains in my head it would be health." She wonders "why I'm not going, 'Well, maybe if you don't get your act together, they'll tell you you have diabetes and they're gonna chop off your feet.'" It seems that Ann is almost afraid to waste any more time in what must surely seem by now to be a futile effort.

As Frank observed about chaos narrators, Ann has been victim to **dominant bodies** in the past. The most notable of those was her mother, who hauled her off to the diet doctor at age 13. Her father is also complicit in domination as is seen in his use of derogatory remarks about both her weight and her mother's. In fact, Ann theorizes that one of the reasons she remained fat as a teenager was to protect her mother from the sting of her father's criticism by being fat along with her.

In most regards, Ann's chaos narrative seems to fit Frank's framework very well. There are deviations, but they can be seen as examples of Frank's caveat that we should not read his theory as suggesting that there are "pure" types. The dimension of desire, in particular, does not seem to be entirely consistent with Frank's explication of how body problems are expressed within each narrative type. I believe that this is largely because of the nature of my subjects and the body condition they represent. When studying OW/O women, it seems impossible for desire to be completely lacking.

Other Chaos Narratives: Charlotte, Diana, Gabby, Grace, and Mae

Charlotte estimates that she has been overweight for about 90% of her life and feels that she would have needed to lose about 110 pounds when she was at her heaviest. She is not currently at her heaviest, having lost some weight as a consequence of treatments for breast cancer. She indicates that it has been some time since she lost any weight, but it is clear that weight loss is not her primary concern at present. She is using complementary-alternative medical approaches for the treatment of her cancer, but these appear to be focused primarily on her overall health, not weight. Life for Charlotte, therefore, is clearly *contingent.* When asked how much she felt she could realistically lose and maintain, she responded with a rueful laugh and a shrug as she replied, "Apparently nothing."

Charlotte's history with weight is complicated by having been brought up with strict religious training that conceptualized concern for the body as "evil." This has surely resulted in a strong sense of *dissociation* of the self and the body. She has some characteristics of a *monadic* body in her tendency to be what she terms an "observer of life," as opposed to someone who participates in frequent interaction with other people. On the other hand, she feels strongly that "whenever I meet another person, I actually meet a soul." She says that she thinks her cerebral nature makes her a "useful person" because "I can listen to someone and I can hear what they're really saying." She also feels that her weight problems may serve to encourage others to relate more easily to her, "because it's fairly obvious to them that I've had my struggles and this is the result." This suggests that there is a strong *dyadic* element present in her other-relatedness,

unlike the typical chaos narrator that Frank posits. Unlike most of the women in my study, Charlotte may be an example of an OW/O woman who has achieved a certain *lacking* of desire. In fact, she was a recipient more than 20 years ago of one of the earliest gastric band surgeries, a choice she made because it seemed to her to be "a nice practical way for me not to be so attached to food." Charlotte, however, clearly desires to live, something that has caused her to reexamine the effects her religious upbringing had on her. Despite the fact that she thought she had long ago "left aside the New Testament" and the Pauline teachings about how "to die is gain," her earlier religious orientation continues to exert an influence, causing her to discover when she found out about her cancer that "I was really only equipped to die quietly. I was not equipped to live." She has had to rediscover both the will to live and the hope that she will.

Diana states emphatically that she has been overweight all of her life, and she feels that at her heaviest she would have had to lose 85-90 pounds to be at ideal weight for her. She admits that she has a problem with control of her appetite, and her life feels very *contingent* because of a host of health concerns, mostly gynecological in nature. Perhaps because of her many health problems, she seems to regard her body as completely unpredictable. Her *dissociation* from her body is illustrated by the stories she tells about how, on at least two occasions, she lost a great deal of weight—enough so that when she now sees pictures from those time periods she realizes that she was alarmingly thin—but even at those times she felt she was overweight. Diana feels very othered. She has a hard time relating to others because of her preoccupation with her weight and how she appears to others. She compares herself to her partner's past

relationships and worries because “I know the other people that she was with, and they were all thin and fit and athletic.” Her *monadic* other-relatedness also extends to her relationships with medical practitioners. “I can see it on their faces. It’s like, ‘No! Geez! Another fat one comin’ through!’” She does not relate to women at Weight Watchers® who triumphantly declare, “‘Oh, I don’t crave candy anymore.’” Diana’s assessment: “I’m sorry, but that’s a bunch of bullshit!” Diana earnestly desires food and she desires to lose weight. However, she has come to doubt that there is anything that any doctor is going to be able to do to help her. She is reluctant to bring it up with them because “I think they would laugh at me. . . . And, plus . . . I just don’t see that any of them would be helpful.” This is consistent with Frank’s idea of the chaos narrator rejecting assistance or comfort (p. 102-103).

Gabby has been overweight for the last 25 years and estimates that she would have to lose 44 pounds to be at a weight she could accept; she is at her heaviest now. Gabby’s story is a particularly complicated one because it contains a number of contradictions. At times she seems to be saying what she thinks she is supposed to think, and at other times she seems to be saying what she really thinks; it is difficult to know which is which. It is clear, however, that she feels a profound lack of control and is frustrated by the *contingent* nature of life. She attributes much of her weight problem to “life circumstances” that cause her to overeat, often out of depression over difficulty in relationships. She has a lot of anger about the treatment she has received at the hands of physicians and family members alike, making her retreat from some people in *monadic* other-relatedness. Interestingly, she rejects the approach that some people take to what

she sees as an "obsession with the exercise, the running, the jogging, whatever." She also notes that for those people, "it's all about the food, what you can eat, what you can't eat," and she asserts,

> I don't want to live that way. I want to go to a restaurant and have a nice meal . . . and be happy and not think, "God, now I have to go home and either purge or not eat for three days because I've eaten a piece of cheesecake."

She regards a thin and healthy body as "that's who I am," but she also insists that "I am who I am regardless of whether I am thin or not." It is difficult to determine, therefore, whether she *dissociates* from or *associates* with her self in her current body. She is *monadic* in her other-relatedness, as is illustrated in her requirements for how people are to relate to her: "If you do not accept me for who I am, the way I look and present myself as a grown woman, educated, right-minded, then you can't say one way or another about me." She is strongly *productive* of desire, regarding all weight loss approaches as unacceptable because of the deprivation they entail; she always wonders, "What else am I going to have to give up?"

Grace has been overweight for 16 years, since the birth of her first child. She is at her heaviest at the time of the interview, and she believes that she would need to lose 100 pounds to be at an acceptable weight for her. Her marriage to her husband was dissolved shortly after the birth of her third child, and she recounts that her husband's decision to leave her was expressly because he was acting on threats he had made since the birth of their first child: that he would leave her if she didn't do something about her weight. Her life as a single mother is harried. In addition to working fulltime, she is

going to school and participating in her teenaged children's various activities. Because she regards herself as somewhat obsessive in her need for order in her life, the inability to maintain control over her weight is the source of great frustration, particularly since the pace of her life means that all things are always *contingent.* Grace feels profoundly *dissociated* from her body. She says,

> I feel like a small person in a fat suit. I don't want to be this way. I want . . . somebody [to] take it away because it's *not* supposed to be there. Almost like you would a tumor or growth or something. This is just not supposed to be here.

A dominant theme in Grace's story is her sense of otherness in relation to the "little bitty cheerleader moms" that she is forced to interact with because one of her daughters is an accomplished member of her high school squad. There have been several incidents in which she has felt keenly their exclusion of her, which she interprets to be entirely based on her weight. She is fairly *monadic* in most relationships, asserting that she is fine with people who have known her a long time, but she has no interest in cultivating other relationships—again, largely because of her weight. Grace is *productive* of desire, especially the desire to make things perfect, especially for her children. She does see herself as somewhat *lacking* in desire for food, not relating to people who eat more than their bodies need. Of all the women who are included in my chaos narrative category, she is the one who has the most potential to reawaken some optimism about the possibility of losing weight. However, she thinks that to do so, weight would have to become her focus—and she is simply not capable of putting it in a position of top priority for the foreseeable future. She says that she tries to do something

every year to lose weight, and her history suggests that this is so; however, none of the efforts have had more than minimal success, and she is discouraged about the likelihood that she will ever be able to overcome this struggle.

Mae is currently being treated for serious health problems. She feels that she has been overweight her whole life, and she estimates that she would have to lose 60 pounds to be at an acceptable weight. She is at her heaviest now. Losing weight for Mae is not an issue of vanity. She is suffering from "end stage kidney disease," and in order to remain on the transplant list she must lose her excess weight. She is on dialysis three days a week. She also has diabetes, which complicates her health situation considerably; in fact, she feels sure that the kidney problems are a consequence of mismanaged care of her diabetes. In order to deal with her health concerns and work toward losing weight, Mae is on a diet prescribed by a nutritionist. Her diet severely limits fluid intake and does not allow her to eat many vegetables or other foods typical of weight loss plans because of the stress they place on her kidneys. She loves vegetables, but she ruefully laughs that she is required to eat "everything that's bad for you!"

Mae's life is a bewildering maze of medical appointments, treatments, nutritionist consultations, and preparation of foods "from scratch." Life is, indeed, *contingent*. She talks of her body as if it were an object that requires her constant ministrations, which is not surprising since her kidneys seem to be operating with a mind of their own. She says, "My body need . . ." as if she is totally *dissociated* from her body. It occurs to me that this might be a means of not having to think of the self as malfunctioning—that the kidneys are essentially malfunctioning on their own but the

self remains viable. She has apparently always compared herself with others, talking about friends in high school or at church as being "like pencils," as though they were not bodies with which she could relate. She believes that most people "don't care, and they don't realize one's struggle." She admits that she has also sat in judgment of other people's bodies. In general, her other-relatedness seems to be *monadic*. Mae desperately desires life, perhaps as only someone who is so seriously ill can understand. She is also *productive* of desire in her "cravings" for the grains and vegetables that she is denied.

All of the women in my chaos narrative category expressed varying degrees of anger and frustration with any number of people and institutions. Parents and siblings and spouses were the source of great pain in many instances, as were medical practitioners. This provides evidence to verify Frank's contention that chaotic bodies are often "victims" of **dominating bodies**. I was particularly struck by how many of the women (four of the six) were taken to doctors when they were very young to get shots or pills for weight loss, and how many husbands (two of six) had rejected their wives in significant ways.

There were many poignant statements made by each of the chaos narrators in my study. Perhaps the most moving, however, was made by Ann when she told me,

> It's like I was telling . . . my daughter. You know, God, if I die . . . she'd say . . . "She doesn't have to worry about being fat anymore." And that's sad, you know. Just look at it and say, "Well, the struggle's over." It's real sad. Not to have ever found the answer."

The Quest Narrative

According to Frank, quest narratives "meet suffering head on; they accept illness and seek to *use* it" (p. 115). Quest stories depict illness as the experience of a journey, and the teller of the tale comes to a "belief that something is to be gained through the experience" (p. 115). Frank observes that most illness stories that are published are quest stories, but that quest stories can also be found in "the *enacted* stories of people's lives" (p. 116). He cites as examples of these the stories of people who, as a result of experiencing the quest, become involved in "patient advocacy" as well as tales of people "making significant vocational and personal changes in one's life" (p. 116).

Frank references the work of Joseph Campbell in outlining the stages of a quest journey—in essence, the plot (pp. 117-119). The hero of the quest must first depart for the journey; the *departure* is usually in response to a "call." In illness stories, for example, the call may be defined as the symptom or any sign that "the body is not as it should be" (p. 117). The hero may initially refuse the call (e.g., ignore the symptom), but eventually a "threshold" is crossed and the quest traveler moves into the *initiation* stage, which includes "the various sufferings . . . not only physical but also emotional and social" (p. 118). In the process of undergoing the initiation, the hero prevails, becomes transformed, and receives a "boon" at the end—"the teller has been given something by the experience, usually some insight that must be passed on to others" (p. 118). The third stage of the plot is the *return*. The hero is "no longer ill but remains marked by illness," living "in a world she has traveled beyond" (p. 118).

Frank conceives the quest narrative as being told by the **communicative body** whose action is *recognition*. The quest teller accepts *contingency*, an acceptance which, paradoxically, affords "control of a higher order" (p. 126). In the quest narrative, the body expresses self-relatedness by *association* of the self with the body. The body is not seen as outside of the self; it is seen as "not only interdependent but inextricable" (p. 49). Quest narrators are *dyadic* in their other-relatedness, which is especially seen in the ethical act of passing on the boon. Frank, however, insists that this "does not mean rescuing this other from his own contingency" (p. 127). The dyadic body "sees reflections of its own suffering in the bodies of others" (p. 49). The quest body is *productive* of desire, "but the direction of this desire—unlike the desire of the mirroring body—is conditioned by its *dyadic* relation to others" (p. 126). It "wants and needs to relieve the suffering of others" (p. 49). Frank further explains the desire of the quest narrator "to touch others and perhaps to make a difference in the unfolding of their stories" (p. 127).

As Frank noted, most published illness stories are quest stories. It is also not unusual to see people who have overcome obstacles—including overweight and obesity—interviewed on television. It is not surprising because quest narratives make good stories. They go beyond the restitution tale. They tell of more than how someone achieved their health goal. They tell of how that person persevered through the struggle, emerging not "as good as new" as in the restitution story, but "new": transformed and different than before. This is an attractive idea for someone who has, for example, suffered with poor self-image for the majority of her life.

It was not, however, a story I found frequently in my interviews. In fact, I found only one story that meets Frank's explanation of the quest narrative sufficiently to allow me to include it as such. I did not add any additional criteria of my own, largely because it was clear without any additional criteria that only one story from my sample would qualify. At first, I was somewhat surprised by this. However, as I thought about it, it occurred to me that in order to tell the quest narrative, the teller has to have overcome challenges and succeeded. As any woman who has read anything about losing weight knows, very few people succeed in losing and maintaining weight loss for any significant period of time. This is particularly true for women who are older or who have gained and lost multiple times. In fact, several of my respondents made note of the discouraging statistics about success rates in their interviews, mentioning figures they had heard that ranged from 3% to 5%. That I found only one out of twenty-three women in my study whose story could be regarded as a quest narrative is, therefore, right on target.

Quest Narrative: Naomi

As she looks back, **Naomi** considers herself to have "always" been overweight, "since I was this little chubby, little child running around." She said that at her heaviest she was 40 pounds over what would be considered ideal for her. She has been on two diets in her life; she lost 30 pounds the first time and gradually regained it, then lost 40 pounds the second time. She has maintained her goal weight for about 3 years. Her "call" occurred when she learned at "my well-woman exam" that her cholesterol was seriously elevated. Naomi remembers that the nurse told her, "'You're a candidate for a

massive heart attack.'" She admits that she did not immediately respond to that warning. Shortly after that, however, a friend had a stroke, and Naomi said, "Whoa-ho! That's not for me. I've got too much earthly kingdom work to do." She began an exercise program, and then joined her exercise facility's diet program, learning things she had never known about proper nutrition.

Her concern that she had "too much earthly kingdom work to do" stemmed from a renewed interest in "walking back with God" that preceded her health wake-up call by about two years. In that time, she reports, she gradually started to see things differently. Most important to her was that "I started seeing *myself* differently." She feels that "He transformed me, like I guess He does everybody, from the inside out." She sees her work on her physical body as a natural extension of the work God was doing in her on the inside, suggesting that her quest both preceded and incorporated her weight-loss transformation. This was important to her because she had never thought well of herself. Her childhood had been chaotic, and she confessed to me that she had been the victim of molestation by a family member, an experience that had serious consequences in many areas of her life. But as a result of her renewed relationship with God and the blessings of her new body, she "realized God loves me! I am the daughter of the almighty God!"

Naomi feels strongly that God's work in her mind and her body is because "God has a call for my life." She believes that the issues with men that resulted from her childhood abuse were because God wanted her to be able to devote herself to Him. "I'm so in love with Him, and I'm going to do His work." She believes that "if you're married, or you're in another relationship, then you're not able to give 100% to Him."

She has been enrolled for the past year or so in a Biblical "college," and she studies and reads constantly about theology and related topics.

She acknowledges that in the past she tended to maintain distance from other people. But now she seeks opportunities to minister to others, including helping to provide care for an elderly woman that she seems not to have had any particular relationship with otherwise. She admits that she is still "not particularly crazy about people," especially "people who are whiners or complainers or negative." But even then, she is working to get past that and be more patient with people because "that's one of the nine fruits of the Spirit."

Naomi seems to have *accepted the contingency* of life and has moved beyond her previous anxiety about it. Although she does not specifically reference the Biblical notion of the body being the "temple" of God, she compares her previous lack of respect for her body to her newfound awareness of its importance to her; this suggests that she does *associate* her body and her self. She admits that she is still working on learning to trust others, but remarks with pleasure about her newly acquired ability to enjoy interacting with men "of all ages" at her church, which indicates that she is gradually moving into a *dyadic* relationship with others. She clearly desires to share her story with others; her zeal and passion in discussing her transformation with me was palpable. Indeed, the driving force in her life seemd to be to share her quest story with others and to remain open to any new journey that God has in store for her and the revelations it might yield.

The application of Frank's theoretical framework to the story embedded within each of my respondents' narratives has been largely fruitful. However, only nine of the twenty-three interviews I conducted have found a home in one of the three types proposed by Frank. I am left with fourteen narratives in search of a plot type. I will, therefore, propose two additional categories that others might also find useful in the analysis of narrative types, particularly in looking at stories of chronic illness.

The Reorientation Narrative

"Serious illness," Frank avers, "is a loss of the 'destination and map' that had previously guided the ill person's life: ill people have to learn to 'to think differently'" (p. 1). Frank's statement seems to me to be true not only for those who find themselves suddenly in Sontag's (1978) "kingdom of the ill," but equally true for those who have gradually come to understand that they must journey through life with a chronic health condition. The old map is no longer useful. The desired destination may be unreachable. What is needed now is for the traveler to pull out her compass and reorient herself to the changing landscape in which she finds herself.

Unlike the restitution narrative, the reorientation narrative tells the story of someone whose original dreams and goals can no longer be reasonably regarded as attainable. The plot goes something like this: "I was headed to my destination but the road washed away. Now I must head in a new direction, perhaps to a new destination." The teller of the reorientation narrative once had a goal, and she worked hard to achieve it; but the goal now seems unreasonable, so she must set a new, more reachable goal in

order to have some hope of attaining it. The ideal type of the reorientation narrative is the **resilient body** and its action is *adjustment*.

The reorientation narrative is in most ways like the restitution narrative except that the teller of the restitution tale is determined to remain on course and intends to complete the journey—or has, in fact, completed it—as planned. The teller of the reorientation story, in contrast, is forced to acknowledge the impossibility of that goal and reorient herself to a new path. Because both narrators remain on journey, their body problems are similar. Frank, however, emphasizes that while the words used to delineate the range of possible responses seem "on paper like a dichotomy," they are "in reality a continuum of responses" (Frank, 1995, p. 29). One of the ways in which the restitution and the reorientation narratives differ is in how the bodies in the reorientation category may be found at different points along each of Frank's continua than bodies in the restitution category.

In both the restitution and the reorientation narrative, the body responds to the problem of control by attempting to regain some *predictability*. However, the reorienting body has moved toward accepting that a certain amount of *contingency* is inevitable. In terms of self-relatedness, both the teller of the restitution tale and the narrator of the reorientation story express *dissociation* from the body, but the reorienting teller is beginning to see that there is something to be gained in recognizing the fundamental inseparability and *association* of body and self. Both storytellers experience other-relatedness as a *monadic* body, and both have encountered othering in their relationships. However, the reorientation narrator has reached a point at which treating

herself with empathy requires that she recognize her own suffering in the bodies of her fellow travelers, moving her in the direction of the *dyadic* body. Desire is *produced* by the bodies in both story types, but the teller of the reorientation narrative must, of necessity, find a way to moderate that desire to some degree, knowing that she *lacks* the ability to satisfy her true desire fully.

In my initial attempts to label my respondents' interviews according to Frank's typology, I tentatively assigned a large number of their narratives to the restitution category. However, closer analysis revealed certain significant differences, leading me to posit this new type. Both the restitution and reorientation narrators share the characteristic that they are still actively attempting to reach a goal; neither is willing to remain as she is. The key distinction, however, is in the reorienting storyteller's acceptance of the need to modify her goals. The reorientation narrator, as a consequence of her willingness to accept the essentially contingent nature of life, is also less optimistic about ultimate success than the restitution narrator is.

A Reorientation Narrative: AnnaMarie

AnnaMarie states that she has been overweight "all my life," and she estimates that she would need to lose at least 50 pounds to be at an acceptable weight for her, though she would like to think that she might lose as many as 70. She has come to the belief that her body frame is such that her original goal to become truly "thin" is not only unattainable, but probably not even desirable. One of her key motivations for losing is that she has a conviction that God has a plan to use her, and "if He has plans for me, how am I going to carry them out if I'm carrying too much?" She has never married and has

had relatively few relationships with men, something that she used to attribute to her weight. As she has started to be more accepting of herself, however, she has decided that it is just because "it was not my time."

AnnaMarie claims that she thinks she has control over her body, but she focuses heavily throughout the interview on identifying external factors to explain her weight problems: genetics, thyroid, blood type, and eating habits instilled by her mother—who was, AnnaMarie notes, a single mother trying to make ends meet and unable to afford the sorts of foods that are conducive to maintaining a healthy body. She seems to be uncertain about exactly how much control she really has. Moreover, she recognizes the reality of *contingency* when she observes that even with her new weight goal, "that can change—either way, good or bad."

AnnaMarie expresses her *dissociation* from her body when she claims that if she were required to describe herself to someone who had not yet met her, she would make no mention of her body size; if asked what she looked like, "I would describe . . . what I would be wearing." She also does not believe that her body expresses who she is, since others, including her, tend to think that "overweight people are lazy and out of control. There is no discipline. And I'm not that type of lady. I am a person—there is discipline there, I do have control."

The description AnnaMarie provides of what she believes to be her identity is of someone who "loves and cares for others, and loves to do for others." She also says that she is "attuned" to other people and, in comparison to others, is "more understanding to how people are." She feels she is able to make a "connection." In these descriptions,

AnnaMarie clearly embraces an other-relatedness that is *dyadic*. However, she also insists that she is very "introverted," and indeed, in many of the stories she tells she depicts herself as having been quite reluctant in the past to form close relationships with others. She also describes a childhood in which she was strongly othered by cousins who "were skinny. They were small, so they made it known, 'You're the heaviest one in our family.'" A source of even greater pain was that when she shopped for clothing with her mother and her brother, they could go into any store and try on any type of garment, "versus me: 'Okay, I have to sit here and wait because there's absolutely nothing I can wear.'" She recounted tearfully that her treatment as an other was so profound "to the point that I never really felt that I belonged in the family." These experiences illustrate that she has keenly felt a *monadic* existence in the past, though she happily reports that she has begun not to let her weight "hinder" her socially, and that she is even working to be more comfortable in interactions with men.

AnnaMarie has a vivid memory of her mother insisting that a family member who was caring for her and her brother should withhold food from AnnaMarie until the mother returned home. She recalls feeling like she was "starving" as she watched the caregiver cut and section an apple for her brother to eat as a snack. AnnaMarie's story is often about desire that went unfilled, and a frustration with herself that she could not figure out how to stop *producing* it. Her decision to alter her previous weight loss goals is at least in part due to the realization that in order to enjoy life she will have to accommodate her desires to some extent. However, she also sees her weight as an impediment to enjoying life fully, so she is working to find some middle ground.

AnnaMarie's new orientation to the problem of her body is best summarized when she says that she has learned to "appreciate myself more as I get older and understand this will be a part of me for a lifetime. . . . I can only do so much and lose so much." She has begun to tell herself that "you can lose some, but just know you're not going to be that skinny person." AnnaMarie's repeated assertions that she was "comfortable—I have accepted who I am" were contradicted by her statement that her current weight "can change, either way, good or bad" and that she was still striving to become "comfortable in my own skin." She was clear that she would never be the thin person she wanted to be, especially because she never had been thin. So she was ready to modify her expectations; she just wasn't completely confident that she could achieve the new goals.

Other Reorientation Narratives: Mary Frances, Mary Lou, Megan, Ruth, Sherry, and Victoria

Mary Frances has "tended to think I've always been overweight . . . but that's not true." She pinpoints the beginning of her real weight problems to her mid-to-late 30s. She says, with bitter humor, "I've probably lost 10,000 pounds, but it's the same 30 over and over." She believes that she is now at her heaviest, which is about 140 pounds over what she considers to be ideal. Although blessed with overall good health, she is currently suffering from a debilitative condition that severely limits her mobility and causes significant pain. She has decided that she does not think she can lose all of her excess weight, leading her to adjust her goal to a loss of 60-80 pounds, primarily so she can do valued activities in her upcoming retirement years. She is currently following a

stringent diet that allows her only 800 calories a day, but she has established a deadline of 6 months; if she finds she has not been successful in achieving meaningful and sustainable progress, she has made a commitment to herself that she will opt for gastric band surgery.

Mary Frances expresses a high need for control in her life. She notes that she is very "competitive" and "professionally driven." Earlier in her life, when she gained to a certain weight that was more than she could accept, she was able to exert a great deal of control, saying that she would "dive down and lose it." Mary Frances' *dissociation* from her body is particularly striking. She suggests that she has "body dysmorphia," because "I thought I was fat when I wasn't, and haven't realized how fat I was when I was." She struggles with the attempt to reconcile her perceptions of herself with the perceptions she holds of her own body. She admits that the stereotypes that others hold about OW/O people—that they are "slothful" and "sloppy"—are perceptions that she probably also holds. Further, she confesses, "Oh, I'm sure I hold them about *myself*!" She realizes that her professional accomplishments alone are enough to refute the notion that she is lazy, but sometimes she thinks that she has just "managed to delude the world all these years" with her productivity

In some ways, Mary Frances is clearly *dyadic* in her other-relatedness. She enjoys a wide array of friends and associates and is obviously a person who interacts with others empathically. However, Mary Frances does confess that she tends to "think that if people don't like me, I often assume it's because of my weight." In that regard, she expresses some sense of feeling *monadic* othering. Interestingly, the one time she

talks of feeling distinctly "other" was when she attended a support group for overeaters. Women there talked of consuming vast quantities of food, something that she didn't relate to at all. Mary Frances seems *productive* of desire when she talks persuasively of how important it is to her to move into retirement years with the ability to enjoy them.

A close reading of Mary Frances' story reveals that she does not fit neatly into the reorientation pattern to which the other women in this category largely adhere. It is true that she has chosen to adjust her goals, but unlike some of the other reorientation narrators, she seems quite content with her new goal. However, unlike many of them, she expresses less willingness to accept *contingency*, and she seems far more *dissociated* from her body. Because of her plan to stick to a very strict diet and then, if it is not successful, opt for the commodity of gastric surgery, she is clearly not *lacking* in desire. In fact, like the women who told restitution stories, her focus on *self-regimentation* and *consumption* seems to place her in the middle of the continuum between the **disciplined** body and the **mirroring** body. A significant difference between her and the others in the restitution category—and the primary reason I have placed her in the reorientation category instead—is that she seems considerably less optimistic that she will reach her goal. This makes it impossible for her to offer a "prospective" story of expecting that "tomorrow I'll be healthy again" (Frank, p. 77). When asked if she thinks that losing weight and maintaining the loss is a realistic goal for her, she initially responded with cautious optimism: "I think because I've sort of mentally agreed that I'll do [the gastric band] if I don't, it probably is." However, the words "sort of" and "probably" tempered any real sense of optimism. Her doubt was expressed even more clearly when she later

said that she knew that it was probably unrealistic to expect that, at her age, she could lose that much weight and keep it off. “That’s what the literature says, and that’s what Oprah lives. . . . So, I don’t know. Ask me again in eight months!”

Mary Lou has only been overweight for the last 15 years. Prior to that, “I used to be a size 2 for most of my life. And 96 pounds. And then menopause hits and the entire thing completely changed and my whole life about changed.” She would like to lose about 35 pounds. She says twice during the interview that image is not that important to her, that her main concern is health, and she outlines the many health-related conditions she hopes to avoid. But she also talks several times about how frustrating it is that she used to be able to buy beautiful clothing without worrying about whether her choices would fit, and now finding anything that is acceptable is a major challenge to her. She has had few interactions with medicine over the years, primarily limited to occasions when she is acutely ill. She admits to having “never” had well-woman checkups because “overall I feel good and it’s . . . I don’t know . . . I just never have.” She is currently seeing a holistic health practitioner who is working to help her become “chemically healthy.” The focus of her healthcare now does not seem to be intensely aimed at weight, but she is hoping that weight loss will be one side-effect of her holistic treatments. She seems enthusiastic about all she is learning about her body from her practitioner, but she also seems to have de-emphasized the necessity of losing weight in favor of simply achieving a healthier body. She does not accept her current weight, but she accepts that she will never return to her former weight.

Mary Lou is extremely frustrated by the lack of *predictability* of her body because of the changes that have occurred because of menopause, but she realistically accepts that aging presents *contingencies*. She wants to maintain some control, however, so as to avoid many of the health conditions that so often accompany aging. She expresses *dissociation* from her body when she describes her relationship to her body as a "fight." She also lives to some extent in *monadic* relationships with others, experiencing a certain amount of othering, especially from men who, she believes, tend to "discard" older women and treat all women as "an item." She also feels othered by her daughter whose obsession with fitness for herself and her family makes Mary Lou feel, by comparison, "neglectful" of her own body. Mary Lou is still *productive* of desire, particularly her desire to grow older gracefully with as few accommodations to the infirmities of the aging body as possible.

Megan reports that she began to gain weight with the birth of her first child and that she is now about 80 pounds over her desired weight. She notes that her husband has tended to tease her about her weight, and her husband's perception has been a significant factor in her perception of herself. Recently, she decided to confront the issue with him, insisting that they "talk together about working out and our responsibilities as a parent, and who has to do what work at home." As a result of their conversation, she feels they have reached a more equitable sharing of household responsibilities that will enable her to spend more time on her weight loss goals. In fact, they are now working out together at home, both early in the morning before the children arise and later at night when the children have gone to bed.

Her optimism about her ability to keep working with her program is tempered by her recognition of the *contingencies* that accompany life in her situation. She notes that "with children, you just never know. If they get sick, then getting up early may not be possible. . . . Life always just turns—takes you down different roads you don't see happening." She expresses *dissociation* of her true self from her body when she opines, "I don't think I'm meant to be overweight." At times she wonders if she has "lost myself" in the process of becoming a wife and mother, which seems to be bound up in her recognition that her body began its change as she bore children. Megan feels that she has undergone some change in her other-relatedness from someone who previously judged overweight people. She would think, "'Oh, they just don't take care of themselves the way they should.' Not really looking in depth. And now, being overweight, I don't see it that way. 'Oh, they're . . . very busy. They don't . . . have time." Her increasing ability to empathize with the suffering of other OW/O women suggests some movement along the *monadic-dyadic* continuum. Megan's *productivity* of desire is best seen in her expression of wanting to lose weight in order to be healthy for her family. However, it is also a goal she has for herself, as she responds to my question about whether she would still want to lose weight if there were no stigma attached to a heavy body: "Probably. . . . If I was the way I was to begin with . . . before I was fat. . . . I liked the way it felt. Just knowing that would make me want to aspire to be svelte."

One of the more interesting features of Megan's narrative was that at several points she expressed admiration and support of women who had opted out of trying to continue battling their weight. "More power to them!" she exclaims, and then goes on to

say that she sometimes does wonder if perhaps she was "meant to be overweight," an idea she then quickly rejects in favor of at least losing enough to "feel comfortable in my own skin." The impression I had was of a woman who has modified her original goals, but who is also not fully optimistic that she can achieve the new ones; for that reason, she is beginning to explore the possibility that there might be a benefit to accepting herself as she is, though she is not ready to make that move right now.

Ruth has been overweight since childhood, and she estimates that at her heaviest she was 150 pounds above her ideal weight. To some extent, Ruth has always recognized that the weight charts present an ideal that is not attainable for her. She recalls losing "quite a bit of weight" just before she married, and she felt that she "looked better than I ever had in my life," but her weight was still 40-50 pounds more than the goal that Weight Watchers® had established for her. She has experienced a great deal of frustration with other diets because they "ran afoul of my diabetes." Finally she decided to undergo Lap Band® surgery. She has "mixed feelings" about the outcome of that surgery. She has lost a modest amount of weight (45 pounds) but seems to have hit a plateau that suggests to her that she is not going to be able to lose as much as she had hoped. She is, however, continuing to visit the doctor to keep "learning how to use the band better to my advantage." When I commented that it appeared that she was working hard to make the surgical outcome a good one, she replied, rather hesitantly, "Yes . . . for now." I took this to mean that she was leery about being overly optimistic.

In Ruth's experience, *contingency* has been the rule, and she has had to learn that it is not likely that she will ever have complete <u>control</u> over her body. She simply has too

many medical issues, and her diabetes seems to be her most pernicious problem. She talks about her body by saying that she is her "own worst enemy," and she repeatedly talks about how she is having to "fight" her body's production of insulin. *Dissociation* is also reflected in her statement that "obesity is kind of a mask; it covers up who a person really is." She is by nature "shy initially." She feels the judgment of others, a judgment that she believes is based on her weight, assuming that others regard her body as evidence that she is "not as competent" as other people. Her *monadic* orientation toward others is such that she is unable to get to know other people until "I think we've gotten past the [point] that they think of me as a fat person." Ruth is quite *productive* of desire, experiencing a lot of frustration that her surgery has prevented her from "enjoying certain foods," and "feeling deprived" because "there's a lot of comfort in foods." Her frustration with herself and her desire for food has led to significant anger directed at herself and, ultimately, a problem with depression.

Sherry has only been overweight for the last 4 years after a lifetime of being, much of the time, anorexic. She has endured a number of serious blows, both figuratively and literally. Her face was fractured many years ago in an incident of domestic violence at the hand of her (now ex-) husband. She has just recently been given a gift from a colleague that has enabled her to undergo cosmetic dentistry to restore her mouth. She also received a diagnosis several years ago of "high stage 4" breast cancer, and she underwent a mastectomy and chemotherapy. She is a survivor. Shortly after her cancer treatment, she suffered a massive heart attack which she believes was a consequence of the chemotherapy. She was placed on a heart transplant list; however, to

receive a transplant and tolerate the medications that would be necessary to prevent rejection of the new organ, she was required to gain weight from her typically underweight level. She did so, but she "overdid" it and gained too much. To be at her ideal weight, she would have to lose 30 pounds. To be at the medical ideal, however, she must restrict herself to losing only 10 pounds. She does not know how she is going to feel about maintaining the weight at the medical ideal, but she realizes, "I *have* to!"

To say that Sherry has had to come to terms with *contingency* would be an understatement. She has, though, and uses her realization of how fortunate she is to still be alive as the source of her optimism that she can prevail. She says that she has learned that she must maintain close watch on her diet or she could regain easily, so she does adhere to a fairly firm regimen of diet and exercise. Her *dissociation* from her body is seen in her awareness that she has never had an accurate perception of her body. When she was underweight, she did not see herself that way; when she was overweight, she avoided looking in the mirror because she felt she looked at least 40 pounds more than she actually weighed. She feels that her thin body "is me." So she is at odds with herself in her present body. As she has gained weight, Sherry has related to others in a much more *monadic* way. She isolates herself, even from people with whom she once enjoyed close relationships. She is embarrassed about her body and fears that they will judge her. It is clear that Sherry is *productive* of <u>desire</u>, struggling as she is to do all that is necessary to merely stay alive.

Victoria feels that she has been heavy "all my life," but she says the real problems started at about the time she entered puberty. She would have to lose 130

pounds to be at what she would consider her ideal weight. However, after numerous attempts to lose that have resulted only in regain (and the gain of additional pounds as well), she has come to accept that it is highly improbable that she will achieve that goal. She is now focused on merely achieving a healthier weight. She is currently on yet another diet, but she has decided that if an acceptable amount of weight has not been lost within a year, she is going to undergo surgery. She suspects it will be Lap Band®, as that is what her physician has recommended.

Through all of her failed efforts at losing weight, Victoria has finally accepted that she is not going to be able to exert the level of control that she would need to achieve her optimal weight. She feels some *dissociation* from the body she lives in because she does not think it accurately expresses to others who she really is. She sees herself as very "active," though she believes her body conveys that she is "sedentary." In order to counter others' perceptions that overweight people are "sloppy," Victoria feels that "you have to be extra put-together, extra, you know, hair done, nails done, because people assume that you're unkempt when you're heavy." She clearly adopts this ethic in her personal appearance.

Victoria's other-relatedness is particularly illustrated in the fact that she has a twin sister who, although not an identical twin, is close enough in appearance that they are occasionally confused for each other; interestingly, this is true despite the fact that Victoria says that her twin is thin. She realizes sometimes that she sees in her twin a representation of what she might look like if she were thin, but she cannot relate to her sister's body at all. She feels very othered in her relationships with normal weight

individuals, noting that they have an entirely different perspective than she does. She recounts a story in which one of her normal-weight friends was talking about having been given some clothing, apparently for a clothing drive, from another woman who had lost a lot of weight. Victoria's friend was aghast when she examined the bundle of clothing, exclaiming to Victoria, "'She [was] huge! She [was] a size 20!'" Victoria winced as she thought, "I'm like, 'Uh . . . Do you know what size *I* am?!'" Victoria's *productivity* of desire is best captured when she says that her greatest regret about being overweight is all the things she is not able to participate in because of it. She laments, "You could be living this life . . . all these different experiences, and you're not. You're living a sub-life that is not as good as the other one because you don't want to try all these things because you're overweight."

All of the women in the reorientation category have lived for a long time with an ideal of what they should look like and what they should weigh. For some of them, the ideal is based on having at one time been at a normal weight; others have never experienced that ideal. All, however, have come to an understanding that is borne out of years of struggle: that the ideal is not attainable, and to continue to desire it is to set oneself up for constant torment. So they have opted for a new map. They have reoriented themselves to their changing circumstances and their enlarged understandings. They are still on journey; they just no longer aim for the same destination, and their past experiences have caused them to be less than optimistic about their chances of getting there.

That Frank does not include a narrative type that is precisely like the reorientation story is not surprising. He was writing about people making sense of acute illness—the sorts of illness for which the ideal scenario is total recovery or, at least, remission. For people with chronic health conditions, those may not be viable expectations. Their future may be marked by the constant presence of symptoms, gradual worsening of the symptoms, or at best, periods in which the condition waxes followed by periods during which it wanes—not truly remission, since the reasonable prognosis is that the troubling symptoms are sure to return. The worst case scenario is that the body will continue to deteriorate until it can no longer be sustained. Restitution is not truly possible. Quest is an ideal, but one that is so powerful precisely because it is so rarely achieved. Chaos is probable, but so unbearable to live with that an alternative narrative is desired. Reorientation offers one possible alternative narrative. There is at least one other.

The Acceptance Narrative

For some people, travel to new places ceases to be desirable. Perhaps they have visited all the sites they have dreamed of seeing. Perhaps they have repeatedly found that the experience of the journey was disappointing. Maybe they are tired of the inconveniences of travel and the interruption of comfortable routine that staying at home permits. Or maybe they are simply tired: they have invested all the energy they care to invest in travel and wish now to concentrate on other things.

For people who are dealing with chronic illness or health conditions, there sometimes comes a point where the efforts to alter the terrain of their lives no longer yield rewards that justify the expenditure of time and emotion. At this point, an alternative narrative is required. One option may be to surrender in despair, to give up and find the nearest exit. This may be an attractive story for a few, but most people wish to write a story for their lives in which they can be viewed as having accomplished something on their journey, no matter how modest. The acceptance narrative offers such a choice.

The basic plotline of the acceptance narrative is: "I took a trip. The destination seemed inviting but the cost of getting there was high. Moreover, I found that I missed the comforts of home. So I am back, at least for the time being." The ideal body type of the acceptance narrative is the **acquiescent** body and its action is *adaptation*.

In some ways, the acceptance narrative is similar to the quest narrative. It differs, however, in that it lacks a powerful insight that the teller feels compelled to share with others. To be sure, there is an insight: it is that sometimes you need to come to terms with what is realistic for you. It is a quiet insight, though. Unlike the insight of the quest narrative, it is not one that is trumpeted in the media or earnestly discussed with any who would hear it. It is more likely shared in intimate conversation. In most ways, however, the acceptance narrative can be analyzed in ways that are similar to the quest tale.

Control is always a problem for all bodies, and the Western value system tends to exalt the ability to control one's self, one's body, one's emotions, one's very destiny. However, the acceptance that life is constantly *contingent* often frees the self from the

pursuit of unattainable goals. As Frank notes when discussing the quest narrative, the paradox is that in accepting contingency, one gains "control of a higher order" (p. 126). This is an idea that is also applicable to the acceptance narrative: to accept what must be accepted means that you are no longer controlled by engagement in futile efforts.

In the acceptance narrative, self-relatedness is expressed with a move toward *association* with the body. Once a person has accepted the limitations of the body, they are free not to regard it as an adversary. Indeed, they may begin to understand that their body has its own wisdom from which the self can learn much.

Other-relatedness in the acceptance narrative is seen in the *dyadic* response to others, particularly to others who share your struggles. After having been othered for so long, the accepting body works to abandon attitudes that erect barriers between people. The requirement that others "accept me for who I am" in order to be in relationship is dropped. The other person's limitations are also accepted, particularly because their perceptions are no longer as central to the maintenance of the acceptance narrator's identity. Relating to others and to one's self in this way is a constant and ongoing struggle, and the accepting body will not achieve this orientation easily.

The accepting body is still *productive* of desire, but those desires have been moderated so that the body does not require in excess of its needs as much as it may have in the past. Its desires are more oriented toward peaceful and fruitful relations with others and less toward what the self may have selfishly wanted before. In one important way, the accepting body moves toward a *lacking* of desire: lacking the desire to achieve goals that cannot be achieved.

My proposal for the acceptance story as a narrative type for OW/O women (and likely for those who suffer from other chronic illnesses or health conditions) results from my observation that many of my respondents had reached a sort of truce—albeit an often uneasy one—with their bodies. They were no longer optimistic that they would ever enjoy the bodies they once enjoyed, let alone a body they had never even experienced. Moreover, they were no longer willing to continue investing the emotional energy in pursuing an obviously elusive goal. In some cases, this attitude was borne from what seemed to me during our interviews to be an unusual level of body acceptance. For others, the factor that made the acceptance narrative a viable alternative was that the woman had already given up a great deal in some other area of her life, and she was unwilling to contemplate additional sacrifice in those parts of her life that brought her any pleasure. It is also possible that the absence of any currently significant health concerns may have made acceptance more feasible. For whatever reason, these seven women have decided to opt out of the journey and find pleasure in the familiar comforts of home.

My exemplar for this narrative type is actually a combination of two women; one is the mother of the other, in both the literal and the figurative sense. I mean by that that they are biologically related in this manner, but also that it is clear that the attitudes of the mother have been thoroughly absorbed by the daughter. Here, then: the stories of Raquel and Vanessa.

Two Acceptance Narratives: Raquel and Vanessa

Raquel estimates that she has been overweight about 90% of her life and that at her heaviest she would have had to lose 70 pounds to be at what she considers ideal weight for body. Her daughter, **Vanessa**, traces the beginning of her concerns with her weight to about the time she entered puberty. She is at her heaviest now, and if she could lose 100 pounds she thinks that would be ideal for her. Neither Raquel nor Vanessa is troubled by any serious health concerns, though Vanessa confesses to a certain level of hypochondria, imagining every physical sensation as some sort of symptom. Raquel also admits that she is beginning to experience some of the unavoidable consequences of getting older, and she does worry that more are to come and that being overweight might exacerbate them.

Both Vanessa and Raquel accept the notion that life is *contingent*—that you go through periods when things are one way and then they change to something else. They have seen this in their weight histories. Both subscribe to the notion that the key to managing weight is exercise, and they have noted that at times when they are diligent about exercising, they do manage to lose a little weight. Those periods, however, are inevitably followed by a phase during which exercise becomes difficult or impossible, owing to life circumstances or to a loss of motivation. When those phases occur, they will regain the weight they lost and, in some cases, more. In that regard, they are comforted by the *predictability* of the cycles. All it will take, they reason, is to get back to exercising. This acceptance of the cycles, unfortunately for them, sometimes results in procrastination in getting back to the program. They do not lament the loss of **control**;

they believe control is in their hands, though moderated by circumstances. They know they *will* eventually resume exercising. They also see weight control as "my own responsibility," which is one reason why neither has talked seriously to a physician about their weight. The other reason they give for not having consulted with health professionals about their weight is that both believe, "I already know what he will say, and I already know what I need to do."

Raquel reports that she was raised largely by her grandmother, who instilled a lot of confidence in her and taught her how to use good posture and carry her body well. As a result, "I've never felt bad about being overweight. I've just always known I'm just a big girl." Raquel, then, passed on this attitude of self-relatedness to Vanessa, who similarly *associates* with her own body. (Unlike Sasha, whose restitution story also includes a discussion of the importance of how one carries her body, Raquel and Vanessa saw the carriage of their body as a way of expressing their selves to the social world. Sasha's view was that it was a way to disguise the weight of her body from others.) When she was teased by a female bully in middle school, Vanessa recounts that her mother would tell her, "'Don't listen to her. She's just jealous because she has a skinny little nothing body.'" Both Raquel and Vanessa describe their bodies as "thick," and both assert repeatedly that they are "fine with my body."

The carriage of their bodies is also a factor in both Raquel's and Vanessa's other-relatedness. Raquel mentions that people often comment on the confidence she exudes in interacting with other people. "They say, 'How can you be so confident and be this size?' I'll say, 'I don't know where it comes from, it just comes from somewhere

because I'm happy with who I am.'" Raquel believes that other women who are about her size especially appreciate this attitude in her, so she believes that she serves as someone who can help them boost their own self-esteem. She never judges other overweight women negatively. She notes that sometimes she sees OW/O women who are "frumpy" or "the hair is a mess," and she thinks, "'You're okay; you just need to fix up a little and you'll be okay.'" Raquel never seems to be troubled by a sense of othering. In this regard, however, Vanessa differs. She has been the target of very cruel remarks from her father (from whom her mother is now divorced, much to Vanessa's relief), and she remarks that even in relationships with peers she has often felt "like I'm handicapped or something" because of her weight. However, she quickly amends her musings by insisting, "It's no big deal" or "I'm fine with my body." It is reminiscent of her mother's repeated theme: "I've always been big, and . . . I've never aspired to be skinny." Vanessa reports that overall her weight has not been an impediment in the development of relationships; in fact, her boyfriend considers her a "goddess."

Raquel and Vanessa both admit to a fondness for "good Mexican food!" Because both adhere to the notion that "diets don't work," they have expressed a near complete unwillingness to give up the foods they enjoy. They would rather exercise twice as hard. Raquel does note that she has been experimenting with serving whole wheat tortillas in response to her boyfriend's needs to watch his diet, but she makes a strongly negative facial expression when she mentions that accommodation. Vanessa also recalls that she once did sustain a period of a couple of months in which she got rid of all the "bad" foods and replaced them with "good" foods and, combined with the

Pilates she was doing at the time, lost a gratifying amount of weight and looked "very good." She thinks that if she could ever find what motivated her to do those things the first time, she might try it again, but she would otherwise not opt to attempt dietary changes as part of any weight control effort. Both Vanessa and Raquel continue to *produce* a desire for the foods that please them and *lack* the desire to lose weight enough to be willing to endure deprivation. Both also desire good health, but neither is sufficiently concerned about the issue at this time to elevate it to a place of priority. In response to a question I asked, Raquel initially maintained that if her physician were to express concern about her weight she would agree with him and appreciate his straightforwardness. She later amended this, claiming that if he began to recommend modifications in diet or prescribe medications, she "would say, 'Now hold on a second! Let's talk about this in the bigger picture. Let's at least look at my blood work and things like that.'" She also remarked that she would probably assume that the doctor was "stereotyping me."

The stories of Raquel and Vanessa provide a provocative glimpse into the mechanisms discussed at the beginning of this chapter about how our understanding of our self is constructed. It is clear that Vanessa has incorporated a great deal of her mother's attitude into her own view of the issue of overweight. There is much to be admired in the obvious success Raquel has achieved in instilling a sense of self-esteem in Vanessa. There is, however, room to debate the ways in which such self-acceptance might work against the need to safeguard one's health.

Other Acceptance Narratives: Angel, GiGi, Lisa, Maggie, and Susan

Angel has been dealing with weight issues for about 30 years, and she says that at her heaviest she was at least 135 pounds over her ideal weight. The interesting thing about this number is that she has undergone gastric bypass surgery and reports that she has lost 135 pounds, which would suggest that she has attained her goal. However, she admits that her true ideal is still considerably below that, that she would love to get to a level that would require her to lose another 30 or 40 pounds. She honestly feels that it is unlikely that she will lose more, however, because "I would have to quit eating everything I do now and that's really hard." Because she has adjusted her ideal to the weight she has already attained, it is apparent that she has made the move to the acceptance narrative.

To be sure, she is still spending some effort talking herself into embracing acceptance. She reassures herself by recounting the positive feedback she has received from others. And she reminds herself, "135 pounds is a lot of weight. That's like losing a person, you know?" She also admits that she accepts *contingency*, observing that one cannot always adhere strictly to a regimen. Speaking sometimes in the first-person and sometimes in the second, she notes that at times "you want some of the junk" and then "you know to offset that I've got to exercise or I've got to do this more." So Angel has accepted that perfect control and predictability are not part of her expectations.

Angel's past *dissociation* of her body and her self is best captured by the quotation from her interview that opens this chapter: "When you're fat . . . well, you're just not yourself." There is still some dissociation in her self-relatedness as she talks

about how she has to try to "knock off some pounds" if she overindulges and gains a little bit. It is as if her body were a plant that needed pruning or a sculpture that needed some part chiseled away to reveal what is supposed to be there. As a result of her surgery, she says, "I'm not that other person like I was before." In terms of other-relatedness, Angel refers to herself as someone who has never quite felt "up to par" because of her failure to achieve marriage as so many of her friends have done. When I asked her to what she attributed her weight struggles, she said (in a voice that is barely audible on the tape), "Oh, I knew you'd get to this," and then she replies, "Probably relationships. It's something I've always kind of done a nose dive on." Later she says that she "wouldn't want anything serious" with men, but she alludes even later to a sense of regret in feeling that a relationship with a man was something that was unattainable for her. She recounts feeling deeply othered in moments when "you would hear people make fun of you or you would hear . . . all the little sly remarks."

Angel's is a story of a *monadic* body until her surgery; now she is "wanting to do more, wanting to be out" with people. Angel seems to have found some peace with where she is at the moment. Her desires "of the heart" have been, according to her, answered by God, so that she is no longer *productive* of the desires that dominated her life before. On the other hand, she still does produce desires for her life: "I've always achieved at everything . . . but it's like you want it all. You just don't want this little piece of it. You want the whole thing." To her, the "whole thing" is "if you're happy."

GiGi has been overweight her "entire life" and at her heaviest would have needed to lose 170 pounds to be at her ideal weight. She has lost 100 of those pounds

after undergoing gastric bypass. She submitted to the surgery after a lifetime trying to lose weight.

> You have to get to a point that says, "I can't." You know? It's a surrendering to a certain extent . . . [It's saying], "So I'm going to admit that, and now I'm going to try to get the tool that will help me because nothing else has."

Her attitude about losing the remaining weight is that "I believe I could if that could be my main focus. But it's very rewarding to have lost at least 100 pounds and in four years not gained any of them back." She admits, however, that at this point in her life, further weight loss is not her main focus.

GiGi recounts that "it was so frustrating when you have success in every single other part of your life but you seem not to be in control of your body." Control, therefore, was a large part of her anxiety about her body. Now, though, she has adopted the attitude that "you can only control what you can control," and she seems accepting that the *contingencies* of life mean that at times she will not be able to place weight loss at the top of her priorities. GiGi's self-relatedness is interesting. She talks about how she was able to manage her body's appearance as she gained weight by virtue of the fact that she is at heart and by training an actress. She talks about how she was able to "disguise certain things," and she acknowledges that she was disguising them as much from herself as from others. She portrays herself as someone who *dissociated* from her body by treating it as something that she was able to manipulate. I cannot, however, make the claim that she is more associated now, as there is nothing I have found in the interview that would provide evidence to back up that view.

In relatedness to others, GiGi recounts many examples in which she felt othered. Perhaps the most dramatic of these was the time when she was in 4th grade and the teacher weighed and measured her students in the presence of everyone, announcing the numbers as she recorded them. GiGi was as shocked as her classmates to learn that she was the first in her grade to reach 100 pounds. Her most poignant remarks about her feelings in relationship with others was when she confessed that she often wonders if she was an embarrassment to her children when they were growing up. And she also felt the sting of othering when she was stared at, as though she were a "freak," by a Spanish man she sat near on a transcontinental flight. She, however, is *dyadic* in her empathic response to other overweight people. GiGi is still *productive* of desire, though her desires now are in the direction of maintaining health. Her weight loss after surgery has resolved those health concerns she once had, helping to explain why she is *lacking* in the desire to focus with intensity on additional weight loss.

Lisa estimates that she has been overweight for about 15 years and that, at her heaviest, she would have needed to lose "40-60" pounds. The most prominent feature of Lisa's story is that she suffers from Polycystic Ovary Syndrome (PCOS), a condition that is brought about by the female hormones. It is her understanding that women with PCOS have greater difficulty losing weight, but that once they have reached menopause and the hormones change, they sometimes "turn skinny" again. Lisa wears this prospect as armor. It is the source of her ability to adopt the acceptance narrative at this time in her life.

Because of her PCOS, Lisa accepts her life as *contingent*. The control of her body is at the mercy of her hormones. Her relatedness to self has been largely to deny the presence of her body, to "cover it up," a dictate that was imposed by her father who sought to have all his daughters protect themselves from men when they reached the age where they became "chesty." She was shocked when she first discovered in a photograph that she was heavier than she had perceived herself to be. When she saw the picture she thought, "I am not my normal thin self." She has attempted to feel more *associated* with her body by placing positive interpretations on it. When she compares herself with others, she sees that "some are smaller, some are larger, and I'm kind of in the middle." She has adopted the term "Mama Bear" to define her body, and it seems also to define her sense of who she is in relation to others.

In her other-relatedness, she is particularly at home with children, who seem to respond well to her, partially, she believes, because she is so short. She enjoys a *dyadic* relationship with them as she does not feel judged by them. Men are another matter. She is *monadic* in her relationships with men. Her friends describe her as "fearful" with men. She has developed that attitude as the result of experiences of rejection. Interestingly, she finds that her weight helps her deal with that rejection; she is able to attribute a man's lack of interest in her to her weight instead of as a rejection of *her*. This provides further evidence of her tendency to dissociate her self from her body. Lisa remains *productive* of desire, particularly the desire to form relationships with men. She had always thought she would be married by now, and the absence of that sort of relationship is keenly felt.

Maggie claims that her weight problems began about 10 years ago, and she says that her goal at her heaviest (and she confesses that she is currently at her heaviest) would be to lose 20 pounds. Maggie attributes her weight gain entirely to menopause. She has a high degree of body acceptance, assuming that this is just what her post-menopausal body will look like. She has no particular angst about attempting to control her body, choosing to let the *contingencies* of the moment determine what her attitude about weight loss will be. At the moment, she is not troubled by her weight. She does not particularly *associate* with her body, preferring to think of it as little as possible. She simply does not see weight as a "big deal . . . it's a little bit of a big deal, but not much." She wishes she were "a little skinnier," but admits that "I won't work . . . I won't do what I should do to make myself skinnier."

In other-relatedness, Maggie does not make judgments about other people's bodies, so she assumes they do not judge her body either. She doesn't indicate that she feels any particular *dyadic* empathy with them—simply that she does not think a person's body is that important and should not be the basis of judgments people make. She is *productive* of desire, admitting that she enjoys eating and is not willing to make changes in her food choices. She acknowledges that if she had some serious health problem she would consider making different choices if necessary, but in the absence of such a health problem, she is not going to think about it. It would be easy to dismiss Maggie as someone who is just in denial, but then there are certain factors that explain her less than anxious attitude about her body: she is not seriously overweight; she has not been overweight as long as most of my respondents have been; her husband has

never made any suggestion that she should try to lose weight; her health is basically good; and no doctor has told her to lose weight. It is easy to see why the acceptance narrative is one that she would prefer to embrace.

Susan has been overweight for about 6 years. She is at her heaviest now, and she believes she needs to lose 60 pounds in order to be at her ideal weight. Susan's weight problems started when she conquered alcoholism and, a few years later, gave up smoking. Her alcoholism has created an addiction to sugar that she finds difficult to manage. However, her doctor is so thrilled about her overcoming her drinking and giving up smoking that he does not dwell at all on her weight. Susan's life was so chaotic when she drank that, by contrast, she feels she has a great deal more control now than she ever did before. Although she is not happy with her weight, she thinks she is doing a good job managing the *contingent* nature of life without resorting to alcohol, so she is willing to relax her expectations of herself with regard to weight. She does admit that in her self-relatedness she feels *dissociated* sometimes. "I am a stranger to myself." She has a picture of herself on her computer "to help me realize I'm not as svelte as I feel inside." It is interesting to me that, unlike many people, Susan does not claim to have put the picture on her computer to motivate her to lose weight; instead, it seems like she is trying to *associate* more successfully with her body. This use of the photograph provides evidence that Susan is not as much planning to lose weight as she is working to accept her weight.

Susan is a very *dyadic* person by nature. Her favorite part of her job is when someone comes to her with a problem and needs help finding information. She loves to

feel that she is helpful to others. She does feel the *monadic* othering, however, opining that both age and weight are particularly difficult for women because "we become more invisible . . . and people tend to ignore you." She goes on to say that "they discount you," and that she feels that people seem to feel "free to discriminate against . . . overweight people." Clearly, Susan has managed to reach a state of *lacking* desire with respect to her recovery from alcoholism. She is not, however, prepared to make many more sacrifices in her life. Particularly, she does not feel inclined to deprive herself of food she enjoys in order to lose weight. She says that if a doctor told her she absolutely *had* to lose more weight, she would want to know "what's the least I can get away with?" She is still *productive* of the desire to lose weight, but would be satisfied if she just lost "some" weight, enough to "feel better in my clothes."

All of the women whose stories I have categorized as acceptance narratives have reached a stage in which the answer to the torment that accompanies the constant pursuit of thinness is to retire from the race. Yet, I do not sense a real "giving up." All of the women seem concerned with at least trying to maintain where they are now. They also retain the option to make weight loss the focus at some later time, but they want to do that on their own terms. They seem to have as their main desire the desire not to think about their weight until they perceive a need to. They desire a little peace in their lives. They have chosen to embrace a narrative of acceptance to accomplish that, though the women are at various points in the process of achieving that acceptance.

This chapter has concerned itself with the identity stories of twenty-three women who are or have been overweight or obese. I have attempted to show how their stories

can be analyzed productively within a theoretical framework that focuses on story types. I believe it is significant that Frank's framework—which works very well as a typology for narratives of acute life-threatening illness—was sufficient for categorizing only nine of the twenty-three stories I heard. By extending the framework to include two new story types, we can see that there is a greater range of variability in how people with chronic health conditions story their lives. The purpose of identifying narrative types is to enhance our ability to listen to stories and, from them, understand something of the lived experience of others. The benefit of hearing stories in this way is, as Frank notes, that it "affords each a right to speak her own truth, in her own words" (p. xiii).

In the next chapter, I will employ grounded thematic analysis to explore the ways in which my informants made sense of their weight. I will present their responses to some specific questions I asked them, and I will also describe two themes that emerged within the overall content of their interviews. In the chapter following that, I will expand on those two themes as they apply to medical interactions.

CHAPTER V

MAKING SENSE OF OVERWEIGHT/OBESITY: GROUNDED THEORY ANALYSIS

> At what age does a girl child begin to review her assets and count her deficient parts? When does she close the bedroom door and begin to gaze privately into the mirror at contortionist angles to get a view from the rear, the left profile, the right, to check the curve of her calf muscle, the shape of her thighs, to ponder her shoulder blades and wonder if she is going to have a waistline? And pull in her stomach, throw out her chest and pose again in a search for the most flattering angle, making a mental note of what needs to be worked on, what had better develop, stay contained, or else? At what age does the process begin, this obsessive concentration on the minutiae of her physical being that will occupy some portion of her waking hours quite possibly for the rest of her life? (Brownmiller, 1984, p. 25)

I often wonder if the scene evoked by Brownmiller in the quotation above is one that the average male reader would recognize from his own life. I suspect that many a "boy child" has scrutinized his physique with intense interest and a critical eye as he negotiates the movement from adolescence into manhood. However, once having attained some maturity, does that "obsessive" preoccupation with appearance that

Brownmiller describes (accurately, I believe) as being true for most women hold equally true for most men?

Evidence suggests that male college students and men who are weight-lifters are, indeed, preoccupied with their physical appearance, especially desiring to increase muscle mass without gaining weight (Morgan, 2000). However, most studies find that women are much more likely to be concerned about their physical appearance (see, for example: Bailey, Gaulin, Agyei, & Gladue, 1994; Peplau et al., 2009) and especially about their weight (Hoffman, Dundes, & Lemke, 2007). The study by Hoffman and colleagues is particularly interesting because it found that 33% of the male respondents who self-identified as being up to 20 pounds overweight, as well as 43% of the men who identified as greater than 20 pounds overweight, believed that most people regarded them to be at a weight that was "about right" for them. By contrast, none of the women in those self-identified categories believed that people held that perception for them.

I have read and heard the opinion expressed that girls are socialized into the cult of dieting at younger and younger ages, and indeed, as I write this paragraph, I have just returned from a brief shopping trip during which this phenomenon was driven home to me. Two young girls, one of whom seemed to be about two years older than the other, were chattering as they half-skipped down the aisle of the department store. They were following a woman who appeared to be the mother of one or both of them, and they headed to the store exit, shopping bags clutched in each of their hands. The older of the two girls appeared to be no more than 8 or 9 years old, and both girls had the bodies of healthy girl children—not rail thin, but not obese by any means. The older girl said very

authoritatively to the younger, “I’m going to have a salad and you should, too. Then we will lose weight and everyone will say how skinny we look.”

Since Susie Orbach published her influential book, *Fat is a Feminist Issue* (1978), the subject of how and why women eat—and don’t eat—has evoked considerable interest among feminist writers. Much has been written about how notions of the ideal female body have evolved historically and the political interests that are served by imposing those standards on women. It is interesting to note that while Orbach certainly decried the over-emphasis on thinness as the standard and called for a new feminist ideal that embraces all sizes, the focus of her book was to encourage women to resist the lures of the diet industry that, she argued, serve patriarchal interests and adopt a new approach (hers) to eating. Her book—the subtitle of the first edition of which is *The Anti-Diet Guide to Permanent Weight Loss*—proposes that women should stop dieting, learn to recognize genuine physical hunger, and respond to that hunger in ways that nourish the body and soul without overeating. The promise is that by reorienting to an “anti-diet,” women can finally be successful in losing weight. Orbach, however, is not without her critics. Lamm (2001), for example, pointed out, “she’s totally missing the point. She’s trying to help women, but really she is hurting us . . . because she’s saying that there’s still only one body that’s okay for us” (p. 139).

And women still strive to get that body. Some women “never cease hoping they will wrestle the situation under control” (Puhl, 2005, p. 279). Chernin (1981) talks of Western culture’s hatred of fat—particularly fatness in women—and remarks that the overweight woman “will not seek to change her culture so that it will accept her body;

instead she will spend the rest of her life in anguished failure at the effort to change her body so that it will be acceptable to her culture" (p. 106). Bordo (1993) asserts that the "pursuit of an ever-changing, homogenizing, elusive ideal of femininity" results in female bodies becoming "docile bodies—bodies whose forces and energies are habituated to external regulation, subjection, transformation, 'improvement'" (p. 166).

Even women who understand the oppressive consequences of the culture's hatred of fat—and who routinely condemn the marginalization of people on the basis of any external characteristic—are not immune from the preoccupation with weight that drives so many of us. Eve Ensler (2004) laments,

> What I can't believe is that someone like me, a radical feminist for nearly thirty years, could spend this much time thinking about my stomach. It has become my tormentor, my distractor; it's my most serious committed relationship. It has protruded through my clothes, my confidence, and my ability to work. I've tried to sedate it, educate it, embrace it, and most of all, erase it. (pp. 5-6)

I am fairly confident that no more than two or three of my respondents might label themselves, as Ensler does, a "feminist." A few of them made general references to the cultural expectations for women's bodies as represented in the media. Gabby, for example, argued quite passionately that "on TV, you look at all these skinny women . . . and they're all thin; they're all beautiful!" Susan contrasted cultural attitudes about thinness by remarking, "You know, you go to third world countries. I don't think they have anorexia problems . . . in the Sudan." Others made comments that reflected that they understood that standards for men and women are different. Ann, for example,

reported that her husband had played football in college 35 years earlier but "thinks he's still on the football team," continuing to eat large portions but never being at all concerned about his size until his recent checkup when he was told he should lose weight because of his blood pressure. Ann recounted this story as a contrast to what she labeled as her "obsession," having spent over 30 years trying valiantly to fit the thin ideal. Mary Lou made reference to her belief that how women are made to feel about their weight is a function of "the attitude toward women by men." Other than these examples, and a few others that are even more oblique, there is little evidence in my interviews of anything that could be construed as conscious cultural or feminist critique.

That my informants did not spend a great deal of time questioning the structures of power that serve to disadvantage overweight and obese women is not really surprising. As MacInnis (1993) argues, "Fat oppression, the fear and hatred of fat that result in discriminatory practices, is so commonplace in Western cultures that it is rendered invisible" (p. 70). There seems to be a taken-for-grantedness that there is some logic behind the cultural preference for thin bodies. GiGi, in fact, remarked that she had read that "there is a biological thing inside of us that is also just drawn to symmetry and to certain bodies that move a certain way, and certain bodies that don't are less attractive to you." Perhaps that is true, but a case could be made that "biological things inside of us" are not always the best guides for human action, and my sense is that the women I interviewed did have at least some awareness that there was injustice in the treatment they had received at the hands of others because of the culture's preference for thin women. While the women in my study did not rail against "the patriarchy" and not a

single one of them uttered the word “hegemony,” they did struggle to understand and make sense of their experience, to figure out the sources of their disquiet and to come to terms with how they might proceed to live peacefully with their bodies.

In this chapter, I will present the results of my grounded theory analysis of the twenty-three interviews I conducted with overweight/obese (OW/O) women. My purpose in this chapter is to understand how OW/O women make sense of their weight. In doing so, I seek to answer my second research sub-question: *What are the factors that OW/O women believe to have contributed to their weight problems? What are their perceptions about how being overweight impacts their lives?* I will start by examining responses to two general areas of questioning that were designed to be part of my semi-structured interview schedule, exploring what my informants believe about causes and effects of being overweight. I recognize that these categories cannot be considered truly emergent, imposed as they were by the protocol, but the responses did evolve into identifiable themes that are worthy of explication. Following those two sections, I will present two categories that *were* genuinely emergent and seemed to pervade a great many of the responses to questions throughout the interview.

Identifying Factors that Contribute to Overweight/Obesity

In the effort to make sense of their struggles with weight, the women who participated in my study talked of a variety of factors that they felt contributed to their having become overweight/obese and to their difficulties in trying to lose and maintain weight loss. At times I could sense their frustration as they tried to pinpoint a cause,

accepting responsibility for some aspects of the problem while also mentioning factors beyond their control. The frustration was particularly evident in those women who were unable to claim, as others could, that being overweight simply "runs in our family."

Physiological and Physical Issues

Some of my respondents reported that they were the only persons in their family who were heavy; others were able to identify other members of their family who were also overweight, and some of those went so far as to specifically attribute their weight to "genetics." Ruth, for example, supported her assertion that genetics played a role by telling me that out of eight children in her immediate family, only one of her siblings did *not* have a serious weight problem.

Many of the women associated the beginning of their weight problems with hormone changes. Vanessa and Victoria pinpointed the onset of their struggles with weight to entering puberty; others did not specifically mention "puberty," but they recounted their mothers first taking them to see a doctor to discuss their weight at about that age. Pregnancy was also cited by several women as a turning point in their weight management. Megan reported that she was urged by her doctor to gain what would usually be regarded as an excessive amount of weight (80 pounds) when she was carrying her first child. Gabby, Grace, and Sasha all traced the beginning of their weight struggles to their first pregnancies and the inability to take the weight off after their babies were born. Grace commented that she had read—and believed from her experience to be true—that after giving birth, a woman's "metabolism just stops." Menopause was specifically blamed as the genesis of both Maggie's and Mary Lou's

weight problems, and others mentioned the effects of menopause on their inability to take weight off as quickly as they once had.

Some of my informants talked of health conditions that either played a role in their weight struggles or posed problems because of what is required to manage the condition. By far the most dramatic of these were the cases of Charlotte, Mae, and Sherry. Charlotte was in the process of dealing with breast cancer. She believed that controlling her weight was important for maximizing health outcomes as she pursued alternative therapies for the treatment of her disease. However, it was clear that she felt that her priority at that moment could not be weight management, as the uncertainties about survival were more important than concerns about weight. Mae was on a transplant list because she suffered from "end-stage kidney disease." Her weight was an important issue because, as she explained it, carrying too much weight jeopardizes the potential for a successful transplant. Unfortunately, the diet that was prescribed to optimize her kidney function while waiting for the transplant included foods that made losing weight almost impossible. Sherry had experienced several health issues, including breast cancer and heart failure, the latter resulting in her placement on a transplant list. She was still undergoing therapies that necessitated maintenance of a fairly narrow range of weight. Until the time of her ill health, she was actually too thin; she admitted that she had been anorexic for much of her life since high school. As a result, she was initially required to gain weight, but she confessed that, largely due to depression, she "went overboard" and was now being asked to lose about 30 pounds. Not only was she finding

it hard to lose, but it was hard to get enthusiastic about losing when her "goal" was a heavier weight than she would like to be. She said, "It's going to kill me to be 140."

Other respondents talked of the necessity of eating frequently to manage hypoglycemia (Megan), changes in metabolism as they aged (Victoria, Ruth, and Grace), changes in metabolism because of repeated weight loss and regain (Marianne), and possible thyroid issues (AnnaMarie, Mary Frances). A particularly intriguing health condition was the Polycystic Ovary Syndrome (PCOS) reported by Lisa. She explained that her understanding is that PCOS is complicated by carrying excess weight, but that it also makes losing weight more difficult.

The inability to be as physically active as would be optimal for weight reduction and maintenance was a concern for several of my subjects. Diminished mobility as a consequence of aging was cited by several women. Others commented that there was a kind of irony in the fact that in order to lose weight, they needed to exercise, but they felt that their weight prevented them from doing anything strenuous enough to actually have any positive effect. Mary Frances observed that "lots of my life I've been physically more active. And even when I'm overweight, I've been physically more active. But I've gained too much weight now."

Lifestyle

In addition to physiological factors, lifestyle issues contribute to the difficulty in managing weight. The women who participated in my study were, almost without exception, extremely busy people, balancing multiple roles and responding to numerous demands on their time. It is not surprising, then, that time was viewed as a scarce

commodity. Shopping and meal preparation were acknowledged as important tasks, but sometimes it was simply more convenient to eat out or pick up fast food. Finding time for regular exercise was a constant challenge.

Several of my respondents also commented that they had difficulty being able to financially afford such niceties as, for example, gym memberships. Some have been more fortunate in this regard than others. Eight of the women worked out fairly regularly at a modestly-priced exercise facility that is part of a national chain of studios designed for women only. Marianne was able to pay for a personal trainer as she worked to lose the last few pounds after her surgery, and Ann had been able to afford enrollment more than once in a prestigious health-related facility that offers programs for both nutrition and exercise. Others have found creative ways to manage some form of regular exercise, but several regarded the cost of participation in exercise programs as a significant barrier in achieving weight loss goals. (To be accurate, it seems important to note that others admitted that the problem was not cost; it was motivation. Charlotte, for example, talked of how she and her husband had set up exercise equipment in their garage with the intention that they could both use it. However, she noted, “I haven’t been able to make myself get up and go out there and do it. . . . I just don’t enjoy exercise.”)

Several of my informants reported that, despite keen interest, they were not able to afford the much-advertised commercial weight loss programs that were appealing to them, and bariatric surgery was beyond the means of several of my respondents. AnnaMarie, for example, recalled the great success she had when her mother and stepfather enrolled her in a popular commercial weight loss program just before she

started high school. But, she explained, “They weren’t able to keep me on that diet forever because, you know, you have to pay. Here we were, a step-family who had two other children, and taking care of two plus your other ones. So they couldn’t keep me on it.” Grace, too, as a single mother of three teenagers, commented that she would love to be on one of the nationally advertised weight loss programs except that she really couldn’t afford the food she would be required to purchase. The sense I got from at least three of my subjects was that if they had the insurance or the cash to cover bariatric surgery, they would readily opt for it. GiGi has had a gastric bypass, and she commented with sincere sorrow that she wished that her daughter, who is also seriously overweight, had the means to afford the surgery that has made such a difference in GiGi’s life.

Eating Habits

The most common perception about people who are overweight or obese is that their problem is simply that they eat too much. Indeed, many of the women in my study acknowledged that this was an important contributing factor. Charlotte said it quite simply when she laughingly confessed, “I eat too much and I move too little.” There were, however, varied explanations as to why they ate too much.

Not surprisingly, the types of food and the amounts that were served as they grew up were cited as one important influence in the development of weight problems. GiGi said that her mother “gained a lot of her self-esteem from being a perfect homemaker . . . and she was an absolutely over the top fantastic cook. So there was always an abundance of phenomenally wonderful food in our house, and it was always very available.” Both Vanessa and her mother favored the food of their culture and, while they were willing to

make some concessions (Raquel, for example, was willing to switch to black beans instead of pinto beans), there were some ways in which they were not likely to compromise. Raquel declared, "I just love Mexican food! Everything I cook, I'm just, 'm-m-m, if I cook this I'm going to make it really good!'" Diana explained that growing up in a Mexican family in which "we believe in food," it was expected that food would be part of any gathering and that everyone would eat heartily, hungry or not.

Several of the women admitted to having developed "poor eating habits" as children. Naomi said that it wasn't until fairly recently that she had any knowledge at all of what constituted proper nutrition. Ruth confessed that she had always been a "fast eater" because she came from a big family; "If you didn't eat fast, you didn't eat." AnnaMarie observed that a problem with her eating when she was a child was that her mother had a difficult time, as a single parent, stretching her family's food budget. "What was more accessible for her to buy?" AnnaMarie asked, rhetorically; her answer: "Carbohydrates." Sherry was also in a position as a child where learning about nutrition was not a focus of her family.

> I was brought up very poor to begin with. We didn't have much to eat, so eating wasn't a priority. I mean, we were on welfare and we were fed by colleges and churches. So I didn't really know what it was like to have really good food.

Although several of my subjects insisted that they ate no more—and often less—than their thin counterparts, portion control was cited as a problem by a few of my respondents. Diana remembered how she ate as a child:

> Eating a bowl of cereal was not one bowl of cereal. And it was not one *little* bowl of cereal. For some reason, there was something in me that I would have one bowl and before I knew it, I had three bowls of cereal. And I could've had another one.

Several other women admitted to problems with controlling their appetites. Ann marveled at the self-control exhibited by her sister who, despite being divorced and now living alone, carefully prepared balanced meals and sat down at the table to eat her modest portions. "One egg for breakfast, one strip of bacon. . . . I've never had *one* piece of bacon in my life!" Both Ann and Lisa noted that a serious challenge they had faced in the past was when they moved away from home to attend college. Suddenly a variety of food was available at all meals and at all times of day, and they had the new opportunity to make their own decisions about what they ate and how much they ate; both admitted to weight gain in college because of the choices they made. To some extent, Lisa saw this as the beginning of her problems with weight.

Relationships with Food

Beyond the problems created by the types and the amount of food they ate, several of my respondents talked about their less-than-healthy relationships with food. Ann, Gabby and Marianne specifically used the term "addiction," as did Susan—whose desire for sugar is a consequence of her having had (and eventually overcome) a serious drinking problem that created in her a persistent craving. Charlotte talked not of addiction, but of "attachment" to food. Because of her strict religious upbringing, such a relationship with food seemed to be a spiritual impediment. Her decision to undergo one

of the very early versions of gastric banding surgery was largely an effort to lose her attachment to food. Ann admitted to "obsessing" about food—so much so that she often thought, "Oooh, I can't go on a diet today because, hey, next weekend I'm going to be at the ranch. I wonder what they're serving!" She commented that when she thought about the story of her relationship with food, "it's really the story of an alcoholic or the story of a drug addict. But it's food." Diana did not use the term "addiction," but she talked of an inability to resist certain foods, candy being one that she mentioned several times. Diana recounted how her mother had worked night shifts as she was growing up, so she and her brother would sneak out during the day while their mother slept and go to a nearby gas station to buy Snickers® candy bars. "And still, when I eat a Snickers®, I feel like I'm doing something really cool!" she laughed.

Emotional and Psychological Attitudes

Just as Diana experienced the thrill of rebellion anytime she ate a Snickers® candy bar, others of the women in my study talked of emotional connections with food. Charlotte traced the beginning of her weight problems to when she was six years old, coming home to an empty house for a period of time before her older sisters returned from school; she assuaged her loneliness by preparing and eating several pieces of toast every day. For Ruth, there was often an "emotional feeling of 'I'm empty inside.' I need to fill it somehow—and putting a lot of food in to try to fill it up." Several women confessed that it was not just a negative emotion that would trigger the desire to eat. Marianne, for example, admitted that she dealt with almost any emotion she experienced with food.

> If I'm by myself, I think, "Gosh, I'm a little bored, I think I'll eat something." Of course I use eating as my tool for everything; I eat when I'm happy, I eat when I'm sad, I eat when I'm bored, when I'm busy . . .

However, negative emotions such as depression and stress were most frequently mentioned as strong catalysts for escaping into food. Marianne talked of eating to counter the depression she experienced when her marriage fell apart, and Gabby, Grace and Sasha related similar responses to the dissolutions of their own marriages. Angel admitted that the failure of relationships was a significant reason that she began to gain weight in her 20s. The word most often used to describe what food represented to them in these times was "comfort." Ann explained that her reluctance to have weight loss surgery, despite her sister's success after a gastric bypass, was that she would have to eat smaller amounts of food, and that would mean giving up the comfort that food provides. She added that, to her, "ecstasy would be having *no* relationship with food; you eat to live, not live to eat."

Emotions that trigger a need for the comfort provided by food are one type of psychological factor that leads to the development of weight problems. However, one of the more interesting psychologically-oriented barriers to losing weight was illustrated by Charlotte's overall attitude toward the body. Because of her religious upbringing, she had spent a good bit of her life "denying the importance of my body."

> I still have remnants of this . . . all of my adult life. I don't want to think of myself as beautiful or sexy or whatever because, in the pure sense of the word, I—somewhere in the back of my brain—think that's evil.

Among my informants, Charlotte's perspective was unique. Others spoke of how they did not regard the body as being the most important aspect of who they were, but none of them denied the importance of their bodies in quite this way, and none had expressed the view of the body as being "evil."

Ann did not see her body as evil, but she did assert that, in her opinion, the inability to lose weight and keep it off is "a mental thing. I think very little of it is physical." In fact, she had concluded that "we're all crazy," that "there's something in the head," "something deep-rooted emotionally," and "I really am nuts." She doubted that her slender sister "ever thinks about what [people] are serving. I think that's the *sick* people [who think about that]."

Denial

Although the women in my study did not deny the importance of their body as a part of their sense of self, they did admit that they often denied the reality of their body size. They acknowledged that the strategies they employed to avoid the truth of their weight enabled them to justify inaction or postponement of weight loss.

Some of the women disclosed that they had developed considerable skill in disguising their body size—often not only from others but from themselves as well. For some, their chief strategy was to "carry" themselves well, attending to issues of posture and presentation to deflect scrutiny of the body. Raquel learned these strategies from her grandmother.

> She taught me at an early age how to stand up straight, have good posture and how to hold in my stomach and breathe while I did that. I'd have to stand against the wall and do that. And so, I think this is why I carry myself with confidence.

She commented that she was so successful in this approach to minimizing her size that people were often surprised to learn how much she weighs. Sasha's grandmother imparted similar advice and modeled how to do that. "My grandmother had this walk that just commanded attention when she walked in a room, so your posture's got to be good, your walk has to be deliberate." Sasha also talked about developing the ability to "camouflage" her weight by the way she dressed, particularly in "girding" herself. GiGi attributed her skill in managing the impression her body makes to her training as an actress. "I have a stage presence," she stated, but she also conceded that "you can really delude yourself" into thinking that you aren't as big as you really are. She divulged that she was able to do that by strategic use of her clothing. "I just started wearing more and more smock-type looking things. So if you don't ever have to *see* how big your thighs are getting and your butt's getting, then you kind of forget that it's getting bigger and bigger."

Several of my subjects reported that they had long adopted the strategy of avoiding mirrors and scales. Sherry acknowledged that for a long time she would only look in her mirror "to put my makeup on and get dressed." Susan speculated that most heavy women play a little trick on themselves when it comes to looking in the mirror. "I think you just see yourself from the neck up. . . . And if you look at yourself, 'Oh, my gosh!' And then you just quickly look away and . . . 'I'll think about that tomorrow.'"

Mary Frances alluded to the strategy of "only looking at the eye you're doing." Hiding from mirrors seems to have prevented several women from coming to grips with the reality of how much weight they had gained. For some women, however, a frank scrutiny of their body in the mirror eventually served as the catalyst for a serious attempt to lose weight. Sherry recalled, "I turned my life around when I got up one day and got out of the shower, and I looked in the mirror and thought, 'I've never been this heavy.'" Many of my respondents also spoke of their attempts to deny the truth of their weight by avoiding being weighed. Ann claimed that she had adopted a policy: when she visited a doctor for a purpose that had no relationship to weight, she would announce, "'Not weighing today; just put that in the chart.'"

Another means of denying the truth of your body is to compare yourself to others who are heavy as well. Naomi disclosed that when "the doctor told me how much I should weigh . . . I was shocked that I could be 40 pounds overweight. I thought I was maybe 20 pounds . . . *just about like everybody else*." Lisa explained that she thought of herself as a "Mama Bear" in terms of where her body size fell in comparison to others she was around. Susan commented, "I thought I was just fine, and my husband is heavier than I am, and so, compared to him, you know, I was svelte." Marianne remembered that when she compared herself to the people she saw in the waiting room at her surgeon's office, she felt small—although she later conceded that she eventually realized that she had been fooling herself.

Some of my respondents talked of the problem they had in seeing themselves realistically. Mary Frances specifically used the term "body dysmorphia," confessing

that “I thought I was fat when I wasn’t, and haven’t realized how fat I was when I was.” Ann talked several times about the problem she had in seeing her body accurately. “I’m working right now to try to be more honest with myself . . . but a lot of times, I would look in the mirror and I’d still see that cute little thing that got married that weighed 130 pounds.” Diana recognized that she didn’t have an accurate picture of herself when she was heavy or when she was thin. She recalls a time when she was so thin that her hipbones “were protruding. . . . Why didn’t I see myself that way? I should have been able to look in the mirror and say, ‘Okay, Diana, you’re done. You’re thin. Quit thinking about it.’” Susan was able to recall with wry humor a recent incident in which she had finally consented to buy a bathing suit so she could go into the water at a friend’s holiday lake party.

> I looked at myself when I bought the bathing suit and it wasn’t horrible. I mean, [I] didn’t want to go slit [my] throat or anything like so many women do. But then I saw myself in some pictures she took, and there’s this obscenely obese woman in that picture that has my head on it! I don’t know where she came from! . . . She’d done Photoshop or something!

Struggle and Deprivation When Attempting Weight Loss

Another significant reason that weight management is difficult is that dieting is often a profoundly negative experience. A few of the women I interviewed could cite certain diets they had undertaken that had been enjoyable experiences. Ann, for example, remembered one diet where she “counted calories; I mean I counted every little morsel. I got obsessed. Oooh, it was so much fun! I had a little calorie counter and I’d count,

count, count." Diana talked of two successful attempts to lose weight that involved intense exercise with a friend as a companion, and she was delighted when "the inches just fell off of me." Vanessa remembered being successful and enjoying the challenges of one weight loss effort but eventually discontinuing it. Her comments illustrated that, for many women, even the most enjoyable dieting and exercising experiences eventually become unsustainable. Charlotte said, "What almost always happens is the holidays come along and the diet goes out the window."

Almost all of my respondents, however, talked of the process of losing weight as a negative experience. When asked to describe efforts at losing weight, responses ranged from "discouraging" to "torturous." My interviewees talked of a great deal of frustration, particularly when they worked very hard and achieved results that were not what they had hoped for. Lisa referred to it as a "start and stop struggle." She talked of participating in a vigorous "boot camp" program that only netted her a 10 pound weight loss after almost a year of effort. The notion of struggle was echoed in other responses, sometimes by the use of the word "fight," suggesting that the respondent felt herself to be doing battle with her own body. Others had been through the process so many times, losing the same weight over and over again (and sometime more besides), that the whole thing seemed "pointless," "hopeless," "impossible," and "valueless." Ruth said that dieting was like "hitting your head against a wall." GiGi pointed out that at one time she entered a new weight loss program with "trepidation" because she feared so much the disappointment she knew she would feel if she wasn't successful. Victoria worried that if she lost weight she might find that blaming all the shortcomings in her life to her

weight would end up not being true, that it was "just a mental construct that I put up," and that she would find out that losing weight didn't make a difference. "You hear of people that have lost weight and they said their lives didn't change that much. That worries me. . . . I think that would be very hard for me. That'd be *hard*!"

One of the most negative aspects of being on a weight loss program was described to me in terms of what my respondents felt they would have to give up. The word "deprivation" was used by several of the women. As Gabby put it, the word "diet" meant to her "what are you going to give up now? What *can't* you have?" Susan said that at the beginning of weight loss efforts, "all I can think about is what I'm not eating—what I'm deprived of." This was a particularly salient issue for her since she had already overcome alcoholism and had given up smoking as well; it is easy to see why depriving herself of yet one more thing would be problematic. One of the interesting ideas that some of my informants offered was that deprivation bothered them mainly because being restricted in what they could eat made them feel different from others. Mae remembered that as a child whose mother was continually reminding her of her weight, "I was constantly watching. I never felt like I could eat like other kids . . . drink cokes or . . ." Diana recalled that when a doctor first told her at age 10 that she had a weight problem, "I think it changed my life. . . . I was just a kid without any worries . . . and then it changed. I had to watch what I ate. I had to watch what I drank. If my friends had burgers, I couldn't have a burger." GiGi pointed out that in so many ways, an OW/O woman already feels different from her normal weight friends, and dieting just makes that worse.

> Maybe it was because that's what makes you feel normal. Because it's like I can't go to Target to buy clothes, but I can sit down with you and I can have a drink. And I can sit down with you and have a piece of chocolate cake.

The sense of deprivation and the frustration that accompanies efforts to lose weight may provide an answer to the question that one often hears voiced by people who have seldom or never experienced a problem with their weight: "Why don't they just *do* something about it?" Especially for people who have lost and re-gained repeatedly, there is undoubtedly a great deal of skepticism about their ability to be successful and, as indicated by some of my respondents, an anxiety about how yet another failure would make them feel. Their responses indicate another kind of struggle that goes beyond just having to work hard to adhere to a diet and exercise regimen: it is the struggle to believe that the effort and the results will be worth what you have to endure and give up in the process.

Lack of Motivation

When I asked my respondents about what motivated them to lose weight, the answers were, not surprisingly, varied. Most (though certainly not all) of the women mentioned health as one of their motivations. However, only a few were emphatic about that, and those cases were the women who were contending with significant health issues. For the rest, their "Health, of course," response seemed very much like a nod to what they thought they should say. When I analyzed this, I recognized that in the majority of those cases, the woman was someone who really didn't have a major health issue, or at least not one they had been advised was related to their weight. When I asked

each woman about her overall health status, I got answers that ranged from “decent” or “average” to “great” or “fabulous,” and the range of answers do not necessarily vary directly with the degree of overweight. Two women who admitted to being 140 pounds and 130 pounds overweight at the time of the interview described their health as “good” and “good outside of weight” respectively. I was particularly interested in how several of the women responded with some version of “other than my weight, my health is good.” The implication was that they did not feel unhealthy, but they had incorporated the “overweight = unhealthy” paradigm into their thinking to such a degree that they could not describe themselves as “healthy” without also indicating that they did recognize that they couldn’t possibly be *really* healthy if they were overweight.

The motivator that was mentioned most often was “appearance.” In many cases the ability to find, look good and feel comfortable in desirable clothing was specifically cited. In fact, out of twenty-three women, twenty-two talked about appearance in some way as an important reason for losing weight, often as the primary motivation. The only woman who did not specifically confess a concern for appearance was Naomi; her primary motivation was health, and the reason health was important to her was that she felt she had “too much Kingdom work to do” and could not serve God as well and for as long as she needed to if she were overweight. Even then, Naomi admitted that the compliments about her appearance that she had been getting since her weight loss were pleasing to her. (It may be useful to note here that she was also the only woman in my group who had reached her goal—a 40 pound weight loss.)

Other motivators identified by my informants included: the ability to be more physically active; the ability to form or maintain relationships; the desire to feel "good about myself" and/or "comfortable in my own skin;" events, such as weddings or reunions; to prove others wrong; and, someone else's success. Two of the women who had undergone surgery said that one of their motivations for finally opting for that approach was the recognition that they had failed in everything else they had tried and, as GiGi explained, "I needed a new tool."

However, despite the talk of what motivated them, the stark reality was that for the vast majority of the women I talked to, their motivations were not motivating them. Naomi had reached her goal. Marianne was within about 15 pounds of the goal she had established when she had her surgery, and it was clear that she was actively working—through diet and exercise with a personal trainer four times a week—to accomplish that goal. Mary Frances and Victoria had made plans to seek surgery. But most of the women were either still struggling to make some headway or were, at the time of the interview, more or less "stuck." They hadn't given up; but they were also not clearly working a plan with intensity. I do not say this in any way to be critical. I suspect it is the status of the vast majority of OW/O women everywhere. The point is that the recognition of what your reasons are for wanting to lose weight and the identification of what "ought" to motivate you are not, apparently, sufficient as motivators.

Indeed, some of my respondents admitted that finding real motivation was exactly what their problem was. Vanessa, for example, recalled a regimen she once undertook that involved healthy eating and Pilates which yielded good results for her.

She spoke wistfully of that time: “I can’t remember why I got motivated to do that in the first place. Otherwise, I would do it now.” The central theme of my interview with Ann was the inability to find motivation. It was with great frustration that she declared, “I just can’t get a motivator!” She asserted, “If I acted like I had any brains in my head, it would be health.” She mused about what it might take to impress upon her the importance of losing weight. “I’m wondering—if they came back and said, ‘You’re going to be diabetic,’ or ‘We’re going to have to chop off your feet.’ Why do we wait until we’re under the gun?!” During our interview, she repeatedly expressed her frustration with trying to find something that would serve as the key to motivating her. She wailed, “I’ve beat this horse to death, but . . . I just don’t know.” At one point, she gestured to a drawer she had pulled out from a cabinet and placed in the corner of the sitting room. It was full of materials related to various attempts she had made over the years to lose weight. She considered it mournfully and said, “You know, this is really sad. I have spent thirty years—*thirty years!*—of screwing with this. You’d think I’d just get by it and say, ‘*No more*!!’”

One of the ways we make sense of what is happening to us is to examine what our beliefs are about the causes of the phenomenon under investigation. In this section, I have presented themes that I heard repeatedly in my interviews with OW/O women—themes that relate to the factors they thought were most involved in their weight issues. Another aspect of sense-making is to assess how the phenomenon affects us. In the next section, I will discuss what my respondents shared with me about the impact of overweight/obesity on their lives.

Identifying the Impacts of Being Overweight or Obese

Only one of my informants (Maggie) claimed that being overweight had little to no effect on any aspect of her life. It is useful to note, however, that the length of time she had been overweight was among the shortest of all my interviewees (she traced her weight issues to the onset of menopause, and she was only 58 at the time of the interview) and that she had the least amount of weight to lose of any of the women I talked to (20 pounds). Additionally, she expressed a high degree of body acceptance, having reached the conclusion that this was simply what her body was going to look like post-menopause. She explained the appearance of health issues that some people would link to being overweight (e.g., problems with joints) by saying, "Age did more of that."

The rest of the women I interviewed asserted that their being overweight or obese had had significant effects on their lives. Those effects included consequences to health and other quality of life issues.

Impact of OW/O on Health

It was clear that many of the women in my study believed that their weight was at least partially responsible for a number of health issues they were experiencing. Those issues included high cholesterol, diabetes or pre-diabetes, high blood pressure, an assortment of gynecological problems, problems with joint pain or weakness, spinal and skeletal problems, shortness of breath, sleep apnea, and general lack of energy or stamina.

In some cases, their belief that their weight was responsible for their health problems was based on what they had been specifically told by their doctors. In fact,

several women reported that it seemed to them that their doctors blamed everything on weight. Diana, for example, chronicled several visits to different doctors, telling me, "It's always the same thing that comes up. 'Well, if you'd lose weight, you probably wouldn't have as many problems.'" Lisa had this same experience, and in several cases it had affected her willingness to continue to see the doctor. "Their solution to everything was 'weight first, then you won't have the issue.' [Weight] was their answer to everything. So, with that I didn't feel very comfortable nor did I want to go back to them." Others had never been specifically told that their problems were weight-related, but they simply believed that to be true, probably reflecting the general medicalization of weight that has evolved over the past several decades.

In addition to health problems they were actually experiencing, several women talked about their fears of health problems that might arise in the future. Ann worried several times during the interview about developing diabetes and "having my feet chopped off." Mary Lou was emphatic when she said,

> I do not want to be on blood pressure medications. I don't want to have pains in my legs because I'm putting this strain on my legs. . . . I don't want to be walking with a walker when I'm two years from now.

Vanessa, the youngest of my respondents at age 21, had already started to worry about whether her weight was responsible for a variety of physical symptoms that cropped up from time to time. She had recently had a sonogram to track down the source of a pain she was experiencing, and when the test did not find anything definitive she fretted,

"There's something, and I know it's because of my weight. I know that." She said she realized:

> Being this young and overweight is not good. And I know that once I get older, it'll just get worse. . . . Maybe now I don't see it as a priority, but later on, I'll start noticing it. And by then I'm scared it'll be too late.

Impact of OW/O on Lifestyle and Career

Other than Maggie, all of my participants admitted that their weight had prevented them from participating in valued activities. Amusement park rides and water parks were mentioned repeatedly as my respondents lamented that they did not feel comfortable going on outings with their children and families because of the restrictions they felt due to their size. Some could cite specific experiences that had humiliated them. Vanessa recalled a trip to an amusement park over a year earlier.

> My big butt couldn't fit in one of the seats. And I was totally embarrassed. The person had to come and help me with my belt. I got squeezed in there, but I was like, "I never want to come back here again!"

And she had not been back, though it is an attraction that is enormously popular with people in her age group. Megan expressed regret about not feeling like she could take her boys to a water park.

> I refuse to go with them. I'm not going to be seen in a bathing suit. Even with a cover-up. It is embarrassing! And my oldest kind of told me, "Well, Mom, you don't have to put on a suit. You can just wear shorts." But I don't want to stand out in a crowd.

Travel is another activity that poses problems for people of size. Several of the women talked of how uncomfortable they were when flying because of the size of the seats and the seatbelts. Similarly, attending theatrical events was made more difficult due to the arm rests that make comfortable seating impossible. Some women reported that they still do travel or attend concerts or performances, simply finding a way to tolerate the discomfort, though they acknowledged that they do those things much less often than they might otherwise. Other women simply said they do not participate in the activities that they find pleasurable because of the limitations they feel they cannot endure.

Although a few of the women admitted that they had never enjoyed sports or intense physical exercise, others were regretful about their inability to participate in activities they had once enjoyed. For her 50th birthday, Mary Frances had given herself a present by becoming SCUBA certified. Both diving and horseback riding were highly valued activities that she wanted to be able to do again during her retirement. She sincerely hoped that with weight loss surgery she could lose at least enough to be able to resume those activities. She laughingly observed, “If I’m 60 pounds overweight, I can still SCUBA dive and I can still ride a horse without breaking its back. But I’m past that now. They’d have to bring me a Clydesdale, and you just don’t find those around!”

One of the restrictions in lifestyle that was most frequently mentioned by my subjects was the paucity of clothing that is both stylish and flattering. Almost all of the women complained of their inability to find appropriate clothing for various occasions. Raquel said that she didn’t have as much trouble finding professional clothing as in

finding clothing "that's fun to wear" for casual occasions and that fit her age and personality. She lamented, "It's all just made for an 80 year old woman or something!" GiGi had found it relatively easy to find professionally appropriate clothing when she was merely overweight, but by the time she had gained so much that she could be classified as obese, this was a significant problem. She noted that the availability of stores for an OW/O woman to even look for clothing was a problem, adding that if she traveled to a convention and her suitcase didn't get there, she would have a problem.

> A lot of women go, "Oh great! I'll just go buy a new wardrobe!" Well, you can't if you're obese. You can't just go to K-Mart® and pick up a pair of pants. . . .
>
> You just can't go to the mall and go into any store and find clothes that fit you.

Victoria affirmed this viewpoint when she noted that "When you're a size 16 you can still shop at the GAP®. You can go in the GAP® and buy a T-shirt. And I've never had that experience. . . . Even with the mall, I've got three options and that's it."

Some of the women I talked to said that being overweight had caused them to be reluctant to attempt to advance in their careers. Grace commented that she would soon be graduating with her Bachelor's degree, and she had aspirations to move into a job beyond the secretarial position she held at that time, but she confessed,

> I do have a little bit of anxiety about . . . how [my weight] will be looked upon. I mean, I have to admit that if they can get somebody who's like a size 10, that looks nice, and she has the same degree and same qualifications . . . they wouldn't hesitate to hire her over me.

Sasha had just recently re-entered the career world and was realizing the importance of needing to immediately make a positive first impression, and she acknowledged that losing weight would be an important part of that goal. Ruth confessed that she felt that her weight had held her back in venturing out for better job opportunities. She said she tended to "hang in there 'til the bitter end" until she was "dispersed out of the job." For her the issue was "just the thought of having to go through the interview process and put myself out there. And then you feel trapped where you are, instead of saying, 'I don't need this place; I'm out of here.'"

Impact of OW/O on Relationships

Almost all of the women in my study concurred that being OW/O had an effect on their relationships with others, though there were exceptions. Maggie did not think that her weight had affected her marriage, her friendships, or any other relationships in her life. Ann insisted several times that she had never felt "discriminated against" because of her weight, and the arc of her story did, indeed, suggest that she was an unusually socially active person who had a wide circle of friends. Charlotte acknowledged that it was possible that some people reacted negatively toward her because of her weight, "but it's just a case of I really don't particularly care, I think." Mae was not aware of any ways in which her weight had been detrimental to her relationships. However, these were the exceptions. All of the others could point to at least some ways in which they felt that their relationships had been impacted by their weight.

For some of my respondents, being overweight or obese had influenced their willingness to enter into relationships with others. Several described themselves as "shy" or "introverted" by nature, and in a few cases they were not sure that they would have been any less shy if they had been of normal weight. But even most of those women admitted that their reticence about relationships was to some extent a concern about how they were perceived because of their weight. Ruth disclosed,

> I'm usually real slow at getting to know people. I'm very shy initially—especially with people I don't know. Once I get to know them, then I think we've gotten past the [point] that they think of me as a fat person or whatever, so I've had no problems after that.

The part of Ruth's statement that is most intriguing to me is that she seemed to be implying that her initial tendency is to assume that her fatness is a barrier that the other person has to get *past*, and that only after she gets to know them is she able to assume that they have gotten past thinking of her only as a fat person. Angel referred to her approach to relationships as being "more sheltered" when she was overweight, and she exults in the fact that since her weight loss "I'm much more outgoing, much more confident." She said that when she was heavy, "I wouldn't want anything serious" with men. Victoria laughingly admitted, "If I wasn't heavy-set, I probably would have hit on some more people. But I—just as a general rule—I really don't hit on people; they really have to hit on me first!" And Sherry declared, "I can honestly sit here and look at you and say, 'It's 100% because of my weight that I won't date.' It's sad. It's a sickness."

The ability to form and maintain relationships with romantic partners was often cited as a problem area that my respondents linked to their weight. Grace conjectured,

> My ex-husband is not the only man who feels repulsed by fat women. I think it's just a man thing. You've never heard of a man who, in his profile, puts "Give me a large, fat woman." They just don't do it!

Ann recalled that after she finished college, her weight had interfered with her social life:

> I had a crush on this guy. I thought he was just the cutest and so much fun. And he said something to me like, "Oh, you're just like a sister." And I remember making a conscious decision, saying to myself, "I'm not going to spend my life being everybody's best friend."

This experience was the catalyst for one of her most serious attempts to lose weight, the successful result of which she described as "*very* freeing." AnnaMarie confessed that she spent "four years of trying to lose weight for my boyfriend to accept me. Then, after then, no more for [men]—more for society, because people won't include you if you're overweight."

In many cases, the concern was not because their partners had rejected them because of their weight, but it was because of the insecurity they felt in their relationships because of their bodies. Mary Frances admitted that in general, "I think that if people don't like me, I often assume it's because of my weight." She seemed to marvel at the fact that her husband "really is fabulous. He'll sometimes grab a little roll and say, 'Look, I love all of you.'" She went on to say that she found that to be "pretty

amazing for somebody who's got an overweight spouse." Diana anguished because she knew about her partner's past relationships with people who were athletic. "And that's not me. Never been an athlete. I'm short. I'm pudgy. And so that gets in the way. I find myself making comments: 'Well, there's a thin one. I'm sure you'd rather be with her than me.'"

Other women felt that their weight had caused them to be rejected by a potential romantic partner. Lisa divulged that sometimes she tried to lose weight in order to develop a relationship when she was interested in someone. When a relationship didn't work out, she rationalized,

> I know the fault; sometimes I can tell, if they select someone after me that—looking at that person's body type—[I] might say "I didn't fit the body type of the person." So . . . yeah, weight could have been a contributing factor to it.

Victoria adopted a defensive strategy, protecting herself from possible rejection by posting pictures of herself on the online dating sites she uses. She explained that when they begin to talk on the telephone,

> I always tell them, "I'm African-American, BBW (Big Beautiful Woman)" . . . because that can be a main huge turnoff for a partner. So you want to put that out there first, because if that's not going to work for you, I kind of need to know that now, before I invest any more time.

For some of my respondents, however, being rejected because of weight was not just anticipated or interpreted. It was made clear. Gabby revealed that her husband had stopped sleeping with her specifically because of her weight. Sasha's husband had

announced after her pregnancy weight gain that he "wasn't going to touch me until I lost weight." And Grace acknowledged that her husband left her because of her difficulties with weight after her pregnancies; in fact, he also claimed that his decision to engage in extramarital affairs was due to her weight.

Most of the women professed to have no real problems in relationships with family members because of weight, commenting in some cases that family members were often very supportive. Mary Frances told of picking up her step-daughter after school one day before going to pick up their husband/father, and she remembers saying something in their conversation about being overweight. "At the time maybe I was 30 pounds overweight—which wasn't horrible, you know; I was still 'purty!' And I remember her putting her arms around me and saying, 'Oh no! You're beautiful and he loves you!'" Grace told of how her nieces loved to cuddle with her because she was "fluffy." She also recalled a time when she suggested that one of her daughters might be happier if her thin aunt accompanied her to an event instead of Grace—an event that would be attended by the other "cheerleader moms" who had so often excluded Grace because of (Grace assumed) her weight. "She was like, 'NO! You're my mom and I want you to be there!' But it's *me* that doesn't want to go because . . . you know. And so, for [my daughters'] sake, I wish that I were more socially acceptable." GiGi admitted to similar concerns when she talked about how both she and her husband were severely obese before their bariatric surgeries.

> I wonder sometimes if our children were not—you hate to say that your children are really ashamed or embarrassed of you. But, in retrospect, you have to wonder

> if they were going, "Well, you don't look like all of our other friends' parents" and that type of thing . . . although they never expressed that to us.

Impact of OW/O on Health-Seeking

Because one of the issues this study focuses on is how women perceive the impact of being overweight on interactions with healthcare practitioners, I was especially interested in the effects of weight on women's health-seeking behaviors. I will discuss this aspect of my findings in greater detail in Chapter V, but for now it seems important to note that being OW/O does appear to have had an impact on how—and whether—my respondents chose to seek healthcare.

Some of the women in my study reported that they did not avoid seeing doctors when ill, nor did they delay routine screening procedures because of their weight—though even most of those women admitted that they often felt uncomfortable or embarrassed during medical visits. Others candidly confessed that their weight had affected their willingness to see doctors and their attitudes when they did. The concern raised by this data is the extent to which other serious health issues may be overlooked because women avoid seeking medical care due to the embarrassment they feel about their bodies.

Perceived Benefits of Being Overweight/Obese

Although it may seem unlikely that there could be any positive aspects of being overweight, there are some benefits that my respondents cited. Several women voiced the belief that because they were overweight, they felt that had more compassion and empathy for others than a person of normal weight might develop. Charlotte told me,

"Whenever I meet another person, I actually [meet] a soul. . . . What's important to me is, regardless of what body you're in, you're a soul. And to me, that is a great equalizer for all people." Raquel expressed a belief that other women, "especially other women who might be about my size," seem to "appreciate" her confident attitude, seeing it as a good example for them to emulate in developing more positive attitudes about themselves. "They say, 'How can you be so confident and be this size?' I've heard that. I'll say, 'I don't know where it comes from. It just comes from somewhere, because I'm happy with who I am.'" Ann revealed that when she sees an OW/O person, she thinks, "Oooh. Sad. There's a story. There's something eating them. There's some kind of unhappiness, or there was some kind of fear. . . . I probably am empathetic because I'm sitting there thinking, 'It's a bitch. It's not fun.'"

Others spoke of how their weight may have made it easier for others to relate to them. Mary Frances talked of how her weight was "great camouflage"—a type of "protective coloring" that "made me look less threatening" in professional settings. Victoria observed, "I think people are friendlier to you because they assume, 'Well, I know what your issue is already. I don't have to uncover it.' Everyone has luggage. It's just *my* luggage, everybody *sees*." Charlotte had a similar perception:

> It's fairly obvious to them that I've had my struggles and . . . that's okay with me if people see that I've had problems . . . I think anybody who has their own struggles and has an anxiety or anxiousness about their struggles can look at me and see that, you know, who am I to be critical of them?

Charlotte also speculated that her body made her seems less sexually threatening to others: “It probably certainly expresses to people that I’m not looking to take their husband!”

Lisa related that while she generally perceived that “weight might push me out of the running” in the attempt to develop romantic relationships, she also believed that “sometimes guys don’t care.” She went on to observe that, in her experience, when a guy didn’t care about a woman’s weight, it was usually because they were overweight, too; however, she laughingly admitted, “I’m now thinking, they’re too heavy for me!” Lisa further elaborated that she is, in general, “fearful of guys or relationships,” a trait that has been remarked upon to her by her friends. In this way, then, her weight may also serve as “protection,” as it discourages attention from men who are only interested in a woman for her body and not for other more important characteristics. She noted that being overweight would “save you the trouble” of getting involved with such a man. It enabled her to enjoy being with men in friendly situations where she could “talk smack” about sports and enjoy “quick-witted” repartee without being perceived as interested in romance. And yet another intriguing idea was revealed when she talked about how she was often searching for an understanding of why “a person may not have wanted to consider a relationship with me.” She explained that she would often attribute that to a combination of her weight and the fact that she was “a dark-skinned African-American,” thereby enabling her to cope with the “rejection” she feared. She seemed to be implying that by rationalizing that her weight and skin-color were the main factors, she protected herself from feeling that it was her *self* that was being rejected.

Another way in which being overweight was perceived as a type of protection was with regard to sexual issues. Ann frankly admitted that as a teenager, "it was a sexual thing. It was the big protection if you were fat. No guys would come after you. So it was a very safe place to be, you know?" She went on to say that later, when she was "so miserable in my marriage, I didn't trust myself, and I thought, 'Boy, if I lose weight, I'm out of here!' And I think that was very scary." Mary Frances concurred with this line of thought when she mused,

> I do think that earlier in my life, that weight was a protection against—I don't want to say sexual promiscuity because that's not correct. But I think that I did feel that "Oh, if I'm 20 pounds overweight, I won't cheat. I won't have an affair." It was a shock to me to realize that you could be married and in love and still be sexually attracted to other people. And that scared me. And I think that there's some degree to which that weight has been protective on that end, because I think of myself as a person with no willpower.

AnnaMarie confessed that at one time, when she had lost a great deal of weight, she did not like the attention she started to receive. "I'm introverted, like I said, but when I lost the weight I was even more so." She explained,

> I don't like the glares and . . . people were looking at me. It just made me kind of shrink inside, because there were more people looking at me and I know it's because the look changed, it was beautiful, and it made me feel uncomfortable.

I certainly did not get the sense that any of the women who were able to identify these positive aspects of being overweight/obese were implying that they consciously

chose to be heavy to experience those benefits. However, in their disclosures they conveyed a genuine struggle to come to terms with the fears that being thin had at times aroused in them. It seems reasonable to at least consider the possibility that those fears might operate on a sub-conscious level to create some degree of ambivalence about achieving a body that is regarded as "desirable" in our culture.

In this section of the chapter, as well as in the section prior to it, I have discussed ideas that emerged in a thematic analysis of the interviews I conducted with my informants. I have outlined two categories, one related to my respondents' perceptions of the factors that contributed to their being overweight, and the other dealing with the ways they believe their weight impacts their lives. These categories were expected, as the questions I asked served to impose that structure on my findings. However, in the next two sections of this chapter, I will be presenting two categories that truly were emergent, teased out from responses to questions throughout the interviews.

Feeling "Othered"

To a very large degree, the world seems like a hostile place to women who are overweight or obese. It isn't just that the chairs are not large enough or that the clothes are not stylish enough—though those are, indeed, keenly felt problems. The hostility, rather, is most deeply felt in the perception OW/O women have that others perceive them as outside the boundaries of what is considered "normal" and that, as a result, they do not deserve the same consideration as a normal-weight person. As Brown and Jasper (1993) note, "Words like *obese* and *overweight* perpetuate the 'normal'/'abnormal'

dichotomy in that they have a pejorative connotation and imply a deviation from some objective standard, something 'wrong' and in need of correction" (p. 14). Because the overweight body lies outside the boundaries of what society deems a "proper" body, it is stigmatized, and as Huff (2001) proposes, the process of stigmatization "serves to secure the boundaries of the normal; that is, the spectacle of the fat body confirms and consolidates the identity of the normal body" (p. 52). The fat body, according to LeBesco and Braziel (2001), "equals reckless excess, prodigality, indulgence, lack of restraint, violation of order and space, transgression of boundary" (p. 3).

As my informants talked of how they felt others perceived them and what their bodies communicated to others, a few reported that they thought others had some positive impressions of them. Victoria, for example, believed that other people assumed that overweight women were good cooks, good with children and not threatening to other women. Charlotte suggested that they might think she would "probably have a good sense of humor." Lisa perceived that she was viewed as "motherly" and "friendly," and she proposed that there are some men who might even find her attractive, though, as noted earlier, she thought those were mostly men who were themselves overweight and, therefore, not as desirable to her as normal-weight men. Raquel's take on what her body might communicate to others was, perhaps, the most positive of all; she thought that it reflected that "everything that I do, I do with all of myself."

The majority of my informants, however, felt that the impression they made on others was generally negative. They surmised that others thought of them as lazy, undisciplined, and lacking regard for themselves. As is true of so much language, these

words draw their meaning from their opposites: energetic, self-disciplined, and self-respecting, words that are used to name traits that are valued and are assumed to be true of healthy, well-integrated—in short, "normal"—people. There are normal people, and then there are "other" people, "other" being a term that "refers to a person or group who is objectified or disenfranchised by the dominant culture and is treated as a nonperson" (Bullis & Bach, 1996, p. 4). Overweight people, then, are "other." Obese people are very "other," possibly not even worthy of consideration.

If that last statement seems hyperbolic, let me assure you that some of my respondents would disagree. Mary Lou, for example, claimed that she often felt "discarded." She observed that "people, a lot of times, don't even make eye-contact with you." Diana reported that she had often had the experience in professional situations of being ignored.

> I'm in a meeting, and there's a nice *thin* person in there . . . they're given more attention. If I want to say something and they want to say something and we're saying it at the same time, that person gets the go-ahead for communication.

Vanessa recalled how she was treated by others when she was in middle-school. "I felt like I just didn't fit. Sometime I would feel like a handicapped kid, opposed to everybody else." Susan proposed that for women especially, being overweight causes people to "ignore" and "discount" you. "I think that it's the one thing that you can still discriminate against is overweight people." She commented that she had noticed that an obese colleague of hers was particularly poorly treated by others. "I can *see* how people view her, because I spend a lot of time with her. People just kind of avert their eyes, like,

'Ugh. Deformity.'" Mary Frances noted that people sometimes have a "visceral" reaction to obese people and Grace opined that when people look at heavy bodies it "sickens" them. Grace also spoke several times of the very painful experiences she had of being ignored by the cheerleader moms she was forced to interact with. She recalled that any time her ex-husband was present, the cheerleader moms addressed all their comments to him, although Grace was the one who was involved in all the fundraisers, activities, and drop-off/pick-up duties. She might have thought that was just because he was the only man there, but she recognized that even when he wasn't there she was generally excluded. GiGi recalled a very long airplane trip to Europe during which she repeatedly caught a Spanish man staring at her. She felt that he was observing her as "an oddity. It's almost like that *freak* show, if you want to put it in really gross terminology." She went on to voice the opinion that "some people are really repulsed just by the mounds of fat."

That OW/O women are acutely conscious of their difference from others was especially illustrated in how many of my informants made reference to the sizes of other people as they responded to my questions with stories. Over and again I heard about a sister who was "tiny," a mother who was "petite," a doctor who was "just this little bitty thing," and friends who were "like pencils" or "like sticks." Victoria had a particularly othering experience in the fact that she has a twin sister who is slender. Although they are not identical twins, they resemble each other in many ways, so much so that people do occasionally confuse them. Victoria confided that it was sometimes distressing to look at her twin and realize that it was like "seeing yourself thinner," but knowing "I

would never have that look." Marianne spoke about how she had, in the past, refused to go to the gym because "everyone there looked wonderful." These characterizations were not in response to any particular questions, but were simply observations offered as the respondent sought to differentiate her own weight status from that of others. Sometimes they were making a point: the doctor could not relate to me because s/he was someone who had never had a weight problem, for example. Most of the time, however, the reference was seemingly gratuitous—an offhand comment that served to say "I'm different from the other people in my life."

The women I talked to compared themselves to others not only in terms of size, but in terms of behaviors as well. They often expressed amazement at the differences they felt between themselves and normal-weight people they knew or encountered. Ann's comparison of her eating habits with those of her divorced sister, discussed earlier in this chapter, were a source of wonder. "And it's fascinating, because we're from the same family!" Ann also recalled an example that illustrated that her skinny friends had a completely different orientation toward food. She was at a party and, as she reports it,

> Our skinny friend looks over at the lemon bars and went, "Hmmm. That looks great. But I sure don't think it's worth wearing it right here." (Ann patted her hip.) Whatever made her think of that?! We're all going, "Oooh! Doesn't that look great? Let's eat it!"

Victoria opined, "You can tell people who have always been thin. I think [they] just react [to things] differently."

Many women spoke favorably of how family members were supportive and loving despite their weight. This was, of course, good to hear, though I confess that at times it was a source of some sadness to me that the tone of the comment sounded almost as if they were grateful for that—as though it was something they should not feel they had a right to expect. Still, it was preferable to some of the stories told about ways in which family members contributed to the othering that the women already felt. Several women recounted how family members repeatedly pointed out that they were the heaviest people in the family. Vanessa referred to her father (from whom she is largely estranged) as one of her two "bullies" as she was growing up because of his constant reminders of how heavy she was. She recalled a time when she and her brother and father had gone to a convenience store:

> I'll never forget it. We were waiting in line, and there was a little magazine and it [said] "Heaviest Baby Ever Born" or something like that. And my dad was joking with my little brother. "Look, there's Vanessa!" And I started bawling in the store in line.

AnnaMarie swallowed hard and suppressed tears as she disclosed to me that she was treated so differently within her own family "to the point that I never really felt that I belonged in the family, because of that difference that I felt, you know, because of [my weight]."

Others of my respondents could recall incidents in their lives where their otherness was driven home by comments or actions of others that emphasized that

overweight people are in a separate category from "normal" people. GiGi had a vivid memory of the first time she realized that she was fat:

> Happened in 4th grade. And we were actually being measured for . . . caps and gowns that we had to wear for our confirmation ceremony. And we had to do it right there in the front of the class—I mean, it's like every female comedienne's plot—and I'm not sure it hit me—it's so weird—when they first weighed me, but my whole class was overwhelmed that I weighed 100 pounds. I knew there were girls that were smaller than me or whatever, but I was the tallest in the class, too. But I remember that everybody was just, "Oh my gosh! She weighs *100 pounds!*" And that's when I first thought, "Oh. Evidently this means I'm fat."

Victoria related two examples of unintentional othering, in this case by friends. She told a story about a close friend and colleague who had made an offhand comment about another woman's clothing size, exclaiming about how her size meant that she was "huge." Since Victoria was larger than the size her friend found so extraordinary, she had to laugh, bitter though the laugh was. On the one hand, there is a kind of backhanded compliment when you realize that your friend apparently does not categorize you as one of "those" people, for you assume the remark would surely not have been made if she did. On the other hand, it serves to remind the OW/O woman that there are categories, that some are acceptable and others are not, and that the truth is that you belong in the unacceptable category.

Victoria's other story involved friends with whom she regularly tailgated at sporting events. It was a mixed group of couples and singles. One of the single women had undergone bariatric surgery.

> But when that friend lost a lot of weight, a friend that I'm close to said that her husband could no longer hang out with the friend that had lost a lot of weight without her being present. . . . Before, she was not a threat—she's overweight, she can hang out with him 24/7. But now that she's lost weight . . .

The implication was that an overweight person is assumed by normal-weight people to have no real sexuality.

Sometimes an OW/O person even feels othered from other OW/O people. Several of my informants expressed frustration at the assumptions people make about how all OW/O women live their lives, and particularly when they felt those assumptions were inaccurately applied to them. Although some of the women admitted that they had a difficult time controlling their appetites, others argued that they definitely were not over-indulging on a regular basis as is generally assumed. Mae, for example, is on a rigid diet because of her health conditions. She described a very restrictive daily menu and a process of logging every item of food she consumed. "I eat probably half the food that most normal-weight people eat and I still put on the weight." Diana related an instance when she was trying to lose weight along with a friend, and despite the fact that she was more diligent in following the program, the other woman lost quite a bit more than she did. To make matters worse, the other dieters in the program reported that they were losing their cravings for foods, something Diana had never experienced and about

which she was very skeptical. Mary Frances remembered a weight-loss support group she joined, and she heard one of the women admitting to regularly eating whole pecan pies and hiding the pie tins under her chair. Mary Frances exclaimed, “My God, if I ate like that, I wouldn’t have been able to walk through the door!” Yet the frequent assumption of normal-weight people is that all OW/O women are compulsive overeaters. Grace protested that she didn’t think she ate any more than her normal-weight friends and not nearly as much as other overweight people she knew. “I have been with people that are overweight and I’ve seen how they pile their plates and put that away. And I have never been that way. I’m not a huge overeater.”

To some degree, some of the women I talked to even felt othered from themselves. As Angel said, “When you’re fat . . . well, you’re just not yourself.” Ruth remarked that “I see myself as my own worst enemy sometimes.” Lisa recalled seeing a photograph of herself and thinking, “I’m not my normal thin self.” Susan’s humorous comment about how she thought her friend might have “Photoshopped” a picture of her in a bathing suit is a reflection of feeling other than who she thought she was. “I’m a stranger to myself,” Susan disclosed, “especially in pictures.” She went on to relate that she had turned the picture into wallpaper on her computer, “to help me realize I’m not as svelte as I feel inside.” Mary Frances revealed that she was perplexed about the fact that she seemed to have two very different self-identities, each at odds with the other. On the one hand, she held a view of herself that was consistent with the societal view of OW/O women being “sloppy, undisciplined, [and] slothful.” Yet, her work habits and professional success were evidence to the contrary, and “that’s really my fundamental

nature; it's not like I have to gin it up! That really is what I'm like, but my perception doesn't match what I'm really like."

One clear expression of feeling other to herself was made by Grace when she confided, in anguish, "I feel like a small person in a fat suit." Victoria similarly revealed that she did not really relate to her body, saying:

> Every now and then, when I dream about myself, I am skinny in the dream. And I'm like, "Why am I—I have never looked like that in my entire life!—why am I dreaming about myself being thin?" I think to a certain degree there is a thinner person in there somewhere. And every now and then, [if] I get the angle just right on the camera, I can get a picture of her. It would be nice to see what I look like thin.

Daily life is full of situations that perpetually remind OW/O women that they are outside the mainstream. As discussed earlier, one effect of being OW/O is the difficulty in shopping for attractive clothing, not only because the clothes designed for larger women are not generally as stylish as those for normal-weight women, but because there are a limited number of retail outlets that offer larger-sized clothing. This is true even for children, as AnnaMarie recalled. She said that when she went shopping as a child and teenager, her mother and brother could "just linger in the stores because there was more for them to try on." My informants also pointed to how restaurant booths are difficult to slide into but chairs at the tables are often too flimsy, how airline and theater seats are too small—in short, the world is not at all accommodating to overweight people.

Media portrayals, particularly of women, were also criticized by some of my informants, reflecting their frustration with the constant presentation of ideal bodies that are realistically unattainable. Gabby asserted that television should

> . . . put real people out there . . . real people that people can identify with. You can't relate to a person that's thin when you're looking at yourself [and thinking], "Oh Lord! What would I have to give up or I have to do to be like that?!"

Susan expressed her great dismay with the overly thin women portrayed in the media. "Look at the magazines, you know, the whole anorexia, the whole mess. It's a mess!" She only half-jokingly asked, "Where are the days of the Rubenesque woman? When are those coming back?" She also commented that there are male actors who are large but still successful, but you hardly ever see large female actors portrayed in a favorable way. And then she made an interesting point: "Especially if everybody's fat, you'd think we'd be starting to think that a little meat on your body would look good." She seemed to be implying that in a world where, we are told, the majority of people are overweight, it would be more logical for thin people to feel "other."

The sense of being other leads to profound disruption of the OW/O woman's sense of belonging. It is expressed in the many ways they compare themselves to others, always coming up short. For many of my respondents, comparison to others resulted in the expression of doubt about their own worth. I heard women tell me that they felt "inadequate" and felt like a "failure." Several women spoke of how they felt "ashamed" of themselves because of their inability to conquer their weight problem. To feel inadequacy, shame, and like a failure assumes that you perceive some standard against

which you are to be measured—a standard that others seem able to meet but you cannot. Toward the end of our interview, Mary Frances had an insight, musing, “Maybe the burden I need to drop is shame. I mean, maybe there really is a psychic burden that I need to drop along with the weight.”

Shame is the emotion that one feels as a result of immoral or improper thoughts or behavior. I would assert that the shame an OW/O woman feels about her body is the product of a cultural belief about the morality of a “good” body and the immorality of a “bad” (read: “fat”) body. Despite abundant evidence that suggests that the causes of overweight and obesity are varied and complex, a great many people hold the view that a person has control over their eating and, therefore, must be held responsible for their weight. When people are blamed for their own problems, stigmatization occurs and moral judgments are made (Crandall & Reser, 2005). If it is not your fault, you are sick; if it is your fault, you are a sinner (Weiner, 1993). Jutel (2003) observes, “In both religious and popular culture, things pleasing to the eye usually connote moral goodness” (pp. 68-69). For that reason, she asserts, “Beauty and normative descriptions of the body become indices of moral and hygienic physical health and dietary conformity, displacing spirituality as the new virtue” (Jutel, 2003, p. 70).

From this perspective, then, thin bodies are good and fat bodies are bad. Therefore thin people are good and fat people aren’t. This is a significant means of othering. You can hear this belief actually internalized by the OW/O women I interviewed when several of them talked about how they had been “good” all day, eating very little, and then when they came home they were “bad,” eating everything in sight.

Marianne stated that when she was around other people "I always thought, 'Well, they're looking at me as this large person; therefore, I'm not a good person.'" Susan mused, "So many people—they want to feel superior to somebody, and you can feel superior to fat people if you're not fat."

Interestingly, most of my informants acknowledged that they were just as guilty of making judgments about other OW/O people as they perceive normal-weight persons to be. In some cases, the judgments were empathic, based on assumptions that their problems were shared. For example, Mae, who is experiencing kidney failure, said that she is likely to assume that an OW/O person might have health issues, that their "body is not working properly." Maggie, who has a high degree of body acceptance, said that she might briefly "wonder what happened to them," which is exactly what she told me she assumed people she had known in the past would think about her if they saw her now. Ann, who has tried almost every way conceivable to lose, including therapy, claimed that she would assume there was a "story" there, "there's something eating them." Charlotte makes "no important judgments" based on a person's body, focused as she always is on a person's interior qualities, their "souls."

But some of the women admitted that they responded in more negative ways. Many confessed that they held the same stereotypes of laziness, lack of self-discipline, and lack of self-care and self-respect that they believed normal-weight people held about OW/O people. Naomi, the only one of my respondents to have reached her goal of losing 40 pounds, conjectured that if she were a doctor of an overweight patient, she would think, "You care nothing about yourself, so why am I going to knock myself out?" Grace

told a story of a man she saw at a concert—a man who was in a scooter and was "so huge!" She recalled:

> During the concert he would—and we were sitting right on this front row with him—and he went out at least four times and came back with a longneck beer in both hands. And I have to say that my opinion was, "What does he think he's doing? You know? He gets a better seat than anybody in the house because he has a wheelchair and he's only in a wheelchair because he's so huge and won't stop drinking beer." *I thought that!* So I know that's what society thinks whenever they look at large people. It kind of sickens them.

Marianne remembered that when she was overweight, she would be critical of a person eating ice cream, even when she knew she was guilty of the same. When I asked her why she thought she had those thoughts, she said, apologetically, "I don't know. I really don't know." Almost all of the women acknowledged—sometimes in words, and sometimes through facial expression or tone of voice—that they regretted holding those views, especially when they were so hurt by the similar judgments of others. One or two said that it was "just human nature," but several were not sure why they had those perceptions, except that it was just the way "society" sees OW/O people. McAfee and Berg (2005) concur with this perspective when they assert, "Even for a plus-size person it is not possible to live in this culture and not be prejudiced against fat people" (p. 285).

The theme of "othering" was one that emerged in many ways during my conversations with my informants, not just in response to one or two particular questions. It appears that a sense of being different from others is, for most OW/O

women, the source of significant disheartenment. However, there was one other theme that was equally prevalent, and that was the notion of control.

Needing and Resisting Control

During our interviews, the word "control" was invoked over and again by virtually every one of my respondents. The women talked of feeling "out of control "and of their assumptions that others viewed them as "lacking control." However, some also spoke of "wanting to be in control" as one of the factors that contributed to why they overeat. To be sure, some of them saw the paradox in this assertion. Ann, for example, observed, "You know, it's the only thing you think you have control of—but really, the food's controlling you." This same idea was noted by GiGi, when she recalled,

> When I wasn't on a diet . . . I remember thinking, "Well, by God, if I want to eat something I want to have the right to eat that if I want?" And to me, that was a control, and yet really, that was an out-of-control.

When I asked my participants to tell me a little about their weight history, several recalled as one of their earliest weight-related incidents a trip to the doctor, initiated by their mother, specifically to discuss weight. Some of these medical visits resulted in the prescription of pills, presumably appetite suppressants. Victoria recalled that it was at a childhood doctor's visit that she first thought of herself as overweight. "As an adult looking back on it, I could see how he made [my mom] feel bad as a parent. 'Your child is overweight, what are doing?' kind of attitude…I remember just feeling bad for my mom." Diana, too, identified a medical visit as the point when her life changed, when

she could no longer be the "carefree kid" who could eat what she wanted as her friends did. As she described it, it seemed to be the moment when she felt she had left childhood and would now have her eating scrutinized by others for the rest of her life. For some of my respondents, then, a sense of control over their bodies was wrested from them at a very early age.

In some cases, a respondent talked of needing to feel in control of at least one thing in their life, since in other areas she did not feel she had any control. In Ann's case, her feeling of needing some measure of control in her life came from several events or situations she had faced. She was working in a family-owned business that she had a "love-hate" relationship with. She was not happy doing what she was doing, but she felt trapped in that job. She also recalled controlling remarks made to her about her weight by both her husband's mother and her husband's step-mother. The mother, for example, commented on Ann's honeymoon-related weight gain of about five pounds by saying, "I just want you to know that [my husband] told me that if I ever gained more than five pounds, that was grounds for divorce." When Ann recounted the conversation she said, "I remember looking at her and [thinking], 'Well, hide and watch, Bitch; hide and watch.'" The implication was that Ann was resisting her mother-in-law's admonitions to her about why she should quickly lose the weight she had gained. Gabby's story is of a woman whose life has been spent trying to please a great many people. Several times she had lost weight specifically to meet the approval of one or another person, reporting that on one occasion the other person's only comment after she lost was, "'Good. Now keep it off.'" Gabby had reached a point where she no longer wanted to be caught up in the

"obsession" she felt some people demonstrated in managing their diet and exercise regimens. To her, their regimens were now controlling them.

As Ann had implied in her stories about her husband's mother and step-mother, other women also suggested to me that their inability to lose weight was a form of resistance to the expectations of others. Grace told of how she gained quite a bit of weight during her first pregnancy and was not able to take it off quickly. A few months before she became pregnant with their second child, her husband told her, "'If you don't do something about this [weight], I'll have to do something about it.'" Grace explained that he meant that he was threatening to leave her. She responded by watching her weight rigidly in her second pregnancy, only gaining 12 pounds. But she was still not at a weight that was pleasing to him, and then she became pregnant with their third child. Shortly after that child's birth, they attempted marriage counseling, her husband asserting that her weight was *the* problem in their relationship. He also had "started having relationships on the side," making it clear to her that her weight was to blame for his actions. Grace resisted being made responsible for his moral choices. "My thought was, 'That's not fair to put this whole relationship on my weight.'" She believed that her inability to lose weight was a form of "rebelling against his over-controlling." (Her husband did, incidentally, leave her a few months after the birth of the third child.)

Sasha recounted a similar tale, saying that part of her weight gain was "probably a rebellion against my husband." She and her husband were still married at the time of our interview, but now that their youngest child was preparing to graduate from high school, they were making preparations to end their marriage. As she talked about this

development, she made it clear that she was glad to be finally asserting herself, and that part of that process would be to begin a serious weight loss program to prepare herself for the demands of re-entering the workforce and for the potential for future relationships to develop.

One source of frustration related to control that was shared by several of my respondents was that they felt they had control over so many things in their life, but they could not seem to get control of their eating. Angel confided,

> I mean, I've always done well for everything that I've done. It's just trying to get control of that part of it, and it was like no matter what you did, it was never enough because I couldn't get the grip of it.

GiGi, too, felt that "it was so frustrating when you have success in every single other part of your life, but you seem not to be in control of your body that just keeps putting on more and more weight." Sherry had, at one time, been a model, and she confessed that during that time she had been fully in control of her body, maintaining a weight that was just on the borderline of anorexia. But now that she had been required to gain weight in order to cope with medications for her serious health issues, she no longer had that control. "I beat myself up, because it's like, 'Why can't you get this weight off? You can do this, and you can do this, and you can do this, but why can't you get this weight off?'" Several of my subjects expressed additional frustration because they had the information, they knew what they needed to do, but they didn't seem to be able to implement it.

One other way in which the theme of control emerged was in the many times that a respondent used the word “obsessed” or “obsession” in talking about their awareness of their weight issues or the inability to escape from thinking about it. Diana said, “It’s *always* on my mind.” Mae, whose health condition requires her to monitor her intake very carefully, moaned that she wished she didn’t have to think about it all the time. “You get tired of having to just . . . *constant* watching, and it doesn’t seem like it does any good.” Sherry declared, “I pray every night to take this obsession away from me.”

The issue of control was a strong theme that emerged in response to a number of topics discussed during the interviews. It surfaced when we talked about causes of weight problems, when respondents discussed how they felt about themselves, and in the discussions of what they assumed to be the perceptions others held about OW/O women. Issues of control and personal autonomy, as well as of othering, can also be detected in the ideas my informants shared about their experiences in medical encounters. In Chapter VI, I will link these two emergent themes to the viewpoints of my participants regarding communication with healthcare practitioners.

CHAPTER VI

ENACTING WEIGHT IN MEDICAL ENCOUNTERS

In Chapter V, I presented a grounded thematic analysis of issues discussed by the twenty-three women I interviewed as they made sense of the factors they believe contribute to their weight problems. I also discussed the many ways in which they perceive that their lives are impacted by being overweight. In addition, I explored two themes that emerged as I analyzed the interviews: "othering" and control. In the context of this study, the finding I reported in Chapter V that being overweight or obese has had a significant impact on the choices my respondents have made to delay medical care and, in many cases, avoid routine health screenings is of particular concern to me. Questions also arise as to the role that othering and control may play in OW/O women's health decision-making.

In this chapter, I will be seeking to answer my third set of research sub-questions: *In what ways have their experiences in medical consultations been beneficial or detrimental in promoting positive health outcomes? What recommendations would OW/O women make to improve medical encounters and practitioner communication with OW/O women?* To answer these questions, I will begin by applying the themes of othering and control to the experiences my informants recounted in their past interactions with medical practitioners. I will also propose an explanatory model that links social bias, personal identity, and medical interactions. I will conclude by making

recommendations that may enable healthcare providers to fill an important role in improving the health of OW/O women.

Othering in Medical Encounters

Problems with Structural Features of the Medical Visit

There are certain aspects of a medical encounter that seem insignificant to normal-weight patients but reinforce the sense most OW/O women already feel of being different. For many, the othering begins in the waiting room. Mary Frances acknowledged that "chairs are going to be a problem for me real soon," grimacing as she added, "I don't want to get stuck in a chair in the waiting room!" Lisa concurred that, for large patients, the chairs in the waiting room are often uncomfortable, and the size of the examining table "could be more accommodating for the bigger patients." Marianne commented on the relief she felt when she went to the bariatric surgeon's office and saw that "they have king-sized chairs . . . and they had set things up for the heavy patient." Two or three of my informants specifically talked about the gown that is required attire for a thorough medical examination. Angel observed that "they never fit around. . . . It makes you very uncomfortable. It's kind of like, 'Hello! Can I get *another one of these* to put around *this*? Because this ain't covering my boobs up!'"

The scales in a doctor's office are a significant source of anguish for OW/O women. They are quite possibly the reason that many of them delay or avoid seeking medical care in the first place. Certainly when the issue is one's weight, it would seem that the scales are an important part of the medical visit. This, however, is not an

uncontested idea. Several of my participants spoke with frustration of the practice of being weighed when the reason for the visit had nothing whatsoever to do with their weight. They regarded the scales as a constant reminder of their otherness. Lisa pointed out that this is particularly true when the doctor's office uses the type of scale that is operated by moving weights along a bar until balance is achieved. She observed that it is disheartening to arrive at the scale with the previous patient's setting still there. She only half- laughingly explained, "It's bad enough that you already had to set it for 100, but then you have to set it for 150 or 200, and you're looking at 'Who's the small person here before me?'"

Not Being Regarded as an Individual

Almost all of my respondents expressed, in one way or another, that a significant source of dissatisfaction with their medical care was the result of feeling that the clinician defined them primarily by their weight. They felt that when doctors and nurses think of weight as the most salient characteristic, they strip patients of their individuality. I think it is important to note at this point that the problem of "othering" is not remedied by treating everyone as all-the-same. Referring again to the definition offered in Chapter V, othering "refers to a person or group who is objectified or disenfranchised by the dominant culture and is treated as a nonperson" (Bullis & Bach, 1996, p. 4). The remedy for othering, then, is to treat people as individual persons, while also recognizing that OW/O people are not exempt from the needs all humans share.

There is a logic behind why doctors might tend, at times, to overlook the individuality of each patient they see. Their medical training, after all, has focused on

empirical evidence that aids in diagnosis. They learn to narrow possibilities based on what is indicated in *most* cases. And in the context of specialization, they tend to isolate their attention to a narrow range of body parts, so that a patient is too easily seen as "the morbidly obese diabetic with end-stage renal disease" instead of the "woman who went back to school after her seven children and step-children were largely raised, and was only six classes away from getting her bachelor's degree when her husband developed a brain tumor so that she had to close down her small business to care for him, and who is now on dialysis three times a week for the past 18 months and is striving to lose 60 pounds to increase her chances of having a successful kidney transplant, and in the interim must religiously weigh to-the-ounce the limited foods and beverages she is allowed to have and must regularly see all the doctors she has, seemingly 'one for each organ,' until she can have her transplant which might not be for another two years."

There are at least two problems in not seeing OW/O patients as individuals. One is that there is a tendency to make assumptions. Mary Frances recounted an incident in which she was referred to a rheumatologist for allergy testing and, while consulting with him for the presenting condition, mentioned that she also had some concerns about arthritis. She recalled that the doctor looked at her and said, "in this extremely curt way, 'Well with your weight, I'm not surprised. It's going to get your knees and your hips.' And I looked, and I said, 'But it's my hands that I've got it in.'" Diana recalled bitterly her attempt to enroll in a medically-supervised weight loss program for which she was required to be measured and weighed on the first visit. She had already prepared herself mentally for the emotional difficulty she knew she would experience during the process,

so she advised the nurse, "'You know, I really don't want to know the measurement of my hips. I know I have large hips.'" Diana remembered that the nurse, no doubt trying to be reassuring, said, "'Oh, honey, please! All women who have had children have big hips!'" Diana paused for a long time at this point in the story, looked intently at me, and then revealed, "I have no children." She concluded by telling me "I just boo-hooed," and then she left the facility, never to return. Later in our interview, she recounted another medical visit during which the doctor had admonished her that if she didn't lose weight, she would never be able to have children. Since Diana had never discussed having children with the doctor—and, indeed, had no desire then or now to have children—she was offended by his assumption. Despite having enjoyed what she regarded as a positive relationship with this physician for several years prior, as a result of this experience she chose never to see that doctor again. In fact, Diana had seen many doctors over the years, and it was her sense that in most instances the doctor's attitude seemed to be, "Here's another fat one rollin' in!"

Several of the women I talked to offered the opinion that doctors tend to assume that if you are fat, that is the reason for all of your other medical concerns. Ruth said that in most cases she did not feel that her weight affected how doctors or nurses perceived her, but she related that there were times when she felt that she was judged from the moment she met the practitioner. She sensed them thinking, "'Oh, she's overweight. So. She's got so many problems and it's all because of the weight.' Rather than getting to know me and finding out what my problems and issues are." Later in the interview, Ruth offered this perspective:

> Obesity is kind of a mask. It covers up who a person really is. And [doctors need to] try to see past the mask and find out who that person really is. Sometimes we put the masks on ourselves and sometimes the masks are just kind of built up without our intention of building them up. [Doctors need to be] willing to find out who a person is rather than just a body type or something like that. A lot of times, labels tend to confine people rather than opening them up to things, you know? Saying someone is morbidly obese or obese kind of puts them into a pigeonhole and then you look at everything else as "does that reinforce this, or does it take away from it," rather than finding out the information and then finding out where a person fits.

A second problem in not seeing OW/O women as individuals is that it causes the clinician to forget that overweight/obesity is a very complex issue that even the best science has not been able to adequately explain. Certainly the experiences of my respondents give testimony to the argument that the causes are not simple. The reason this is a particularly important insight is that when the assumption is that "all overweight people are fat because they eat too much," which seems to be the default positions of many people (including some medical practitioners), the logical conclusion is that "it is her fault."

Communication That Blames the "Bad Patient"

In the previous chapter, I discussed the problem with blaming the patient and the assumptions of moral defect that accompany that position. My respondents pointed to many instances in which they felt that they were blamed by the doctor, and to other

times when it was clearly communicated to them that the practitioner considered them a "bad" patient who was not being truthful or who was willfully non-compliant. The unspoken implication is that other patients—"good" patients—do what they're supposed to do. Ann recalled a conversation she had with a physician about the possibility of having bariatric surgery, and the doctor responded, "'You are so non-compliant, you would figure a way around the Lap-Band®.'" Gabby claimed that one of her past doctors had conveyed his clear disapproval when, after the birth of her first child, she had not lost all of her pregnancy weight within a period of time he thought reasonable. Angel remembered being told by a "gynecologist who had no heart" that she was a "'walking time bomb'" and that she was doing it to herself. Mary Frances recounted a time when she was rigidly following a diet, but "there was no amount of food I could eat and not gain weight." She talked to her physician about it, "and it's clear that he believed I was cheating. Because he would say, 'Well, if you *really* follow this diet, you *will* lose weight.'" She went to another doctor who discovered that Mary Frances was suffering from a thyroid disorder.

Patients who feel that the doctor regards them as a "bad" patient logically wonder if they are being treated as a "good" patient would be. Diana maintained that she had once gone for over a year to a doctor whose communication style with his normal-weight patients was noticeably different from the style he used with her. She acknowledged that it could have been a perception that was affected by her sensitivity about her weight, but her suspicion was given credence when she was told by someone who worked for him that he was "very sexist" and had a reputation for hiring only good-

looking women in his office. Ruth had a doctor who once said, "'I give up; I don't know what else to do for you.'" She acknowledged that ultimately this was a good thing because the specialist he referred her to, an endocrinologist, was able to discover a problem the other doctor had not detected. However, the entire event had left her feeling "like a failure." Several women mentioned that they had had doctors who were quick to point out any weight gain but rarely ever made mention of any successes at losing unless it was called to their attention by the patient, making them feel that no matter what they did it would not be sufficient for them to be viewed as a good patient. Susan pointed out that OW/O women already hold negative self-images; when doctors contribute to that self-perception, it isn't likely to be helpful. Susan summed it up when she said, "Just because you're overweight doesn't make you a *bad* person. It makes you a *big* person."

A Strategy to Overcome Othering: Choosing Female Doctors

Fifteen of my twenty-three respondents indicated that at some point they were under the care of a female doctor, and twelve of them were seeing female doctors at the time of our interviews. Seven of those confirmed that the choice of a female doctor was deliberate and aimed at finding a physician who might be more empathetic about their situation or with whom, as Mary Frances said, they could be more "frank." AnnaMarie and Victoria said that they would not be able to consent to a gynecological exam by a male doctor.

The deliberate choice of a female doctor can be viewed as a strategy to lessen the feeling of otherness that women—OW/O women in particular—so often feel. It is true, however, that simply choosing a female physician is not sufficient to accomplish this

goal. Victoria disclosed that she had had recently had a “gyno” checkup, but that she “wouldn’t have done it if [my doctor] was a male.” Despite that, however, she doubted that her female doctor could really relate to her because “she is a size 3 . . . probably never been overweight a day in her life.” Grace recounted a female obstetrician she once had who was “little bitty,” and who happened to be pregnant at the same time as Grace. Grace admitted that “the reason that I wanted to have a woman doctor is because I felt like she would be more understanding, since she’s a woman, too.” She quickly learned that “Uh, no. Not with her. She was just like, ‘You’re not going to get any compassion from me; this is the way it is.’” To add insult to injury, the doctor “went back to a pencil” immediately after her baby was born. Obviously, there are many reasons why this particular doctor might not have related to Grace the way Grace had hoped, and it is at least possible that part of that was because of the disparity in their sizes. However, it is instructive that for many women—certainly for some of the women in my sample—the desire not to be othered may affect the choices we make in selecting our physicians.

Control in Medical Settings

There is an inherent inequality in medical settings due to the difference in status between physicians and most of their patients. The most salient difference is that doctors and nurses possess greater knowledge about human anatomy and disease processes than do most people who seek medical care from them. The difference in status easily transfers into an asymmetry in perceived power. As a consequence, patients have too often relinquished control and autonomy in their encounters with healthcare

practitioners. Though there are noticeable changes in this dynamic in recent years, patients often have to be educated about the need to be assertive and to advocate for themselves in medical interactions. Patients do not always recognize that they do, indeed, have control within this relationship, if for no other reasons than that clinicians cannot force patients to accept medical advice and treatment and that patients can always seek healthcare elsewhere. There are, however, some elements of the typical medical encounter that serve to diminish the patient's perception of control.

Introduction of the Topic of Weight

Perhaps the primary source of frustration about control was expressed when my respondents talked about the issue of whether the topic of weight should or should not be broached at all—and, if it were, when and how it should be broached. There was much variability in preference on this issue, ranging from those women who said they would prefer that the topic of weight never be introduced by the clinician to those who claimed that they would prefer for their doctors to open up the subject for discussion more often. This, of course, puts physicians in a difficult position, an idea that will be considered in greater depth later in this chapter. For now, though, it is important to note that many OW/O women expressed a need for greater control over the introduction of discussions about weight. As Marianne said, when explaining why her doctor's introduction of the topic had not been fruitful for many years, "I had to be ready."

Time Constraints

Many of my respondents talked about the feeling they have of not being free to discuss all their concerns with their doctors because of time constraints, many of them

noting that their experiences with doctors in HMOs are particularly restrictive in this regard. Ruth remarked, “A lot of times doctors [are] scheduled to the hilt. So you can sense when they come in, ‘Okay, you’ve got your time; let’s get it over with so I can move on.’ Just a cog in the wheel type thing.” AnnaMarie noted that it was frustrating to her that her doctor had had to implement a “one topic only” policy. She reported that “in fact, they make you fill out a paper now that you only come to talk about what you called in for.” She explained that this was a problem for her because she would like to talk with the doctor about weight issues, but typically she only saw doctors for specific concerns, such as blood pressure or acute illness, preventing her from ever getting to broach the subject.

Disregard of Patient’s Expertise and Preferences

Some of my informants conveyed that over the years they felt that they had been pushed into certain treatment modalities because of their doctors’ personal preferences and biases. The over-reliance on pills was frequently cited. Many of the women I talked to admitted that they had at some point been on pills. Several recounted how they had actively sought pills, either from their general practitioner or from clinics that specialized in offering pharmaceutical approaches to weight loss. In other cases, the pills were prescribed and the women accepted them, largely because that was the only thing their doctors seemed to be able to offer. Only two of my subjects claimed that they had positive attitudes about the experiences they had with weight loss pills; the others were uniformly negative.

Other women talked of their doctors seeming to hold "pet theories." Ruth reported that the doctor who gave up on her "had one train of thought" and that was "'if you eliminate the fats, you'll lose weight.'" It was frustrating to her because she was trying hard to implement that recommendation, but she was not successful. Yet, no matter how often she pointed out that the low-fat diet was not a plan that worked for her, he continued to insist, "'Eliminate the fats, you'll lose weight.'" Her referral to the endocrinologist revealed that she had diabetes and that blood sugar issues were complicating the situation.

A significant frustration reported by several of the women was their belief that they probably knew as much or more about diets and weight issues than their physicians did. Ann said, "I should probably go into the diet business." Others expressed the perception that doctors know very little about nutrition. Lisa suggested that she could sometimes learn more about weight issues from the Internet than from doctors. These claims are important for two reasons. First, they indicate that the women I interviewed do not hold to the notion that doctors are the repositories of all information about health and that their only access to health information must come from medical practitioners. This, of course, serves to alter the power balance a little. But the second reason these perceptions are important is that they help account for why so many of the women I interviewed were put off by what they perceived to be "condescending" attitudes expressed by their physicians.

Over and again, I heard my respondents talk about how their own expertise was discounted. Lisa, for example, maintained that her doctor was "dismissive" any time she

wanted to talk to him about her Polycystic Ovary Syndrome and its relationship to her difficulties in losing weight. Ruth talked about the difficulty she had in getting her doctor to listen to her as she explained why she did not think that the diagnosis he was offering was correct, an important issue since the treatment he prescribed resulted in significant weight gain. AnnaMarie was particularly frustrated because she felt that her overall history with weight was not being discussed, much less considered, in the recommendations made by her doctor. Because they felt that their own expertise about their own bodies was not being honored, my respondents seem to be frustrated by their physicians' unwillingness to act in a partnership where they shared control with their patients.

One slightly different slant on the issue of control was implied by Charlotte when she suggested that she would like to see doctors take a little *more* control, not leaving so much up to the patient. She remarked,

> Nowadays, it seems like we're expected to go in to the doctor with a preconceived notion about what the doctor is going to do to solve our problem. For instance, with my thyroid. I've gone in and I've said, "Look, I've got these symptoms. It sounds like to me that I have thyroid [problems]. Would you check my thyroid?" The doctor checks my thyroid, comes back and says my thyroid is fine. And then the impression I get is, "Come back if you think of something else." He can tell me it's not thyroid, but he doesn't really care what it is! And I need to come back and give him another $25 when I have another idea.

A Strategy to Overcome Control Issues: Avoiding Medical Care

Of course, control issues are not unique to medical encounters between physicians and OW/O people, but there may be especially detrimental consequences in those relationships. When OW/O women feel that their need for at least some control in medical encounters is stripped from them, they have a number of strategies they adopt to regain some autonomy. The first and most obvious is to refuse to go to the doctor. To be sure, several of my respondents had never chosen this course of action. GiGi explained when asked about her history with routine health screenings, "I always felt like I was a healthy person, and this is what a healthy person did." Both Sasha and AnnaMarie acknowledged their reluctance to see their doctors for annual exams, but both had adopted the belief that it was something that just had to be done. Sasha maintained, "I mean, you think about . . . you know you've got to be undressing in front of people, they're going to see you. But you've gotta go." Others of the women I talked to explained that they had no choice but to see a doctor fairly frequently because of ongoing health issues. Charlotte's breast cancer, Mae's kidney failure, and Sherry's heart condition made it imperative that they seek regular healthcare. Lisa pointed to her blood pressure, her seizures, and a "bad Pap" as reasons that she had to see various types of doctors on a frequent basis. Megan, too, was fairly diligent about doctor's visits because of her hypoglycemia and endometriosis.

However, many of my informants admitted that they often delayed seeking healthcare due to their weight. Marianne, for example, flatly stated, "Being overweight

really caused me not to go to the doctor." When I asked Victoria about how often she went for routine screenings, she replied,

> You are probably going to scream. I just had my first gyno; so that's one. I put it off forever and a day. It's . . . being naked at this weight is something that I just don't want to do, you know? And my doctor finally put her foot down.

Ruth echoed Victoria when she explained, "Well, it's just an embarrassing thing. And I've never done the routine things and probably should." When I asked how often she went for well-woman checks, she initially said, "Uh, I probably haven't had one in 3 or 4 years." I asked if that was a pretty typical timeframe for her, she smiled sheepishly and said, "Yeah," and when I asked if it were sometimes longer than that she responded, "Yeah . . . probably," nodding her head and wincing to concede that it was probably much longer in some instances. Mary Lou confessed that she had never had a well-woman exam, and Ann admitted to avoiding medical visits, often changing appointments several times in an effort to put it off.

Avoiding medical visits and annual screenings is a strategy that I find most worrisome, believing as I do that the health of OW/O women is jeopardized more often than we might know when they fail to seek necessary healthcare because of their weight. It is not, however, the only strategy that my informants reported. Some admitted to doctor-hopping, a practice that can sometimes lead to improvements when more satisfactory patient-practitioner relationships can be established elsewhere, but a practice that also compromises continuity of care. One of my subjects suggested that the Internet could be a substitute for consultation with a doctor in some cases, but this approach

obviously has a number of drawbacks, notably in the possibility of erroneous self-diagnosis. Others demonstrated a desire to take back some of their power in their refusal to be weighed, an act of resistance that has implications in terms of open communication with practitioners, as well as for the potential to result in the OW/O woman's continued denial of a weight problem.

Noncompliance is, of course, an act of resistance, and the possible consequences of those behaviors are obvious. Some respondents go to the doctor but choose not to discuss their weight concerns because of fears that the doctor will merely "push pills." And others do not mention weight with their practitioners because they sincerely believe that there is nothing the doctor can do, that it is entirely their own responsibility. This is an attitude that would be unproblematic if it always led to better health outcomes—but it doesn't. A better option would be for practitioners and OW/O patients to work to negotiate an appropriate distribution of power.

An Explanatory Model

In Chapter V and to this point in this chapter, I have presented the results of my grounded thematic analysis of the twenty-three interviews I conducted with OW/O women. I have examined the responses of my informants that revealed their perceptions of the causes of their difficulties with weight and the effects of their weight status on many aspects of their lives. I have also explored two pervasive themes that emerged throughout their interviews, and I have linked those two themes to their attitudes about medical encounters. Looking at the material in these two chapters, as well as ideas

suggested in previous chapters, I propose an explanatory model (Kleinman, Eisenberg, & Good, 1998) that elucidates the relationships among social bias, personal identity, and medical interactions. Then I will offer some recommendations based on ideas generated by my respondents and some of the relevant literature that supports their views.

In setting up an explanatory model, there is a natural desire to try to locate where the phenomenon under investigation begins—to determine a "first cause." And, of course, this is not usually possible to identify. The concept of a "vicious cycle" is often more accurately invoked, where a series of connected phenomena serve to reinforce each other in an endlessly recurring loop. It appears to me that this is to some degree the case when examining the relationships among social bias, personal identity, and the role of medicine in responding to the issue of overweight and obesity. Figure 2 depicts this vicious cycle.

I believe most people would agree on an intuitive level that social bias leads to discrimination, and that being discriminated against would have the effect of reducing one's self-esteem. In addition, ample evidence exists to support these ideas, particularly well explored by Brownell, Puhl, Schwartz and Rudd (2005). Literature in Chapter I and the responses of my informants give credence to the belief that personal feelings about their weight cause many OW/O women to forego doctor's visits and the routine screenings that could indicate the need for timely medical intervention. Chapter I also included literature that supports the concern that medical professionals often hold negative opinions of overweight people, that these attitudes may be communicated to their patients, and that quality of care may be compromised. Certainly several women in

my study could recall instances in which they felt keenly that their clinicians held negative views toward them because of their weight, and they questioned whether their care was, thus, affected. Obviously, reductions in the quality of care will have consequences in terms of health outcomes.

Figure 2 The vicious cycle: Relationships among social bias, personal identity, and medical interactions.

As discussed in Chapter I, there is an abundance of reporting that has occurred in the media in the past two decades that has trumpeted the obesity "epidemic." Monaghan (2006) notes that the use of what he calls "epidemic psychology" in the discussion of

obesity is a practice that "brands literally millions of people as 'at risk,' 'unhealthy,' or 'diseased' because of their weight" (p. 134). Logically this leads to a greater perception in the public's mind that being overweight is dangerous, which then fosters more attention to the problem. Sometimes the attention is achieved through direct means by news reports of research that links weight to morbidity and mortality. Other times the attention is more oblique, captured in the fascination with, for example, Oprah's ever-shifting weight status. In any case, the master narrative is established: thin is best; fat is deviant, unhealthy, and shameful. My informants had clearly been exposed to—and had largely adopted—this narrative. Many of the women told me that they considered their health status to be "good, except for my weight," suggesting that they had embraced the notion that to be overweight means that you cannot be truly healthy. Certainly their sense of being outside the boundaries of normalcy was clear, and there were many expressions of embarrassment and shame about that.

When intense interest in a problem is generated, a search for solutions will inevitably follow. That solutions for the problem of OW/O have proliferated is evident in the sheer volume of diet books that are published every year. In addition, we see the ubiquitous advertisements for weight-loss programs in print and electronic media, and there is a near certainty that every issue of every magazine that is aimed at women (the prime consumers for anything promising weight loss) will include at least one article that purports to be the answer for how a perfect body can be obtained/reclaimed/maintained. In my interviews, it is clear that my informants had been exposed to the myriad solutions offered. "You name it," some of them replied when I asked what sorts of approaches

they had tried to lose weight, and they went on to catalogue numerous weight loss programs, fad diets, pills, exercise plans, therapy, and support groups. As noted earlier, Frank (1995) asserts that there is a "modernist expectation that for every suffering there is a remedy" (p. 80).

With so many solutions out there, it is not surprising that the general consensus would be that this must be a solvable problem. As Edgley (2006) points out, "The idea that virtually anyone *can* achieve standards of health and fitness through a proper regimen of diet and exercise quickly translated itself into an ideology that everyone *ought* to" (p. 236). If we all assume that the problem is solvable, then we are left to wonder why some people have failed to solve it and, since they have failed, what this tells us about them. Edgley (2006) summarizes the contemporary narrative about the human body this way:

> Fit bodies are healthy bodies, the standards of fitness are largely settled, medicine and nutritional science have given institutional imprimatur to a foreordained conclusion, and those who do not measure up are not only courting a self-induced disaster, but are socially irresponsible as well. (pp. 231-232)

Of course, negative attitudes about OW/O people are the basis of social bias. And the cycle continues.

There are clearly three entities involved in the relationships I have linked in the model: the OW/O person, the healthcare practitioner, and the culture as a whole. In order to break the cycle depicted in my conceptual model, the practices of at least one of these will need to change. While my own view is that the culture is a crucial factor in the

vicious cycle and that alteration of cultural attitudes about body size is a worthy goal, it is also true that culture is difficult to transform and changes in cultural attitudes will, inevitably, be gradual. Therefore, it seems more fruitful to focus on breaking the cycle at the level of either the OW/O person or the clinician. Frank (2002) suggests that in patient-provider relationships, the patient is the more vulnerable party, which is why he holds the view that the task of beginning the process of effecting change falls to the clinician (p. 14). I would concur.

In the final section of this chapter, I will propose some recommendations that practitioners may want to consider in adjusting their practices to better suit the needs of the OW/O women they treat. In most cases, I will relate the recommendations to how they may be used to counter the othering and the control issues that seem to be an impediment for many OW/O women in medical visits. Many of these suggestions are based on what might be called the "best practices" recalled by my respondents in past interactions with physicians and nurses that have been positive and helpful. Other ideas are gleaned from what my informants told me about upsetting experiences they have had and what they specifically told me they would like to see changed in order to improve communication with healthcare providers. I will also include at some points relevant literature that supports my subjects' ideas.

By no means do I intend to suggest that all the blame for poor relationships between OW/O women and their healthcare providers are to be attributed solely to the clinicians' shortcomings. My informants themselves were quick to acknowledge that they often bore or shared responsibility for relationships that were less than optimal.

Repeatedly I heard them say, “It’s possibly just me,” or “I know I should . . .” However, I think that most practitioners would agree that the way they conduct their practice sets the tone for interactions with patients. It is with that belief that I offer these recommendations.

Overcoming Othering: Recommendations

Improving Structural Features of the Medical Visit

Overweight and obese patients would appreciate some attention to structural features of the medical visit. Ahmed et al. (2002) writes of a patient’s medical visit that includes all of the uncomfortable features of medical encounters that I heard many of my respondents talk about. Ahmed confirmed that the scenario depicted in the article was an actual patient of his. “She brought to my attention that she stopped seeing me due to [the] unfriendly atmosphere in the clinic. She put it this way, ‘I love you Dr. Ahmed, but I hate your clinic’” (S. Ahmed, personal communication, June 8, 2009). Waiting rooms and restrooms that do not make OW/O people feel like they are out of the mainstream of society would reduce the othering that narrow chairs with armrests and cramped toileting facilities engender. Equipment such as blood pressure cuffs and scales that can accommodate heavier patients should be readily accessible so that members of the healthcare team do not have to make an obviously special effort to locate them. Examination tables that are large enough and easy to access, as well as gowns that are comfortable and provide adequate coverage of the body should be provided.

Some of these suggestions are so obvious that they seem unnecessary to mention. However, the fact that both my respondents and the patient in Ahmed's case history have experienced these shortcomings in the medical environment should indicate that physicians might be well advised to take a look at their facilities. Dr. Ahmed did so, asking his former patient to walk with him around the clinic where she "pointed out all the flaws, and for the first time, I saw my clinic through a patient's eyes. We did make significant changes because of her" (S. Ahmed, personal communication, June 8, 2009). It is interesting to note that studies indicate that bariatric patients have, on the whole, much greater satisfaction with the care they receive for their weight than non-surgical OW/O patients report (Anderson & Wadden, 2004). This finding is consistent with what I learned from my respondents, particularly when the surgical patients commented on how pleasant it was to be in a medical office that was set up to accommodate larger people.

Seeing OW/O Patients as Individuals

The women I interviewed for this study seemed to be saying that they would like practitioners to understand that they are like everyone else in that they are not like anyone else. In other words, they wish to be treated as individuals, not as people who can be lumped into any category, particularly one that would be labeled "Other: Fat." Marianne, for example, confessed that one of her interactions with a healthcare provider was marred because she "wanted to be a *special* patient." When she said this, she immediately reflected with a wry smile that she recognized the seeming grandiosity of this expectation. And yet, there was a sense in which this was exactly what she was

telling me was the problem with that particular physician. She did not have the sense that her doctor was willing to take the time to really understand her. This idea was not unique to Marianne, either. Many of my respondents talked of feeling that their physicians didn't really regard them as individuals worthy of care and concern because of their weight. Ann speculated about her doctor:

> She goes home every night, she doesn't think about me. . . .You know, if I have a stroke, she'll probably go, "Damn! If she'd only lost some of that weight she probably wouldn't have had a stroke." And then [she'd] move on down the road.

My respondents also made it clear that they did not want to be defined by their weight. They see themselves as whole people, not just as fat people. They would like their doctors to see them that way as well. Not only do they have many roles they fill and many personal characteristics beyond their size, they want doctors to understand that their health is not solely connected to their weight. As I have noted previously, my respondents are frustrated when every health issue is linked to weight and the assumption is made that the loss of weight is all that will be required to remedy the concern. There seems to be an implication that unless and until the weight is lost, the physician is not interested in taking the complaint seriously.

Related to the concern about defining patients by their weight is the issue of assumptions that are automatically made because of weight. Previously I have mentioned the assumption made by a physician about the relationship between Mary Frances' concern about arthritis and her weight, as well as the assumption made by a nurse about Diana's hip size being related to childbirth, neither of which had any basis in

fact.Lisa told of a heavy friend whose doctor who was so certain of his diagnosis of sleep apnea because of its connection with being overweight that he was noticeably surprised when the sleep study came back with no indication of the disorder.

A particularly distressing assumption that OW/O women feel is often made is that they are not really trying to do anything about their weight: that if they were "good patients" who were making a serious effort they would be successful. A few of my respondents talked of doctors who thought they were "cheating" on diets, but consultation with other physicians revealed that thyroid or blood sugar issues were involved. Others did not have complicating factors, but they reported instances where despite their best efforts, they seemed unable to, as Angel said, "get the grip on it."

Personalizing Medical Care

Several of my respondents expressed the view that there should be a branch of medicine that specializes in the treatment of overweight and obesity. Mary Lou was particularly fervent when she observed, "Obesity—is it not like *the* major problem in our country? You know, the medical community is saying that, although . . . there's not a specialist that's actually addressing this head-on." When I offered to the women who expressed this idea that there were doctors who specialized in bariatrics, the typical response was a shaking of the head and an immediate insistence that they did not mean "just surgery." It was clear to me that the term "bariatric" has come to be primarily associated in many people's minds with surgery instead of being understood to be focused on prevention and treatment of obesity using a wide range of modalities. What I heard my respondents say is that they would find a medical practice that was

"comprehensive" or "all-encompassing" in the treatment of weight to be an inviting option for them. Their opinion is consistent with recommendations in the literature. Frank (1998), for example, advocates a multidisciplinary team approach where many of the providers would be practitioners other than physicians, though physicians would be actively involved in referring, supporting, and monitoring patients. Early and Johnston (2005) also strongly advocate the multidisciplinary approach.

Based on what my respondents told me, it would appear that team members in a multidisciplinary approach should ideally include nutritionists and dieticians. Mae felt that her greatest help came from her consultations with her nutritionist. An exercise physiologist or personal trainer might also be a good addition to the team, since many of my informants concur with the idea that exercise is a vital part of losing and maintaining weight. Raquel and Vanessa rely on exercise as their primary means to manage their weight, noting that when they were on a program of physical activity they always felt better about themselves and about their bodies. However, it is important to recognize that no single form of exercise is a good choice for everyone. Ruth reported that her physician had prescribed walking for her; she laughed when she told me this, implying that the idea was preposterous because it was not an activity that she could imagine herself sustaining, Marianne admitted that she had been unable to go to the gym to work out before her weight loss after her surgery, primarily because "everyone there looks so wonderful." Now, however, she exercises regularly and feels much better as a result.

It is clear from the thematic analysis in Chapter V that overweight/obesity can have a serious impact on a woman's psychological well-being. Poor body image, for

example, is often disruptive to an OW/O woman's sense of worth. More than one of my respondents talked of having been in counseling about weight issues, and others proposed that therapy might be beneficial to them. Ann had been in therapy on several occasions, yet she still thought that one way a physician could be especially helpful would be if s/he could refer her to a therapist that focuses on weight.

Multidisciplinary teams could effectively follow a "stepped-care model" (Anderson & Wadden, 2004), an approach that favors using different interventions based on levels of obesity and other factors. Although several of my respondents specifically rejected the idea of surgery, five of them had undergone either gastric bypass or a gastric banding procedure, and several others had considered surgery or were actively planning to pursue it. Surgeons, therefore, should be included in the multidisciplinary team. It seems obvious that surgery is something that most women would consider only as a last resort, after other less risky methods had been tried. However, as Kral (1995) found, "Some severely obese patients . . . clearly express a preference for guaranteed weight loss with the possible risk of early death to living as obese for the rest of their lives" (p. 513).

The obvious emphasis in a stepped-care model is on finding solutions that are tailored to the individual, a concept that my respondents would heartily endorse. For example, recommendations for eating programs must take into account patient preferences. Lisa insisted that she had to have variety in any eating regimen in order to have any chance of adhering to it, while others indicated that they might prefer more limited choices. On the other hand, for some people, restrictions on what food you can

eat only serves to make food more important (Bordo, 1993, p. 103). One theme I heard several times was, “Not like Weight Watchers®!” but others said that it was probably the best plan they tried. For some, the communal aspect of Weight Watchers’® group meetings was motivating and for others it was discouraging. Some find the successes of others to be inspiring and others, like Diana, are frankly skeptical when they hear a group member claim to have lost cravings for foods they used to enjoy. AnnaMarie expressed frustration in finding an eating plan that would work for her, commenting that she had heard many recommendations over the years from various sources, and that she had come to the conclusion that “you finally have to take a little bit here and there and make your own plan.” She longed, however, for a clinician who could help her sort through everything. “If we come together, both of us, her knowledge and me come together, we could maybe come up with something to help.”

Recognizing Cultural Differences

Another important consideration in personalizing medical care is the need to recognize cultural differences. People in minority groups already contend with the othering that occurs because of race or ethnicity; additional othering on the basis of weight should be avoided. Much study has been done in recent years to discover what differences, if any, may exist in how various ethnic groups respond to the issue of weight. Many studies suggest that people in African-American and Hispanic cultures are more likely to accept greater variety in body size than do people in Anglo cultures (see, for example: Befort, Thomas, Daley, Rhode, & Ahluwalia, 2008; Buchanan, 1993; Freedman, Carter, Sbrocco, & Gray, 2004; Hebl & Heatherton, 1998; Pompper &

Koenig, 2004). Yet other studies have found evidence that challenges that notion (see, for example: Cachelin, Rebeck, Chung, & Pelayo, 2002; Grabe & Hyde, 2006). Whatever the studies show, it is clear that there are many people in minority groups that are concerned about weight loss. In my study, I interviewed four African-American women and four Hispanic women, and none of them were completely happy with their weight, though Raquel and Vanessa (both Hispanic) had greater body acceptance than most of my subjects did. Even at that, Raquel told me that her experience within her family and immediate cultural community as she was growing up inculcated the idea that being overweight was highly undesirable.

None of my minority respondents commented on anything about medical visits in their experience that suggested that they felt they had been poorly treated because of race or ethnicity, but they did comment at times on aspects of their culture that posed special problems. Foreyt (1995) asserts that there are characteristics of minority populations that practitioners need to keep in mind when working with those patients. For example, he points to the role of food as ritual in some cultural groups, suggesting that certain types of food restrictions would be unlikely to be acceptable. I heard that same idea in my interviews with Raquel and Vanessa; they talked about the importance to them of the foods of their culture and their struggle to find ways to make that food more healthful but still palatable. Diana commented on the unspoken rule—explicitly linking it to her culture on her mother's side of the family—that when her Mexican grandmother offered food, you eat—and you eat it all.

Communicating Empathically

Perhaps the most important thing clinicians can do to avoid making OW/O women feel othered is to attend to how they communicate interpersonally with their overweight patients. Healthcare practitioners are just as influenced by cultural attitudes as anyone else, and it is understandable that they will have absorbed some of the prejudices about overweight people that are prevalent in society. Furthermore, Hall, Epstein, DeCiantis, and McNeil (1993) report that doctors generally tend to respond more favorably to their healthier patients than to their unhealthier ones, underscoring concern that physicians might inadvertently communicate dislike for patients who exhibit characteristics associated with poor health.

As discussed in Chapter V, practitioners who blame OW/O patients for their problems and pass moral judgment on that basis would be especially likely to have trouble communicating in an empathic manner. Wadden et al. (2000) found that 60% of the respondents in their study felt that clinicians do not really understand the difficulties that result from being overweight. The authors suspect that the perception that doctors lack empathy may be one reason that overweight patients do not turn to their physicians for help. Mary Frances reinforced this idea when she conjectured that she might have been more willing to go for regular gynecological exams "if the doc I had before, instead of not saying anything, had said something about . . . 'I know this is uncomfortable' . . . [and] gave me permission to say, 'I feel really bad about this.'" By contrast, Grace recalled an instance in which empathy was clearly shown to her when she went to a clinic that focused on weight loss. The staff there did small things, such as holding their

hands out in a very natural and unobtrusive way to assist the patient in standing up after being on the examination table, knowing that it is difficult for heavy people to arise from that position.

In the interviews I conducted, the women who had the most positive feelings about their physicians and nurses gave examples of interactions that demonstrated communication that was empathic and personal. Angel especially valued her ob-gyn doctor who always took time to ask about her life in general and who also talked of her own life. Angel told of a time when her doctor shared with her the sorrow she felt when she experienced a miscarriage; in that act, Angel felt that the doctor communicated to her that she saw her as more than just a patient. Grace was touched by a moment when her doctor was especially empathic during a pelvic exam. Grace recalled that she had "said something to her about, 'I know this can't be pleasant [for you with] me being so big.' And she said, 'Oh, no! Don't say that about yourself!'" A few minutes later the doctor was directing her to scoot further down on the examination table, a feat made more difficult because Grace is so short. She recalled that the doctor coached her by saying, "'Down closer; no, closer—because you're such a bitty little thing.'" In the context of Grace's earlier remarks to the doctor about her weight, she found it to be "kind of a nice thing to say" to refer to her as a "little bitty thing."

Even though Grace knew that the "little bitty thing" remark was a reference to her height and not to her weight, it had a strong impact—in this case, positive—on how Grace viewed her healthcare provider. Language always has power, and when the choice of words implies that the patient deviates from the normal or the expected, it has the

effect of othering. Marianne and AnnaMarie both remarked about the use of the term "morbidly obese." While it might have usefulness to statisticians who are calculating the number of people who fall into various categories based on BMI, its effect on patients is often to make them feel alienated.

Other examples of language use that my respondents found objectionable included Angel being told that she "was a walking time bomb" and that "you are doing it to yourself." Being told by a doctor that you are "noncompliant" or "I give up; I don't know what else to do for that" can be very defeating for someone who has already felt defeated with every attempt to lose weight. Ruth contrasted the doctor who gave up on her with her surgeon who, during one of her regular follow-up appointments, listened closely as she talked about the problem she was having with food getting stuck so that she had resorted to eating ice cream and any soft food that would go down. She recalled, "Instead of telling me what a stupid person I was, he said, 'Let's back up, let's go back two units on the Lap Band® and get you working with a coach and see if we can get you back on track.'" In this way, he made Ruth feel that her problem was not because she was a bad patient, but simply that adjustments needed to be made for awhile. Fabricatore, Wadden, and Foster (2004) concur that language is important, and that doctors need to choose words in discussing weight that are not as likely to evoke negative emotions about a subject that is already fraught with negative connotations. Rand and MacGregor (1990) contend, "The verbal victimization of obese patients should be considered at least a breach of medical professional ethics" (p. 1393).

By treating OW/O women as people deserving of the same care that would be offered to any patient with any type of health problem, physicians can help to counteract the othering that is already a prominent feature of living as an overweight person in our culture. Tailoring treatment options to the patient's unique situation is appropriate care for any medical problem, and overweight/obesity is a problem that is no less worthy of such an approach than cancer, heart disease, or any other serious health concern would be. Diana made this point especially well when she observed:

> And they don't want to treat us like someone who has cancer or [other serious diseases]. You know, they pay a lot of attention to people who have cancer. "My! What can we do for you? And here's this and here's that." But for those of us who struggle with [overweight], it's, "Tell 'em about it. Let 'em suffer with it." But that's it.

Overcoming Control Issues: Recommendations

As I have noted, the issue of patient autonomy in medical interactions is not a concern unique to OW/O people. The negotiation of control is part of any patient-provider encounter. However, the issue of control in medical encounters is complicated. It is clear that patients differ as to how much control they desire when consulting with their clinician.

Increasingly, the emphasis in health communication scholarship is to encourage the mutuality that is found in patient-centered communication rather than the paternalism of physician-centered communication (Roter & Hall, 1993). While Roter and Hall

observe that, in general, physicians "set the tone" (p. 100) in medical interactions, Street and his colleagues (Street et al., 2007; Street, Krupat, Bell, Kravitz, & Haidet, 2003) found that interactions are subject to mutual influence; in other words, the partnership-building behaviors of the physician encourage greater participation from the patient, and vice versa. A key issue in accomplishing a partnership in which both the patient and the clinician are satisfied with their level of involvement is the extent to which the patient and the clinician share similar expectations for the relationship. When preferences are not congruent, a mismatch occurs that can have serious consequences for both parties, but especially for the patient's health outcomes (Cuengros, Christensen, Cunningham, Hillis, & Kaboli, 2009).

Introducing the Topic of Weight

One of the most significant mismatches in communication preferences I found in my interviews relates to whether/when/how to broach the topic of weight. Many of my respondents were quite clear in affirming their preference that the topic would never come up. Diana said that she doubted any physician could bring it up without upsetting her. Maggie was glad that her doctor never introduced the topic, speculating that if he ever did, "I'd probably cry." When I asked Charlotte about who it was that usually initiated discussions of weight in her medical encounters, she laughed and said, "Oh, I'm pretty sure the doctor would have brought it up . . . because it's really not something I would want to discuss." These are just a few of the examples of the women whose clear preference was for the topic to remain undiscussed.

Others admitted to skirting the issue. For example, Angel explained that when a doctor said something about her weight gain since the last visit, she would make up some excuse for the increase and change the topic. Others suggested that they tended to tune the doctor out when s/he began "harping" on weight, and a few of the women claimed that they had changed doctors specifically because of their physicians' constant references to weight during medical visits. Some of the women said they thought a practitioner certainly should introduce the topic of weight, but only if there were some clear and convincing health issue related to weight that would warrant it. Others did not concur, saying that a doctor should not wait until health problems developed.

A few of my respondents conceded that they might welcome the doctor's introduction of the topic if it were handled appropriately. GiGi, for example, was amazed to realize that, despite her having eventually gained to 170 pounds over her ideal weight, no doctor had ever brought the subject up. She speculated that it may have been because she had never had any serious health issues that could be related to weight until just before her decision to undergo surgery. However, she wondered if it might have actually been more motivating to her at an earlier stage in her life if a physician had discussed it with her and had prescribed a specific regimen. Marianne said that her doctor had talked with her about it, but she felt that he hadn't been "aggressive" enough and could have "pushed it" more.

Naomi was one of the few who had no trouble with having a clinician broach the topic of her weight; she noted that it was a nurse's statement that she was a "candidate for a massive heart attack" that finally made a motivating impression on her. Victoria,

too, observed that a patient's weight should not "become the elephant in the room." Indeed, as Downey and Stern (2003) assert, there is too often "a mutual conspiracy of silence" about weight in which both patient and physician "view the exchange as successful if it has not been mentioned at all" (p. S42). Roter and Hall (1993) caution that clinicians should not assume that a patient's reticence to discuss health issues is an indication of a lack of interest (p. 47).

Several of my respondents suggested that physicians might simply ask patients if they are concerned about a variety of health issues—including weight as one of those issues—and then use that information as a launching point for a discussion of weight when indicated. Grace, for example, said that she would appreciate it if her doctor would not just ignore the subject, particularly since Grace had already indicated her concern when she made the apologetic comment (discussed earlier) about her size during her recent pelvic exam. She suggested that her doctor might take an approach such as, "'Well, you know, you've made some comments to me about your weight that makes me know that you're . . . sensitive about it. . . . Here are some things I can suggest to you.'"

Communicating Straightforwardly but Tactfully and Helpfully

I mentioned above that many women welcomed discussions of weight if the topic is handled "appropriately." Almost all of my respondents, including those who said they preferred that the topic not come up, used the words "straightforward" or "honest" in describing how they thought practitioners should address the issue of weight with them. They seemed to think that straightforward communication indicated that the clinician regarded them as intelligent and mature people who did not have to have truth shielded

from them. The women who were most satisfied with their practitioners' handling of the topic were those who felt that their doctors' genuine intentions were to be helpful. Angel, for example, contrasted the bluntness of the doctor who told her that she was "'a walking time bomb'" who was "'just doing it to yourself'" with the blunt honesty of her surgeon. She explained, "The difference was: he was really trying to help me."

While the vast majority of my respondents say they prefer straightforwardness and honesty, most also qualify that by saying that they think physicians need to be tactful. Marianne felt that her doctor had often been "too diplomatic," but she also acknowledged that she would respond best to a doctor who was straightforward but also "kind." Sasha recalled an instance in which a physician had made a remark that she may have intended to be straightforward but that Sasha considered "rude." This underscores the necessity for the clinician to determine the OW/O patient's openness to discussing the topic, as well as the need to assess the level of candor that can be tolerated.

No matter how the subject was handled, though, a significant number of the women I talked to noted that they were not pleased when the topic was introduced without any suggestions for how to remedy the situation. Several of my respondents observed that the only advice they were offered was that they needed to lose weight and a generic recommendation to watch what they ate and get some exercise. Sometimes there was a recommendation that they look into Weight Watchers®, an approach that seemed to them to mean that the doctor did not want to take an active role in the process. It is easy to see how a patient might think that a doctor's detachment from being part of

the solution could mean that s/he didn't really see it as that much of a problem or that s/he didn't really care.

Communicating Belief in the Patient

Several of the women I talked to cited instances in which they felt that their healthcare providers had communicated a lack of faith in them or the belief that they were not genuinely trying to lose weight. Diana had sensed that the doctors she had consulted blamed her weight issues on a lack of "willpower,"—a word that Diana had grown to hate—and that they assumed "that all I do is sit around and think about food." Ann believed that her doctor was thinking, "'Just shut up and do it.'" Mae felt that her doctors were blaming her for her inability to lose weight, although her very serious health condition forced her to adhere to a rigid diet and to account for every morsel she ate. "I spend half the time thinking about it and working on it . . . and they don't think [I] do; they think, 'it's your fault.'" Gabby's doctor who expressed doubt that she was working hard enough because had not lost her pregnancy weight fast enough, as well as the doctor who insisted that Mary Frances *would* be losing *if* she were following his prescribed diet are other examples of women who felt that their clinicians did not believe them. And Ruth still felt the sting of the doctor who told her, "I give up," implying that she was a hopeless case.

Ruth noted that sometimes patients may not be telling the truth about the efforts they are making, but she pointed out that often they are, and when a doctor communicates disbelief it adds to the OW/O woman's sense of failure. Several of the women commented that they work to gain their practitioner's approval, so it is easy to

see how expressing doubt in a patient's honesty or in their ability to succeed can put the patient into the role of "naughty child," a vantage point from which a sense of control is hard to hang onto.

Taking Time and Following Up

Time is an important aspect of patient control. Several of my informants made reference to their awareness that physicians are always pressed for time, but when clinicians communicate that they are in a hurry, the patient does not feel she has the ability to exert any control over the pace of the encounter. Megan observed that often her doctor made a comment about her weight as "kind of a wrap-up . . . when he's walking out the door. So I don't have a chance to rebuttal [*sic*] or say anything." AnnaMarie was especially troubled that time constraints had caused her practitioner to institute a one-topic-only policy. Because of this policy, AnnaMarie earnestly wished that the doctor would bring up the issue of her weight. Her finances were such that she only went to the doctor for acute illness, meaning that she never had the opportunity to bring the topic up herself. She longed for enough time to tell her story to the doctor in ways that allowed her to talk about what was important to her. Referring to the questions I had been asking in the interview, she said, "It is important for the doctor to ask each person [about] history, goals, 'How do you feel?' The same questions here, you know? 'Are you *wanting* to lose weight?'" Diana shared a similar frustration:

> I don't think that I've ever found a physician where I could have the conversation that you and I are having, to tell them, "I know what you're telling me, but it's just such an emotional subject for me. And it's not superficial. It goes down to

> my deepest core." And really, what physician would take that time with me? I just don't really see that anyone would ever give me that much time.

Indeed, on several occasions when I asked a respondent what had been so effective about an interaction that she regarded as effective, one of the first things mentioned in the response was, "S/he took time with me."

One of the suggestions I received most frequently from my informants when I asked what they thought would make a positive difference in getting help for OW/O women from medical practitioners was "follow-up." Ruth recalled with gratitude the doctor she had in high school who had her walk during her school lunch break to his nearby office for a weekly weigh-in. She said that it provided accountability and showed that he really cared. She was able to develop a supportive relationship with his nurse that provided additional encouragement. My respondents had a variety of ideas about how follow-ups could be accomplished. Sherry pointed out that they should be low or no-cost. Lisa said that they could be in a group setting. Sasha suggested that follow-ups could be achieved using emails or other technology, and that doctors could send out regular newsletters with helpful tips in this manner as well. Grace observed that follow-up appointments could be used to re-strategize when things were not going as well as had been anticipated. Victoria mentioned that follow-ups need not involve the physician every time, that a nurse could be the person the patient would see. The general consensus was that the frequency of follow-up visits should depend on the particular patient's needs, but that the interim should not be too long as it was hard to sustain anything when the next appointment was a long time away.

Negotiating "The Scales"

Another issue related to control is illustrated in the great frequency with which my respondents talked about the scales. I have already discussed this element of the medical visit elsewhere in this chapter, so I will not reiterate the examples I have already offered, nor will I offer others—though there were others. Indeed, the frequency with which being weighed was mentioned makes it clear to me that this is no small matter to OW/O women. I mention it again here because it is pertinent to our discussion of control, as the scales are a site of resistance. Some of my respondents told of exercising agency in refusing to be weighed. However, many other women would not have the courage to do that because they desire to be seen as a "good patient." I worry about these women, as they are the ones who might choose to exercise their agency by simply avoiding medical care. Olsen et al. (1994) concludes that overweight women often cancel or postpone medical appointments because of the fear of being weighed, which means that the focus on weighing may be "an important barrier to medical treatment" (p. 71). A sensible recommendation would be that clinicians allow women to have the option of being weighed or not. In cases where there is some compelling medical reason that makes it necessary to be weighed, the reason should certainly be offered.

Strategizing and Sharing Decision-Making

It is clear to me that the vast majority of my informants prefer the mutuality model for their communication about weight in medical interactions. The ones who were happiest with their medical care were those whose encounters were marked by strategizing and shared problem-solving. Ruth's doctor who suggested an adjustment in

the Lap Band® to overcome a feeding problem, Mae's nutritionist who was always looking for ways that Mae could incorporate new or favorite foods into her rigid renal-friendly diet, and Sherry's doctor who, when she had regained a few pounds, stopped to ask, "'What are you doing that you weren't doing the last time?" are all examples of physicians who involved their patients in working to seize control of their own health. GiGi appreciated her surgeons' attitude that they were "partners" in working toward her health, and Marianne liked how her surgeon would always respond to any small weight gain or problem by saying, "Let's figure out why." I think it is interesting to note that Ruth, GiGi, and Marianne are all women whose best experiences seem to have been with their bariatric surgeons, additional evidence to support the study (Anderson & Wadden, 2004) mentioned earlier about surgical patients' greater satisfaction with their obesity-related care. It might be simply a function of their having had success with the procedure, but there is also reason to speculate that their surgeons may have learned—either through training or through experience—the most effective ways to communicate with OW/O patients.

AnnaMarie gave high marks to a nurse practitioner who engaged her in a discussion about information contained on a wall chart in the doctor's office, explaining about vitamins and making suggestions about diet and exercise. Sasha commented specifically on how important it was to her that her new physician was stressing that the choices were hers. She was especially impressed by an analogy her doctor used to help motivate her:

> She just understood that I haven't put enough value on myself. I'm always doing for others. She used the analogy that when you fly on the airplane, the stewardesses come on and say, "If [the cabin pressure] changes, the oxygen masks are going to come down." They want you to put your mask on first before you help the child sitting next to you. So the whole premise is: you can't really be effective helping other people if you don't help yourself first. That was an *Ah!* Lightbulb moment!

Unfortunately, some of the women I talked to felt that their doctors tended to discount their ideas and dismiss their experiences as invalid, an action that negates mutuality. Lisa's theory about her Polycystic Ovary Syndrome was often brushed off without any explanation for why the doctor did not attach much significance to it as it pertained to her weight. Sherry and Charlotte both told me about interactions with physicians that, although not related to weight, were examples of being discounted. In Sherry's case, she had to make multiple requests for a mammogram that the doctor finally ordered, telling the nurse in exasperation to schedule it, "just to make her happy." (It was subsequently discovered that Sherry had "high stage-4 breast cancer.") Charlotte's theory that trauma she experienced in an automobile accident may have played a role in the development of her breast cancer—a theory that the doctor could have empathically understood to be an attempt on Charlotte's part to make sense of what was happening to her—was dismissed with the comment, "Well, you can't prove it."

By contrast, Vanessa had a very favorable attitude toward her physician because of his willingness to listen to her with respect, something that is particularly noteworthy

given that Vanessa is only 21 years old. She liked her physician so much that she claimed that she goes to see him frequently—"Every payday, I take my little $20 co-pay!"—about nagging concerns. He teases her a little about her hypochondria ("'No, you don't have this illness. Get off WebMD!'"), but he also offers encouragement when she has lost a little weight and makes suggestions for small measures she can take to make additional progress: "'You're doing good! Whatever you're doing, just up it a little and maybe take the stairs instead of the elevator.'"

Empowering Patients

It is true that for many of the women in my study, motivation was a problem. Ann, for example, wailed about her inability to find motivation after years and years of trying to lose weight. Vanessa wistfully remembered one time when she had been highly motivated and successful, remarking that she wished she could remember what had motivated her then as she would like to try it again. All of the women could name the things that motivated them—or things they thought *should* motivate them—but the stark reality was that, for many of them, those motivations were not sufficient to propel them toward attaining their goals. Others, however, were motivated, some with very strongly-felt reasons related to health and family.

My contention is that one of the key tasks of the physician who hopes to be helpful to OW/O women is to help them reclaim their control. Every one of my informants could point to a time when they had been able to lose weight—sometimes impressive amounts of weight—but they had not found the key to keeping it off or at

least maintaining a weight level that would improve their chances of living healthy lives. But they *had* been successful, so they clearly *could* be successful.

Befort et al. (2006) argues that OW/O patients would benefit from a physician's collaborative efforts to assist them. They especially recommend that clinicians be trained in a technique called "motivational interviewing," which involves

> . . . reflective listening and directive questioning whereby the provider refrains from drawing conclusions but rather first assesses patient motivation and expectations in a collaborative manner that both validates and provides guidance that the patient may be more likely to accept and act upon. (p. 1089)

The guidance that Befort and her colleagues are suggesting—guidance that will be accepted and acted upon—may require the practitioner to shape persuasive messages carefully. As noted above, patients differ as to what sorts of messages are most effective. A message that is regarded as "straightforward" by one patient may be viewed as "rude" by another. But when the OW/O woman is struggling with motivation, or when her goal or her planned course of action is unrealistic, the physician must find a way to be persuasive.

In the case of my respondents, there were many references to persuasive messages that tapped into fears of not "being here for my children" or being a "candidate for a massive heart attack." GiGi said that she thought it was good that her doctor "put the great scare" about diabetes on her, pointing out the potential for problems such as amputation of legs. Vanessa admitted that, while she hates to have the topic brought up, she thinks that "scaring" her with specific health consequences might get her to pay

attention, something that is hard to do since she is so young and relatively healthy at this stage of her life. However, she indicated that she was keenly aware that at some point that could change, and she worried that "by then, I'm scared it'll be too late."

Of course, if a patient's health is generally good—as was true for many of my informants—it is harder to be persuasive about health risks. Yet many of my subjects specifically said that if physicians would take the time to explain those risks in a manner that suggested they genuinely cared about the patient, they thought they would be inclined to follow their doctor's advice, in some cases because, as they told me, they would want to avoid disappointing their clinician. It appears to me that the help that many of my respondents most desired was help in finding their motivation—their desire and their ability to control their own bodies.

Breaking the Vicious Cycle

As noted above, Frank (2002) asserts that the responsibility for making the changes necessary to achieve better health outcomes belongs to the clinician. His rationale for this view is that the patient is the more vulnerable party in the relationship (p. 14). I would add to this idea that, judging from the responses of the participants in my study, patients still concede a considerable amount of authority to practitioners, even when they clearly indicate that they see their own roles as being in active partnership with their healthcare providers.

Figure 3 proposes a model to conceptualize how the relationships among social bias, the personal identity of OW/O patients, and medical practitioners might be altered to break the vicious cycle and facilitate improved health outcomes.

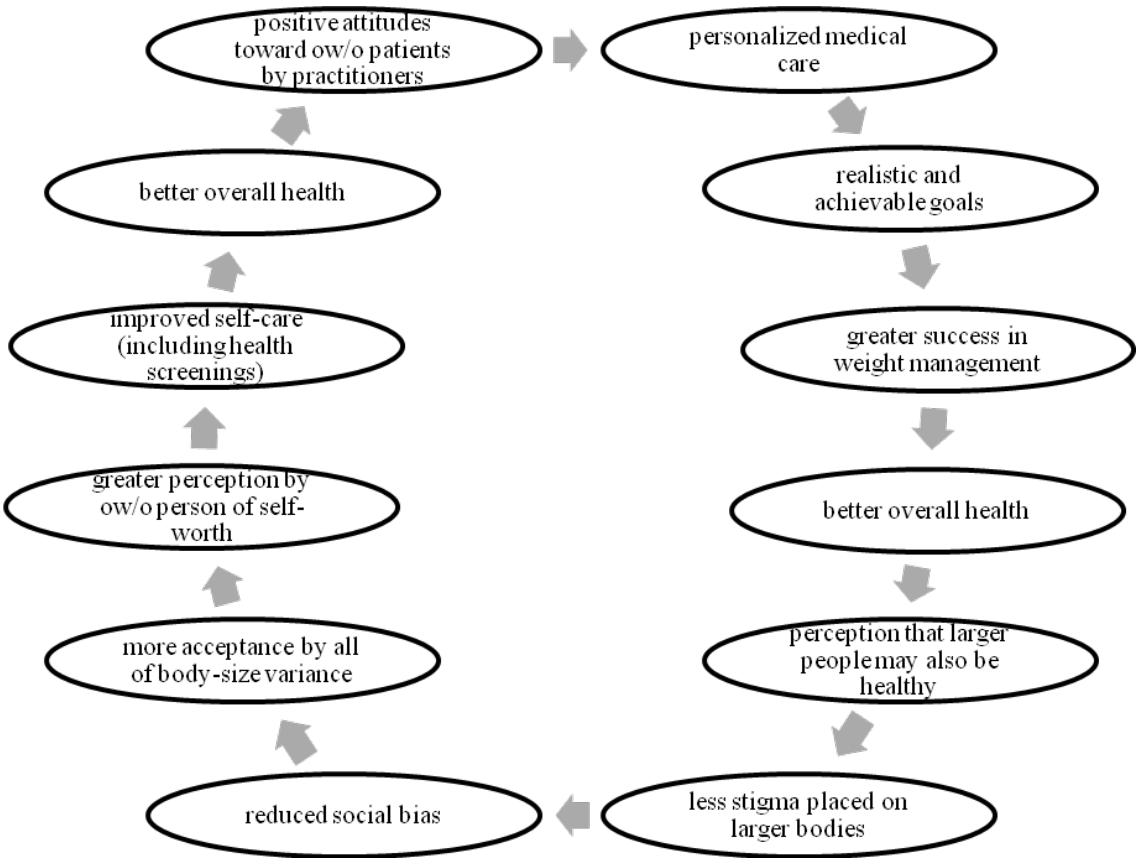

Figure 3 Breaking the vicious cycle: Achieving better health for overweight/obese patients.

If the responsibility for initiating change is accepted by healthcare practitioners, a good place to begin would be with an examination of their own attitudes toward OW/O patients. Attitudes, of course, are socially conditioned, so it may require a conscious effort on the part of clinicians to make adjustments in their thinking. They should begin

by acquiring as much information about the lived experience of OW/O people as possible, perhaps from studies such as this one or from other written accounts, but most productively from interacting personally with the OW/O women in their care. It is clear to me from my interviews with my informants that they long to tell their stories and to be empathically listened to. I believe that the struggles and the courage that came through to me in my interactions with my respondents would be as compelling to practitioners as it has been to me, and that any negative attitudes they may have would be altered.

The majority of the recommendations made in this chapter relate to the notion of providing personalized care. Seeing OW/O people as individuals—not merely as members of a marginalized group—is the first step in achieving such care. Providing a clinical setting that is welcoming to patients of size is part of that process. Negotiation of issues such as when to broach the topic of weight, whether the patient will be weighed, and how much follow-up may be required are also important aspects of personalized care. The establishment of realistic goals would seem to be an inevitable outcome of personalized care, and attainable goals are much more likely to yield successful weight management and, consequently, better health outcomes. It is important to realize, though, that "successful weight management" does not mean that the expectation is that everyone will lose enough weight to meet the contemporary thin ideal. The goal would be that each person would find the weight level that they could successfully maintain with reasonable adaptations of diet and exercise that they can realistically live with.

When OW/O people are healthier, they will be able to live their lives in ways that are less limiting: improving professional opportunities, enjoying recreation and travel,

engaging in social relationships, and generally being able to participate more actively in society. Interactions with other members of the culture may permit an alteration of the currently accepted narrative that large people are necessarily unhealthy people. A reduction in the stigma placed on larger bodies will likely reduce social bias toward OW/O people, which will then lead to a greater acceptance of the notion that body sizes vary, that such variance is normal, and that there is nothing inherently "bad" about larger bodies.

When a person is accepted regardless of body size, their self-esteem will surely be positively affected. If one feels valued and worthy, one is more likely to care for oneself, and caring for the self would include seeking medical treatment and screenings that would optimize health. Of course, better health would follow. Practitioners would, no doubt, be pleased with the patient's improved health status, which would likely reinforce positive attitudes toward the patient.

And the cycle is broken.

In this chapter, I have applied the themes of othering and control that emerged in my grounded thematic analysis in Chapter V to medical encounters. I have proposed an explanatory model that synthesizes findings presented in previous chapters, illustrating the vicious cycle that links social bias, self-identity and medical interactions in a recurring loop. I have also used the experiences—both positive and negative—of my respondents in their past medical encounters, as well as relevant literature that reinforces their views, in making recommendations for how healthcare providers can counter the problems created by othering and more effectively negotiate control with their OW/O

patients. Finally, I have proposed a new model that conceptualizes the potential for improved medical interactions to positively impact the health of OW/O patients and, not insignificantly, assist in altering social bias against people of size. In the next chapter I will summarize my findings and draw some conclusions. Following that, I will offer a performance script that further synthesizes the work accomplished in this study.

CHAPTER VII

SUMMARY AND CONCLUSIONS: WEIGHING THE FUTURE

The purpose of this study was to enlarge our understanding of the experiences of overweight and obese women as they have come to understand what being overweight means to them—what it means to their sense of personal identity, to their relationships with others, and particularly to their decisions in health-seeking. To accomplish this goal, I first posed an overarching research question which was: *How is an OW/O woman's weight implicated in her self-identity, how does she make sense of the experience of being overweight, and what role does her identity and her understanding of her weight play in her health-seeking behaviors and in interactions with physicians and other health professionals?*

To investigate this issue, I elected to conduct in-depth interviews with women who consider themselves to be (or to have been in the past) overweight or obese. Twenty-three women agreed to participate. I chose to examine my interviews using the approach of crystallization, wherein multiple methods of qualitative analysis and representation of the data are employed. My autoethnographic narrative and analysis served as a launching point for the development of my study. I used narrative analysis and grounded theory techniques in dealing with the data contained in my interviews, and I culminated my study with a performance script that can be used to further interrogate the data as well as to offer additional opportunities for dissemination of my findings.

Because the research question was so broad, I broke it down into three sets of sub-questions, the first of which was: *How does their weight affect the development of self-identity in OW/O women, especially with respect to their views of their body and its relationship with their sense of "self"? How has the OW/O woman's view of her body influenced her sense of self in relationship with others?* In Chapter IV, I explored those questions by examining the interviews with my respondents as storytelling acts, and then I applied a theoretical framework developed by Arthur Frank for examining the types of stories being told in health narratives. I found that Frank's typology was certainly useful, though his three types did not address the majority of the stories I heard. I proposed, therefore, two additional story types.

Within the five story types that resulted, I found answers to my question about how women viewed their bodies in developing their sense of "self," and how their bodies had influenced their sense of self in relationships with others. I learned that many women see their heavy bodies as connected to their self-identity. This was found in assertions that essentially expressed, "This is who I am." However, many women did not associate their bodies with their "true" selves; they saw themselves as normal-weight people who were living in a large body that was alien to them. Not surprisingly, this view was most often expressed by women who had been thin or normal-weight until some event—onset of puberty, post-pregnancy, disruption in significant relationships, menopause—had altered their previous control of their weight. However, even some women who had never really been thin (except for relatively short periods of their lives when they had temporarily wrested their bodies under control) were still struggling to

figure out how to achieve the thin ideal. Many others were attempting to reconcile their identities with their bodies, either by reorienting themselves to new goals or by accepting that where they were at that time was likely to be where they would remain. Some had come to see that control of their weight would likely fluctuate, as it always had, based on the contingencies of life. I concluded that for most OW/O women, weight is a significant factor in how they see themselves, either because they see their body as intimately connected with their sense of identity, or because their struggle to reconcile themselves with bodies that seem alien to their sense of self is a prominent feature of their daily lives.

All of the women in my study expressed, to at least some degree, a sense of "othering" in relationship with others. For some, this sense of being different from others created difficulties in feeling empathically connected to people. None of my respondents reported being completely devoid of any meaningful relationships because of their weight. Indeed, some of them talked of very satisfactory relationships with romantic partners or spouses. In a few instances, however, the women seemed to regard the affection of their partners as something worthy of being remarked upon, as though they themselves were accepting the societal view that fat women cannot be sexy or desirable. On the other hand, there were several women who reported severe disruption of marital relationships because of their weight, ranging from two respondents who told of husbands who refused to sleep with them because of their weight, to one woman whose husband had expressly terminated their marriage because of her inability to lose weight after three pregnancies. Additionally, several women explicitly linked their inability to

form romantic relationships to their weight. All of the women enjoyed friendships and/or warm relationships with family members who seemed untroubled by their appearance, but a great many also reported instances of exclusion and discrimination by family members and others, attitudes that they perceived to be based on their weight. It appears that women do perceive that their bodies have significant effects on how they form relationships with others and how they feel about those relationships.

In addition to knowing a little about how OW/O women view their bodies as related to self-identity, I wanted to know how they make sense of their weight. My second set of sub-questions, therefore, was: *What are the factors that OW/O women believe to have contributed to their weight problems? What are their perceptions about how being overweight impacts their lives?* In Chapter V, I undertook a grounded thematic analysis. First, I focused on how my informants responded to explicit questions about the factors they attribute to their weight status, as well as how being OW/O had affected various aspects of their lives. I also examined the interviews using grounded theory techniques to identify themes that recurred during our conversations.

The OW/O women in my study attributed their having become overweight, their difficulties in losing weight, and their inabilities to maintain weight loss to a variety of factors. Some women reported that they had been overweight all their lives, hypothesizing that genetics may have played a role since others in their family shared the same condition. Others were the only people in their families who were overweight, so they theorized other causes, including a variety of physiological factors such as an underactive thyroid. Others pointed to specific events in their lives that marked the

beginning of their weight struggles; as noted earlier, puberty, pregnancy weight-gain, and menopause were notable examples. Lifestyle issues, particularly revolving around a lack of time to focus on weight, and problems with eating habits were often blamed for the difficulty in losing weight. Women also reported problematic relationships with food—seeing it as a source of comfort, for example—as a major reason that losing and maintaining weight loss was nearly impossible.

Emotional and psychological issues, including dysfunctional relationships with others, were often cited. Some women admitted to a tendency to deny the severity of their weight problem, hiding it as best they could from others and, in the process, from themselves. Others found it difficult to cope with the deprivation that dieting inevitably entails. And most of my informants frankly confessed that finding and sustaining motivation was difficult. When looking at the theme of control that emerged in my data, I found that for many of the women I talked to, resisting the attempts by others to control their lives often took the form of over-eating or refusing to lose weight because someone wanted them to, an example of how the need to exercise personal agency was at times in conflict with goals for weight loss.

The most striking implication of these findings to me was that they highlight the complexity of the factors that contribute to overweight and obesity. The prevailing view is that overweight is simply a function of too much food and not enough physical activity, and in some sense that is true. But it is also a simplistic point of view. Many people have an unproblematic relationship with food and weight. We have all heard the anecdotal examples of people who can “eat anything they want and never gain a pound.”

For some, that may be the fortuitous result of a well-tuned metabolism. For others it may be a function of—unlike many OW/O women—being satisfied with relatively little food. Some people use food as fuel to sustain the body, and others require it for emotional sustenance. Many people gain a little weight at some point in their lives and are able to quickly lose it and have little problem maintaining that loss.

For most OW/O women, however, weight loss is invariably accompanied by regain, often with the discouraging addition of even more pounds to try to lose the next time. People who have few or no problems with maintaining or losing weight congratulate themselves on their "willpower" without ever having actually been required to exercise any, while many OW/O women have had to muster willpower over and over again as they deprive themselves daily of food and push themselves to engage in physical activity that is often not enjoyable, frequently awkward, and at times even painful. To simplistically attribute the problems of OW/O women to too much food and not enough exercise denies the reality of the experiences of OW/O people and the complexity of the issues that contribute to their condition.

Being overweight also has significant impact on the lives of OW/O women. There are the oft-cited and undoubtedly true linkages between excess weight and a number of serious health conditions. In addition, OW/O people experience a reduction in their quality of life, including restrictions on activities and on the ability to seek career advancement without concern about discrimination based on weight and appearance. Certainly, OW/O women report serious difficulties in the development and maintenance of relationships due to their weight. On the other hand, some women divulged that being

overweight conferred some advantages in terms of protecting them from unwanted attention, particularly in relationships with people who communicated a desire to be romantically involved or intimate with them. Many of my respondents also admitted to not taking care of their health needs as they recognize they should, pointing to embarrassment about their bodies as an impediment in seeking medical care and routine screenings.

One of the most significant effects I found was in the "othering" that my respondents reported in their relationships and in their experiences within a variety of social settings. I heard of how they often felt "ignored," "discarded," and "discounted." They were very conscious of how their bodies compared to the slender and normal-weight bodies of those around them, often referring to people's size in describing an interaction with someone when that person's size was largely irrelevant. They recalled incidents in which their size was commented on in negative ways, including being teased and bullied by others. They recounted overhearing comments that suggested that a heavy woman could not be legitimately regarded as attractive or sexually desirable. My respondents talked a lot about how the world was not set up to accommodate people of size, illustrated by features of daily life such as the dearth of outlets for purchasing stylish clothing, as well as problems associated with seating in public places that was uncomfortable or inaccessible. Many of them lamented the negative portrayals of large-sized women in the media and the obvious focus on thinness as the ideal for women. Perhaps most pernicious is the implication embedded in language and in attitudes expressed about OW/O people that their girth is evidence of moral inferiority. As

accomplished women, my informants also talked of the frustration of feeling that they had control of nearly every other aspect of their lives except their weight.

The conclusion I reached in talking to my informants about the ways in which being overweight had affected their lives, particularly with regard to the overwhelming sense of otherness they felt, was that the negative effects of being overweight are so profound that if losing weight were a simple thing, they surely would have had ample motivation to do so. That they all—with the exception of one woman—still struggled with managing their weight is testimony to the intractable nature of overweight and obesity.

Because a significant goal in my study is to provide healthcare practitioners with a larger understanding of the lived experience of OW/O women, my third set of sub-questions emphasized medical interactions. The questions were: *In what ways have their experiences in medical consultations been beneficial or detrimental in promoting positive health outcomes? What recommendations would OW/O women make to improve medical encounters and practitioner communication with OW/O women?* To answer these questions, I continued my grounded theory approach in Chapter VI, focusing specifically on how othering is often present in medical encounters and how control issues often complicate communication between clinicians and OW/O women. I presented examples of both unsuccessful and successful medical interactions in outlining what my respondents would recommend for more effective patient-provider communication that could encourage positive health outcomes for OW/O women.

I learned that there are many aspects of medical encounters that reinforce an OW/O woman's sense of being outside of the mainstream. These include such simple things as the chairs, examination tables, equipment, and gowns that do not accommodate women of size. My respondents also talked of feeling that their practitioners defined them primarily by their weight, a practice that prevented them from being seen as individuals and led to assumptions about them based on stereotypes. They talked of feeling discounted and ignored because of their weight, and they sometimes doubted that the medical care they received was of similar quality to that received by normal-weight individuals.

In terms of control, my respondents felt keenly the traditional asymmetry of power that obtains when relatively higher-status medical personnel interact with patients. In this case, the imbalance seemed to be exacerbated because of perceived clinician disrespect—and even, in some cases, dislike—of OW/O patients. Respondents often felt that practitioners discounted the patient's own expertise, dismissing the women's ideas and theories about their weight in favor of their own preconceived ideas. Some of the women I talked to complained of feeling pushed into treatment modalities that clinicians favored despite the obvious evidence that those approaches did not work for their patients; the attitude was conveyed that the problem was undoubtedly with the patient and not with the treatment. My subjects often felt that they had no control over the pacing of the conversation with their practitioner because of time constraints and policies that dictated how many topics could be discussed at any one medical visit. Furthermore, many of my informants expressed a strong preference for having some

control over whether/when/how the topic of weight should even be broached in the medical visit. For many of them, the perceived disregard for their need to be seen as competent partners in decision-making about their healthcare and strategizing about their weight issues was a significant factor in delaying or avoiding routine screenings and regular medical care.

Based on what I learned in my interviews with my respondents and in the literature I have cited in this study, I conclude that there is widespread social bias toward overweight/obese people in general and especially toward OW/O women. Not only are medical practitioners subject to those biased attitudes, but OW/O people are as well, internalizing those messages as being proof of their own moral inferiority.

I proposed a model that shows the relationship between social bias and discrimination against OW/O women and the effect of those attitudes on their lowered self-esteem. It appears that the shame of being overweight is linked to less self-care, including the avoidance of routine medical screenings. I theorize that the tendency to put off routine screenings and other medical care is one cause of the poorer health status of many OW/O women, and that this reinforces the already negative attitudes of practitioners toward overweight patients. There is reason to be concerned that the practitioner's negative attitudes may affect the quality of care the patient receives, which further jeopardizes the possibility of an OW/O woman achieving good health. When their weight is blamed for all of the health problems of OW/O people, societal perceptions of the danger of being overweight are increased, and more attention is paid to the "epidemic" of obesity. While this is not in itself a bad thing, leading as it does to

needed research, one potentially problematic aspect of the increased attention is that an abundance of solutions are offered, not all of which are valid. Regardless of whether a proposed solution is valid, however, when there are so many solutions being advanced, it is logical that people come to the belief that the problem is solvable. If people believe that the problem is solvable, then their attitudes toward OW/O people become even more negative as they "blame the victim" and assume character flaws and moral inferiority of the heavy person. This, of course, reinforces social bias. And the cycle continues.

I contend that it is important that this cycle be broken. Therefore, I concluded my recommendations with a second model that illustrates how the cycle can be re-routed. I proposed that positive attitudes by practitioners toward OW/O people can lead to more personalized care, and that such individualization of medical recommendations should take into account patient preferences and needs which would foster the establishment of realistic goals. When goals are attainable, successful weight management is possible, which should lead to better health. As a result, social perceptions of OW/O people could be altered as people realize that large people can still be healthy people. As a consequence, there should be increased recognition that the population naturally includes a variety of body types, meaning that the larger body is no longer regarded as deviant. Social acceptance can lead to improved self-esteem, which, in turn, may lead to better self-care, including medical screenings and treatment as needed. Health outcomes should, therefore, be improved, which reinforces the positive attitudes of practitioners toward OW/O people.

While it would be highly desirable for social bias toward OW/O women to be eliminated, I recognize that cultural attitudes are relatively enduring and that it is not reasonable to expect such macro change to occur in the near term. Changes at the micro level, however, can be encouraged, with the anticipation that cultural attitudes toward weight might eventually evolve toward a more enlightened view of the problem. This is not an unreasonable expectation, given that attitudes about bodies have varied across cultures and throughout history. Therefore, it is primarily to those persons at the micro level—the OW/O women and their healthcare practitioners—that I direct my recommendations for how this study might be used in the future.

Concluding Thoughts and Recommendations

Before suggesting how this study may be used in the future to address the issue of overweight and obesity, it is important to acknowledge its limitations. Although I was able to achieve some diversity in my group of respondents, the women I interviewed were more highly educated on average than the population at large. One of the reasons this occurred is because of the ethical constraints in enlisting participants for a study of this sort. It would not be ethically feasible to approach strangers and ask them to self-identify as overweight or obese, so my recruiting methods were aimed at reaching a group of people who were most likely to be willing to acknowledge their status as OW/O women. In choosing to begin my recruitment by posting flyers at a for-profit exercise facility, I inevitably screened out women who could not afford such a program. I did choose a facility that is comparatively modestly priced, and I was also able to get

referrals from those women and from friends and acquaintances, so I did eventually reach women from a range of socioeconomic groups. I believe, however, that the lower socioeconomic groups were underrepresented in my sample. Future study of women from that group would undoubtedly yield interesting differences in perspective.

The majority of my respondents were aged 50 and older. It is possible that women in younger age groups would have different perspectives because they would not have the history of gain-loss-regain that older respondents typically had experienced. It might have been revealing to talk with more women in their 20s and 30s to explore how weight-loss interventions could be shaped to meet their needs so that they would not eventually acquire the discouraging weight history of my older participants. Again, this limitation points to a possible avenue for future study.

The women in my group were also disproportionately heavy. Ten of my respondents had reached a high weight that would easily qualify them for bariatric surgery independent of any other health issues. Very few moderately overweight women volunteered on the basis of my flyers at the exercise facility, though my own observation suggests that the majority of them are, indeed, no more than moderately overweight. Referrals through the snowball were also most often to women whose weight problems were fairly significant. It may be that people who are or have been seriously OW/O are more likely to have a story they want to tell, or perhaps they are especially drawn to the possibility of contributing to an effort to improve the health status of other women who suffer similarly. Or it may be that moderately overweight women have not yet reached a point where they are willing to self-identify as overweight. In any case, the perspective

of those who are even a little more successful in weight management would be helpful, possibly helping to uncover other best practices of the clinicians with whom they have interacted. This, too, suggests a need for further study.

Despite these limitations, I believe that this study has made some potential contributions to the scholarship related to overweight and obesity. I will discuss those contributions by relating them to specific stakeholders.

Health Communication Scholars

The subject of obesity has generated a high degree of concern in recent years, both in scholarly circles and in the mainstream media. My search for literature on the topic revealed that the majority of work on the subject of obesity has been confined to quantitative studies that prove correlation to a number of health problems, searches for biochemical or environmental explanations of obesity, or surveys of attitudes toward overweight and obese people. In my search for literature in the health communication discipline, I have found very few examples of research that considers the topic of overweight and obesity in the context of patient-provider communication or that seeks to explore the lived experience of OW/O women. Most obesity-related studies in the communication field focus on the creation of health messages and educational campaigns, particularly to address childhood obesity. These are worthy areas for study, but I believe that my work in this study can add something useful to the scant literature about overweight and obesity in the health communication discipline by looking specifically at the perspectives of the overweight women themselves.

I also think that my work in this project suggests other questions that could be raised in studying overweight/obesity and communication. In addition to the suggestions I made earlier about extending research to explore the perceptions of younger, less educated, and less overweight women, I think it would be useful to explore the experiences of men who are overweight and obese. Much has been made in this study and elsewhere of the special problems posed for women who are overweight, but this does not negate the very real struggles with which I suspect many OW/O men contend. It would be interesting to discover the extent to which the lived experiences of OW/O men and OW/O women are similar and different. Further, there are other voices that have not been accounted for in this study, and these may provoke new questions: What are the challenges experienced by medical practitioners in caring for overweight patients? What do we need to know about clinicians' lived experiences? How are family members, friends, and colleagues affected by the weight-related struggles of their heavy associates? How can friends and family members be encouraged to shape their communication practices to be supportive of the OW/O people with whom they have relationships? Finally, although a sizeable number of quantitative studies have been done to assess social attitudes toward obesity (see, for example, Brownell et al., 2005), qualitative studies of the sort I have undertaken might provide additional insight into the subject of social bias and discrimination.

In addition to raising new questions that other health communication scholars may find fruitful for future research, this study makes a contribution to health narrative scholarship. Arthur W. Frank's (1995) book *The Wounded Storyteller* is regarded as a

significant exemplar for the study of illness stories. Frank's work, however, focuses only on the stories of those who become acutely and seriously ill. The experiences of those who deal with chronic health conditions are not fully represented in the typology he established in his theoretical framework. The present study was able to locate stories of OW/O women that fit well into Frank's framework, but the majority of the stories that emerged in my interviews were not accounted for in his Restitution, Chaos, and Quest types. Therefore, this study contributes to narrative scholarship by proposing two additional types of narratives—Reorientation and Acceptance—that may expand the use of Frank's approach to include the stories of people dealing with chronic though not imminently life-threatening health conditions. These new story types should help health communication scholars to hear the stories of people with chronic health problems with greater clarity.

Members of Contemporary American Culture

I have already noted that I do not think cultural attitudes can be easily or quickly changed. For that reason, this research is aimed primarily at OW/O women and their healthcare practitioners. However, I do think that this study has some potential to reach members of the culture and, hopefully, to encourage a more thoughtful response to people of size. In particular, the final chapter of this project is a performance piece that is intended for public dissemination. I make no grandiose claims about its potential to materially alter social attitudes, but I do believe that it has some usefulness as a way to facilitate private reflection and, perhaps, more public dialogue.

Healthcare Practitioners

A primary goal of this study has been to investigate the lived experiences of OW/O women in an effort to provide healthcare practitioners with some insight into their struggles with weight. As I noted in Chapter VI, Downey and Stern (2003) observed that there is "a mutual conspiracy of silence" (p. S42) between patients and clinicians that makes it hard for physicians and nurses to access the thoughts and experiences of their OW/O patients. In Chapter IV, I analyzed the stories told to me by my respondents, hoping that in doing so I would provide clinicians a window into those experiences. By hearing patients' stories and understanding what types of stories they are hearing, practitioners may be able to more successfully gauge motivations and develop approaches that are more likely to be effective when they counsel a particular OW/O woman about weight loss. It is also important that they realize that they are, as Frank (2002) notes, characters in their patients' stories. The recognition of this concept may be useful in helping a practitioner to reflect on what sort of character s/he wishes to be.

My study also suggests that many women would welcome assistance in weight management from their doctors, their frequent silence often resulting from a lack of comfort or a sense of shame and masking their actual preferences. I offer strategies that practitioners might consider using that would encourage more open communication between OW/O patients and providers. My recommendations are outlined in Chapter VI, gleaned from my informants' direct statements of their desires as well as from their stories of both satisfactory and unsatisfactory encounters with clinicians over the years. I

hope that my study will contribute to greater empathy toward OW/O patients from their healthcare practitioners, and that productive dialogue will result.

Overweight and Obese Women

Although Frank (2002) asserts that the task of beginning the process of encouraging health changes falls to the clinician, it is clear that the patient also has an important role to play. In this study, I have attempted to provide several vantage points from which OW/O women may begin to engage in thoughtful analysis of their own experiences and the ways in which their perceptions have contributed to their struggles in weight management and in interacting with medical professionals. The analyses of my autoethnographic narrative in Chapter III and the stories of OW/O women in Chapter IV can help an OW/O woman to think about how she wishes to story her life, what sort of character she hopes to be, and what arc she wants her story to follow. The thematic analysis in Chapter V may serve to help an OW/O woman to endeavor to make sense of her own perspective, perhaps locating herself in the experiences of other OW/O women and finding other salient issues in her own life that are not represented in my respondents' views. Certainly it is hoped that my findings might help OW/O women to realize that they are not alone with their thoughts and feelings, that they are deserving of humane and compassionate healthcare, and that they can advocate for themselves. As Street et al. (2003) notes, if patients desire "information, support, and personalized care," they can use "simple but powerful communication tactics (asking questions, expressing concerns, offering opinions) that will elicit more of these resources from physicians" (p. 614).

Overweight/Obese Women and Practitioners Together

As a final thought, Downey and Stern (2003) propose a contract that OW/O patients and their practitioners might want to consider entering into when working with each other to achieve positive health outcomes. I include it here because it captures succinctly many of the themes I heard articulated by my respondents.

> I, your doctor, am concerned about the growing problem of obesity among my patients. I am more concerned that many of you find it difficult to talk to me about your weight. You might feel this way. Therefore, I promise: (1) to keep up to date on the latest scientific and medical understanding of causes and treatments of obesity; (2) to work with my office staff to make sure everyone is comfortable and respected in my office; (3) to commit to work with you on your weight issues, if any, and if you want to; (4) to research community resources that might be helpful to you; (5) to make appropriate referrals if you need greater expertise than those I can provide; and (6) to work with you to obtain insurance coverage and to help with discrimination you face because of your weight.
>
> I, the patient, agree: (1) that my weight is an important part of my health; (2) to provide you with a history of my family's weight, my weight, and my efforts to lose weight; (3) to work with you on a plan for weight loss or weight maintenance, and improving my fitness; and (4) agree that, if you do your homework, I will work as hard as I can to follow your recommendations. (p. S42)

In the final chapter of this work, I present a performance piece that is designed to disseminate my research findings beyond the arena of the conventional dissertation or

academic work. It is my intention to perform it at every available opportunity, to make it available for others to perform if they so desire, and to place it on some electronically accessible site where it might reach people I will never see. It is also intended to further contribute to the self-reflection that I hope my work will inspire in OW/O women, the increased empathy I hope it will generate among healthcare practitioners toward their OW/O patients, and a small but meaningful catalyst for change in social attitudes.

CHAPTER VIII

PERFORMING WEIGHT

In previous chapters, I have talked about the power of narrative, I have constructed and analyzed an autoethnographic narrative, and I have examined the narrative types I found represented in the stories told to me by the women I interviewed. I have also employed some of the language of my informants in supporting the ideas I developed from my grounded theory analysis of my interviews. I have not, however, presented the narratives of my respondents in any detail.

The purpose of this chapter is to further crystallize my data by using a performance lens. I turn to the personal narratives of my respondents to accomplish this task. It is, of course, beyond the scope of this project to re-present the narratives of all twenty-three of the women I talked to. To be sure, there are many stories in the group that could be interesting individual studies and would be amenable to a variety of analytic approaches. However, in order to create a performance script of manageable length, I will focus on only a few of my respondents' stories.

Ellis (2004) asserts, "The primary purpose of personal narrative is to understand a self or some aspect of a life lived in a cultural context" (p. 45). In her view, presenting personal narratives in performance is a valuable approach to research because it is "a response to bodiless voices in ethnography and voiceless bodies who have not always been allowed to speak" (Ellis, 2004, p. 207). The role of performance in enlarging cultural understandings is also supported by Bowman (1998), who maintains that in

performance, “culture is constructed or deconstructed, affirmed or challenged, reinforced or altered” (p. 191).

Cultures produce master narratives. Japp and Japp (2005) define master narratives as “those taken-for-granted explanations and assumptions that drive public and political action and infiltrate individual consciousness” (p. 119). Master narratives function as a way to explain, in some comprehensive fashion, the practices of a culture. In the attempt to account for everything, however, master narratives fail to contend with the variability of human experience. Staged personal narratives, according to Miller and Taylor (2006), are significant because performance “contests master narratives: those narratives that presume to represent universal human experience but, in fact, regularly ignore race, class, gender, sexual orientation, and much more” (p. 177). Presentation of a counter-narrative, therefore, is one way to critique the coercive and hegemonic structures that are reified within master narratives.

A great many master narratives about overweight and obesity can be identified, but perhaps the most pernicious of those is that being overweight is fully the fault of the overweight/obese (OW/O) person and that the condition can easily be rectified with the application of “willpower.” Another of the master narratives is that overweight/obesity is a form of pathology and is, therefore, most effectively dealt with through medical intervention. Other master narratives could be articulated, some related to how the character of overweight people is revealed in their bodies, and others about what is justifiable in terms of how society treats and responds to OW/O people. Like all master narratives, these are ripe for interrogation.

Leavy (2009) refers to a genre of performance called “health theatre,” in which performance is used as “a vehicle for communicating the experiences of sick people” (p. 150). Citing the example of a study that used interview data about a health condition to create a performance script, Leavy noted that “the performance both confronted and dispelled misconceptions and prejudices” (p. 150). Langellier (2009), in discussing staged narrative performance, observes, “Performing narrative medicine reminds us of [*sic*] that some body has been hurt and that somebody speaks and gestures, touches and is touched, feels fear and pain, hope and despair” (p. 151).

My goals in creating a performance piece are precisely as articulated by Miller and Taylor, by Leavy, and by Langellier: to contest master narratives, to dispel misconceptions and prejudices about the experiences of OW/O women, and to remind us that these are stories of the struggles of real people. To a large degree, my objectives are captured by the claims of Langellier and Peterson (2006) that performance has the potential to be a “political act” that serves to “ground possibilities for action, agency, and resistance in the liminality of performance as it suspends, questions, plays with, and transforms social and cultural norms” (p. 155).

At one point, I considered creating a performance script that was essentially my own personal narrative, enhanced with sociological introspection based on a great deal of research I have done on issues of personal identity, body image, weight bias and discrimination, as well as the medicalization of obesity. In preparation for that approach, though, I was struck by Miller and Taylor’s (2006) admonition that there are dangers to offering one’s own narrative as a counter-narrative. They observe:

> [There is an] inevitable privilege that adheres to a staged autobiographical performance. . . . The performer makes space for a voice formerly excluded, but immediately has to deal with the assumption that she is now speaking not only for her particular experience, but for all those who share aspects of that experience. . . . [The performer can] try valiantly to resist this universalizing impulse, but in truth there is no simple solution to the problem of speaking for others. (p. 178)

It was this concern that led me to focus less on my own personal narrative—though it is included—and more on the stories of my respondents.

There are certainly many considerations in conducting any research, but especially in research that produces a piece of work that might have the potential to be more widely disseminated than the average dissertation chapter. One of those considerations is the obligation that I-as-author—and ultimately I-as-performer—have to my potential audience. One of the great advantages of performance is its capacity to create a "'we' of identification and shared experience" (Langellier & Peterson, 2006, p. 160). But in their relationship with each other, the storyteller and the audience tacitly enter into a "compact" that "involves mutual risk-taking and responsibility" (Langellier & Peterson, 2006, p. 159). For me, this responsibility is to present my material in a form that is engaging and aesthetically pleasing, but that does not manipulate my audience's emotions. I want to open them to the possibility of seeing perspectives that go beyond the totalizing constraints of the familiar master narratives, but I do not want to demonize them or depict them as people of ill-will. This last concern is particularly salient when I

consider the possibility of audiences that include medical practitioners. There were plenty of stories of humane healthcare in my interviews, but there were also instances in which my informants felt especially diminished in medical interactions.

My greatest concerns, though, are in the sense of responsibility I feel toward my informants—"my ladies" as I often think of them. As Langellier & Peterson (2006) note, as a storyteller I speak "from the authority of experience," "as an expert on others," and "*for* others" (p. 162; italics added). I do speak from experience, being someone who has suffered from overweight and obesity for my entire life. I cannot and do not claim complete expertise on the lives of my informants, but I certainly have gained knowledge about their experiences, even—as I was told several times—experiences they had never articulated before. It is in speaking *for* them that I feel a particular obligation to represent them honestly and ethically.

Estroff (1995) points out that people who experience chronic illness inevitably feel a "loss of authority, control, and self," and that we, as researchers, can easily "replicate or worsen the process" by our investigation of their experiences, a risk that is "compounded by the narrative privilege of author/scholar" (p. 79). She points out, though, that we can, to some extent, "reverse and counteract the sense of loss by giving some additional voice and empathic moments of reflection to the subject that they would otherwise not have" (p. 79). I might add here that during the course of my interviews, and in chance encounters since, I have had several of my informants tell me that they appreciated the chance to talk about their feelings and thoughts. One, (AnnaMarie), told me that she wished that doctors would ask the same questions I was asking in the

interview; she believed they were the kinds of questions that would help health practitioners to understand the perspective of OW/O women better. Vanessa told me in an email that she had learned so much about herself in the interview that she had subsequently had constructive talks with her doctor and was now in the process of successfully losing weight. It is gratifying to know that some of my respondents felt that they were afforded voice in the interview process. But I also feel keenly that my respondents need an accurate presentation of their voices in my performance script

The content of my interviews is often dramatic. At times, an informant would divulge information that was highly personal. Although I was fortunate that none of the women appear to have experienced any adverse reactions to participation in the interviews, there were occasions when I found myself needing to back off from a question in order to reduce what I sensed was a moment of discomfort. On two or three occasions, I was told, “I’ve never told this to anyone.” Clark and Sharf (2007) point out that there are ethical implications in researching personal topics, and they particularly cite the example of a respondent who, encouraged by the experience of empathy from the interviewer, divulges information about a traumatic event that had been a secret until that moment (pp. 405-408). In my interviews, I had one such case, and have had several opportunities to encounter that woman since. Fortunately, I have not experienced evidence of any distancing on her part. However, I have made conscious decisions to include only those parts of her experience that seem to have clear relevance in explaining her story; of course, I have also taken care to protect her anonymity.

In constructing my script, I tried a variety of approaches in deciding how to incorporate the stories of my informants. I struggled with where I would place them. Would they become characters in *my* story? Would I narrate them, essentially summarizing what they had told me? Would they engage in dialogue with each other? Would I embody them in some way, re-presenting and re-materializing them? Ultimately I decided to let them speak for themselves.

I used their interviews to piece together their stories. The goal was to achieve some coherence in their narrative, as well as to tease out ideas and themes that are discussed in other parts of this project—parts that prospective audiences might be unlikely to encounter in any other way. By deciding to generate fairly lengthy narratives, I was necessarily restricted to focusing on only a few of my respondents. I intentionally chose to use the stories of women who had not already been discussed in detail in earlier chapters, though Marianne's story is used in detail in both Chapter IV and in the script because it is a much better exemplar than the other available alternative. However, I felt keenly the need to represent all of my responents in some way. So, at some point, each of them is given at least a small space in which to speak.

This, then, is my script.[5]

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[5] Because of the visually obtrusive quality of in-text citations that are standard in the APA style used throughout this dissertation, I have chosen to use a footnote approach to citations of literature appearing in the script. This is done for ease in reading, particularly for any who are performing the script. I have used brackets to indicate where my own language was inserted to make coherent sentences. Often those insertions reflect a question to which the woman responded when she made the remark that follows. Other times, they summarize previous material needed to make sense of the remark.

Loose-ing Weight

(*The narrator is sitting in an easy chair, with an end-table next to her, an assortment of magazines, books and stacks of paper on any available space on the table and on the floor near her feet. Also on the table is a box of facial tissues and a soft-drink bottle clearly labeled to show that it is a diet beverage. As the audience files in, she is reading from a magazine and occasionally sipping from her beverage. When the audience is seated, and a little time has passed, she looks up, taking surprised note of the audience's presence.)*

Narrator: Oh! There you are! I'm sorry; I hadn't noticed you had arrived. It's good to see you! Oh, forgive my manners.

(*She quickly sets her magazine aside and rises from her chair, hurrying to a nearby table on which is laid a large platter of cookies. She carries the platter toward her audience, speaking brightly to them.*)

As they say, "I knew you were coming, so I baked you a cake!" Well, okay, it's not a cake; it's cookies. If you're allergic to calories, though, I'm sorry; you're out of luck! One of my favorite things about having company is that it gives me an excuse to bake really yummy stuff—instead of using one of those no-fat, no-sugar, no-taste recipes that just take all the fun out of it!

(*She hands the platter to an audience member to begin passing to the others, and she returns to her chair*.)

I was just reading an old issue of *People* magazine. Do you remember this one? "Half Their Size!" And here's another one: "How They Lost 100 Pounds!" Ever since they started publishing back in the mid 1970s, *People* has always done stories about celebrities and their "shocking!" 20 pound weight gains. I'm always especially intrigued by those "body after baby" ones, where the stars go from "baby-bumps" of varying sizes to concave torsos and protruding hipbones before their children have even started smiling or rolling over by themselves. And they often publish a couple of the recipes that the celeb allegedly cooked for herself while she was dieting—dishes like Fricasseed Hummingbird Tongue or Broiled Eye of Newt Tuscan Style. But when they do those celeb weight-loss stories, the next week they get all the snarky letters-to-the-editor saying things like, "Well, if I had all the money in the world and could hire my own chef and personal trainer, yada yada yada."

So about 6 or 7 years ago, they started doing articles like these (*pointing to magazine*), the hook being that they feature "real" people. Folks like you and me. Here was the first one I remember seeing, January 2004: "Losing It! Meet 8 People Who Without Gastric Surgery or Celeb Perks Like Private Chefs or Fancy Home Gyms Went from Fat to Fit the Hard Way: By Eating Less and Sweating More."

Which, oddly, is pretty much how the celebs did it, too.

Since then they almost always have an issue like that around the first of the year, just in time for our New Year's resolutions, and often at other times of the year as well, like right before swimsuit season. They always feature people—by far mostly women—who have gone from "flab to fab" by the sheer force of their determination and their

rigid adherence to this diet and that exercise regimen. Inspirational, right? Sometimes. But also sometimes depressing. Because, if you're an overweight reader, you can move emotionally very quickly from (*as if suddenly enlightened*), "I could do that!" to (*as if in abject misery*), "Why can't ***I*** do that?"

And here's another thing. They show you the "before" and "after" photos. And they are amazing! But I suspect that the majority of women who read these articles wonder the same thing I do: What happened *after* "after"?

Once, back in September of 2007, *People* did an article that followed up on 7 of the contestants who appeared on the first 3 seasons of the "Biggest Loser" TV show. Only 1 of the 7 had continued to lose weight—8 pounds—and the rest had gained some of their weight back, two having gained 21 and 26 pounds in the previous 9 months. I keep wondering: Where are the follow-ups of *People*'s own "Half Their Size" veterans? In January of 2007 they did an article about 3 of them who were described as having had a "setback," but they had, happily, gotten back on track. Where are the rest of them? Would this not be a totally logical story for the magazine to publish? My hunch? I figure those people have been contacted about doing a follow up, but they declined. And if I'm right about that, why do you think that might be? Hmmm.

We all love to read stories like these. (*Narrator gestures toward magazines*.) We like them because they are "good" stories, "proper" stories. There is a hero who battles the forces of evil and wins. But as most overweight or obese people will tell you, winning one battle does not necessarily mean you've won the war. In fact, it hardly ever does. We have all heard the statistics and they are pretty grim: the vast majority of

people who lose weight will regain it within 1-5 years.[6] Most of those will tell you that they typically regain what they lost and more besides—sometimes a lot more.

The vast majority of people who try to lose weight are women, and they will typically keep trying no matter how many times they lose and regain.[7] As the feminist writer Susan Bordo says, "The obsessive pursuit [of the slender body] has become the central torment of many women's lives." [8]

In the past couple of years, I've had the chance to talk to 23 overweight or obese women at length about their thoughts on the subject. Just like the folks in *People,* each has a story to tell. I'm pretty sure you don't have time to hear them all. But I want you to hear at least a little from each one. So, I've gathered together brief thoughts from each one to share with you, and I'll present the longer stories of just a few of them.

Why? Well, because while you may not know these particular women, you do know others like them. You work with them, you shop at the grocery store with them, you go to movies and concerts and church with them. You live with them: They are your mothers and daughters and sisters and wives. If you are a doctor or nurse, you take care of them when they are sick. But no matter how much you are with them and how well you think you know them, there is a good chance that you have never really talked to them about this, the "central torment" in their lives.

So let me tell you about a few of them in, as much as possible, their own words.

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[6] See Wysoker, 2002.

[7] See Wysoker, 2002.

[8] See Bordo, 1993.

Anytime someone tells a story related to their health, we all want it to be a "good" story. Tellers and listeners both hope there will be a happy ending. Sociologist Arthur Frank in his book *The Wounded Storyteller* calls these stories "Restitution" stories. Their plot lines go like this: "Yesterday I was healthy, today I'm sick, but tomorrow I'll be healthy again."[9] For overweight/obese women, this translates to, "I used to be thin; and then, life spun out of control. But now I am on the road to getting back to where I want to be."

The stories in *People* are Restitution stories. However, of the 23 women I talked to, only two of them could tell me this type of story. One of them, **Sasha**, wasn't there yet. In fact, she was about 50 pounds away from where she wanted to be. She had to tell her story prospectively, as Frank puts it. But she had been slender in the past, and she said she was "absolutely" confident that she'd get there again. She had a plan, and was motivated, she said, because her marriage of nearly 2 decades was dissolving, a marriage that had been stressed at times because of her weight. Now, she said, "I have to get 'my house' (*gesturing to indicate her body*) ready for the market!"

But the main Restitution story I want to tell you about is the one that Marianne told me. Here is her story:

Marianne: I've been overweight pretty much half my life. I was the yoyo—up and down, up and down—when I was a young mother and active in PTA and stuff like that.

[9] See Frank, 1995.

But it was mainly after I got divorced that I started putting on more and more of the weight.

I think my divorce was . . . I was very depressed. My life was just all of a sudden . . . **all of a sudden!** . . . you know? Just **over**, as I had known it for 18 years. And my children were in their teenage years, and it was just a depressing time, which led me to not want to get out of bed, not want to do things, not want to get up and go to work, which, of course, then led to eating and going straight to sleep and not caring for myself and not having enough self-confidence. I have *never* had a good self-image, but now . . . I saw myself as just fat, and I couldn't get around real good, and . . . (*laughing)* I was a little cranky. (*more serious*) I was just an angry person . . . angry at everybody, everything. Of course, angry at myself, that I didn't have the self-discipline to lose this weight and be healthy for my children and be able to live a life . . . a *good* life. And it kept me from doing a lot of things. I just couldn't look at myself very well. I had to think, "People don't like me because I'm so ugly . . . because I'm so fat." People look at overweight as . . . some people say, "Disgusting!"

I didn't want to interact with people. I would have my group of close friends . . . 2 or 3 people that I would associate with . . . but I was not one to wander out. I always thought, "Well, they're looking at me as this *large* person, therefore I'm not a *good* person."

To me, a lot of overweight is a disease. Eating is a very addictive behavior. My worst time of day is after work until I go to bed. I think I have to eat the whole time! (*laughs*). It's a constant. If I'm by myself, I think, "Gosh, I'm a little bored. I think I'll

eat something." But of course, eating is my tool for everything. I eat when I'm happy. I eat when I'm sad. I eat when I'm bored. I eat when I'm busy . . . I like to eat! (*laughs*). I remember when I was overweight, and I would look at somebody and see them eating ice cream, and think, "Well, they shouldn't be eating that ice cream!" Well, I just came back from the store buying a pint of ice cream and ate the whole thing! But *they* shouldn't be eating that!

I was not real good about going to the doctor. I never really felt I had any health issues, so I wouldn't go. [And I didn't go] because I was overweight. I used to say, "Only God and I know my weight," and I was going to keep it that way! I was embarrassed to go to the doctor because I didn't want to get on the scale. Every time you walk in a doctor's office, that's the first thing they do is weigh you—even if it's for an earache! I didn't want to actually see what the pounds were. I still thought at my fat-heaviest, "Oh, I'm not over 300 pounds." But of course [I was]! But I would still think, as far as the scale, "I'm 150."

I do not like to go to the doctor. I don't know why I felt that way. I've never . . . I can't *remember* any incident where I was offended or anything like that. I just didn't want to know how much I weighed. *I really did not want to know how much I weighed!* I wouldn't want to go have a Pap smear or anything because I didn't want to be checked out with all this weight on me. And I always had a fear that they would say something for me to lose weight. It took me a long time to admit that I was obese . . . and that I was . . . morbidly obese. I would look on my chart and see "obese" or "morbidly obese," and

think, “They’re not telling the truth! That’s just a word they use; I am **not** obese!” Well, I *was* obese. But being overweight really caused me not to go to the doctor.

I’d been in the hospital a few times for what they thought was a heart attack. And you know . . . even *that*! You would think I’d lose weight after being in the hospital and having [an angioplasty]. You would think after that I would get up and *do* something. I really wish my [internist] had pushed it more. But it was always, (*gently*) “Well, you really need to lose some weight.” Like he wasn’t going to step on my toes. He was very diplomatic. And I was just like, “Well! When I’m *ready* to! I’m not *ready* to, so I’m not going to!” I’m a very stubborn person! (*laughs*) [So] I don’t know if he *had* pushed harder, if that would have made me go the opposite way. When I asked him about having a gastric bypass, he said that if I was going to do it, gastric bypass was the way to do it. But he really thought that I could do this on my own. Well hell! I’d been sitting there since 1990, progressively getting heavier! With me he probably was [in a no-win situation]. If he said something about it, I’d say, “Hide and watch!” But then when he wouldn’t, I’d think, “Hmmm. Am I just a number to him? Am I not a special patient?” I wanted to be a *special* patient. (*Smiles with amusement at her admission)*

I have been with a gentleman, Mitch, for 9 years, and over the last 9 years I’ve gotten larger and larger. And, you know, he **never, ever** said *any*thing until he really pushed me to have surgery over a year ago. He said, “I cannot live here watching you kill yourself. You eat, sleep, eat and sleep. And you’re killing yourself. And I’m not going to sit here and watch you not be here for your children, your grandchildren.”

[So I had my surgery] about 9 months ago. I had gone in wanting the Lap Band® and Mitch researched it and he said, “Well, you really need to have gastric bypass,” and I said, “Well, no, I’m going to have the Lap Band®. But we went in together, and the doctor told me . . . the gastric bypass would be better for me because of my diabetes.

My first visit was real interesting because I walked into the waiting room [and] I thought, “My Lord! The whole world is fat!” (*laughs*) “I am **not** as big as these people!” Well, apparently I was, too. It made me feel better about myself . . . [that] they had set things up for the heavy patient. They told you what you had to have done before you could be qualified to have [the surgery]. You had to be so much overweight, and if you weren’t, you had to have a medical reason. I really qualified in every aspect, but I would say, “Well, I really don’t fit the weight part because I’m not 100 pounds overweight.” Well I *certainly* was! I was fibbing! But I [kept thinking], “They’ll do it because I had the diabetes.” I was *still* not going to say, “Yes, I’m overweight.”

They were wonderful. They were very helpful. You knew that everybody in there was overweight. Nobody in the office looked down at you. [I would] feel a warmth and encouragement, and it’s a really nice office. In follow up appointments, they were just very happy, and “You look great! You look wonderful! Don’t you feel better?!!” And they were just kind, really . . . showed a lot of empathy. It’s a very different experience [than other medical visits].

Before I had my surgery, I was not good at exercising. Exercise bored me because I couldn’t do it. I didn’t have the drive to do it. I didn’t want to go out and take a walk. I didn’t want to go to the gym, and that’s only because I was large and I didn’t

have the energy [and] everyone looks so wonderful there, and here I am, this *big* person. But I exercise now. I work out with a trainer about 4 times a week. And it's made me feel terrific! I mean, it's completely changed my whole outlook!

Like I said, it wasn't until Mitch really said, "You're going to die. And I don't want to see you die! You've got children; you've got grandchildren . . . (*on the verge of crying*) That's what it was. You know (*stronger voice*), he wanted me alive. He didn't want to see me die. And which . . . you know . . . I was *good*.

[Doctors] need to know that overweight women are the same as slim women. Our needs are just the same as everybody else's. They like to hear that they're smart. They're attractive. They're likeable. I think a lot of heavy people don't feel like they are. We're as human as the next people. And . . . we're obese for a reason. Let's find that reason and work on it. But be *kind* about it. I know that time is precious to them, but just, sometimes, just a couple more minutes . . . 5 more minutes of saying "Gosh, you're doing a good job. Let's keep it up, you're doing so good!" But if I'm *not* doing what I'm supposed to do, let's figure out why. Let the patient talk.

I guess I'm being a little selfish if I want them to **remember** me, and everything about me. But [I want to feel that I'm a special patient. And maybe if I had felt more like a special patient], I would have worked harder at losing weight.

Narrator: Sasha has a plan, and she is optimistic that it is realistic for her to achieve her goals. Marianne is almost there! But some of the women I talked to could not tell a story of plans and optimism, let alone success. Their stories fit the type that Arthur Frank calls

"Chaos" stories. For overweight women, this story line is basically: "My weight is out of control, I've tried everything, nothing works, and it's never going to get better." Six of the women I talked to told a version of the Chaos story.

For over 30 years, **Ann** had tried everything and had a drawer full of diet books, weight-loss logs, and journals to show for it. As she said, she had "whipped that dog" and "beaten that horse" endlessly, and the only thing she could conclude was that she was "crazy" and had some "deep-seated" problem. She lamented that when she died, her daughter would most likely say, "God, she doesn't have to worry about being fat anymore . . . The struggle's over." And, as Ann said, "That's sad. Not to have ever found the answer."

Charlotte and **Mae** both had stories that were complicated by other extremely serious health issues: breast cancer and end-stage kidney disease. For the previous couple of years, Charlotte told me, "I had a really hard time imagining a future at all," so her concerns about weight had to become a "side issue" while she was focusing on her breast cancer. Mae did have to focus on her weight, though, because she needed to lose 60 pounds in order to stay on the kidney transplant list. However, a renal-friendly diet does not include the foods that are customarily thought of as beneficial for weight loss. Vegetables and grains, for example, were severely restricted. So she was in a daily battle with her body on many levels, and, regrettably, had not been winning. She said, "You get tired of having to just *constant* watching and it doesn't seem like it does any good . . . You're trying to make all the best choices, but . . . it just seems like it's hopeless."

Grace had lost a marriage over her weight, and as a full-time secretary, full-time student, and full-time mother of three teenagers, she had little-to-no time to focus on her weight. She said, “I feel like a small person in a fat suit. I don’t want to be this way! I want it—somebody, take it away, because it’s not supposed to be here! Almost like you would a tumor or growth or something—this is just not supposed to be here!”

Gabby had struggled without success for 25 years with her weight and expressed considerable rage about how she had been treated by doctors, family members, insurance companies and society as a whole. She rebelled against the regimens of deprivation that dieting entailed. She said, “I don’t want to live that way. I want to live where I can go to a restaurant and have a nice meal, good quality food, and be **happy**, and not think, ‘God, now I have to go home and either purge or don’t eat for three days because I’ve eaten a piece of cheesecake.’ I don’t want that! I want to be who I am, all the time, whether I’m heavy or I’m skinny.” But she also acknowledged that she could not give up the fight, because she could not be truly happy with herself if she did not lose the 44 pounds so she could say that she weighed less than 200 pounds, an important marker for her.

The story I want you to hear today, though, is Diana’s.

Diana: [I’ve been overweight] all my life. I remember when I was 10 years old. I was having some problems of some sort, and my mom took me to the doctor. And the doctor said, “Okay, tomorrow you are going to do a fasting test to see if you’re diabetic or not.” [After the tests were done], the doctor said, “Uh, Diana, you’re a little on the large side, and if you don’t want to have diabetes, you need to lose weight.”

So that's when the actual losing of weight was started. I was just a kid without any worries. And then when that happened, I think it changed my life. It changed because I had to watch what I ate. I had to watch what I drank. If my friends had burgers, I couldn't have a burger. And no matter how much I tried, no matter how hard [my mother] tried—I would say at those young years, she tried harder than I did to get me to lose weight—it just didn't work. My mom finally quit after awhile and just let me eat whatever I wanted to eat. And, of course, I started putting on even more weight.

When I was in junior high, I was walking by one of those full-length mirrors, and it dawned on me: I'm walking around looking like a pregnant woman! It horrified me, because now I'm getting to the age where people are judging me on [my] looks. So from that point until I was about 16 years old, it was my mom and I together. Everything that has ever came out that says, "It will help you lose weight," my mom and I tried. Then [the summer before my senior year in high school], I had a friend who knew I always had a problem with weight. [We worked at the same place], and she would come get me, and we would jog to the gym, which was a couple of miles away, and we would work out at the gym and then we would jog back home. And then we would go and work our shift at the nursing home, get all of the little elderly people fed, finish there, and then she and I would jog back to my house. And that was the first time that I ever thought, "I am such a pretty person. I am just—I'm thin. And the boys are looking at me, and there's more than one looking at me, and how exciting!"

So high school, senior year, was fantastic. But then when I left and started college, of course, the pizza comes out and I couldn't stop eating. Since then it's been

yo-yo dieting. From that point, I don't think I have ever reached another moment where I look in the mirror and say, "I'm happy with the way I look." [I'm 42 years old], and from 10 years old, when I started dieting, it's been pretty torturous, with only one year, probably, of happiness out of all that.

I think there's a lot of emotion that goes along with comfort and food. So, for me, when I'm stressed, it's food. When I'm frustrated, it's food. When I'm happy, it's food. Every single emotion, I wanted to eat. I grew up in a Mexican family that—we believe in food. You gather together anytime . . . We would go see my grandmother and if she had a plateful of arroz con pollo, frijoles, and I didn't eat it all . . . well, I got in trouble. I had to eat it all because my grandmother offered it to me.

[Being overweight] lowers my self-esteem by miles. The relationship that I have: she's very tall, she's very thin. I'm short. I'm pudgy. And so that gets in the way. I find myself making comments: "Well, there's a thin one. I'm sure you'd rather be with her than me." Then her response is "No, you're not fat, you're not fat!" But I don't take her opinion. No. My opinion is the opinion that matters. I guess it's because I know the other people that she was with, and they were all thin and fit and athletic. And that's not me.

I'll have to add one more time [when I was successful at losing weight]. When I was doing my undergrad, one of the professors said, "Hey, Diana, let's go do the ROTC thing." It's an exercise program where you work out with [the ROTC students]. And wow! The inches just fell off . . . and I wasn't watching what I was eating. As a matter of fact, I saw a picture the other day [from that time]. And I was thin—by somebody else's

definition. But I still look at myself and say, “While I looked good for me, that was not thin.”

And what’s funny is that, there was that one point after I had lost weight in high school . . . My mom had a picture . . . about 4 months ago . . . and she said, “I want you to see something.” We had gone to [an amusement park]—and I’m wearing a little top with my belly showing and some shorts. And Mom said, “You were thin. You were ***too*** thin.” Because these bones right here (*gestures to her hipbone area*) were protruding. I know they’re there somewhere right now, but you know, they were ***protruding***.

But I do ***not*** see myself that way. I would have to be bone-thin. Why didn’t I see myself that way? Of those times, I should have been able to look in the mirror and say, “Okay, Diana, you’re done. You’re thin. Quit thinking about it.” [But] it’s always on my mind.

I have to go see a doctor next month for a gynecological visit, and I dread it. I dread it because it’s a new doctor and I know that he will say something about my weight. I have a lot of gynecological problems, and it’s always the same thing that comes up: “Well, if you’d lose weight, you probably wouldn’t have as many problems.” About 10 years ago, I had a lot of asthma problems, and they said, “Well, if you’d lose weight, you probably wouldn’t have as many problems.” I have problems with my knees and my hips, and if I go to a doctor and try to get treated for that, it’s always, “Well, if you would lose weight, you wouldn’t have those problems.”

I prepare myself [when I see a doctor] in terms of how I will react when they say that. How do I want to be at that moment they say it? Do I want to look at them and say,

"Oh, yes. Uhm, thank you so much for that information." Or do I want to say, "Listen, you SOB, I can't help it. I've tried. It's tough for me. There's just some of us that aren't thin." Or do I want to be very placid about it and just look at them and let them write whatever they're going to write in their notes?

Four years ago, I went to one of those places where you get medical help specifically for weight loss. So, they measure you, weigh you. And I didn't stay very long, because the nurse was measuring me and she measured around my hips, and I said, "You know, I really don't want to know the measurement of my hips. I know I have large hips." And she said, "Oh, Honey, please! All women who have had children have big hips!" (*Long pause*) I have no children. I just boo-hooed and didn't even make it through that. She caught me off-guard. I had prepared myself for the reaction, but I had never heard that before.

I had a physician when I was in my mid-20s and he was ***great***. He was ***fantastic***. When I started with him I was a little pudgy, but as I stayed with him, I started gaining more weight and gaining. And then, after I married, I instantly put on 10 or 15 pounds. And then, he made a comment to me that was just in passing, but that was enough to sever our relationship. I'd never talked to him about kids before, and he said, "You know, if you keep gaining weight, you won't be able to have children." And I didn't go back. I never told him I wanted kids. I was not trying to have kids. I was on birth control. That should have told him. So why make that comment? So even though he was nice, it just seemed like I reached a point where he thought I was an ugly person because I was fat, and that's how he told me.

When I went to have [some gynecological procedures] done last year, they put you on that little thing with the stirrups, and I remember thinking, "God I just feel so bad!" I hate . . . not like I was totally uncovered, but it's just a little sheet. And people were coming in and out, in and out, looking to see, "Oh have we done this, have we done that." And I just remember feeling mortified. Not because they were seeing my vagina: Because they were seeing my ***fat***. And I ***hated*** it! I ***hated*** it!!

Whenever I go see the doctor, I try to do things so I can lose a little bit of weight before I go. Because they make you undress and they poke you and touch you; and when I feel fat, I don't want anyone touching me. They ***touch*** you! And it makes me feel very uncomfortable.

It's the disappointment, you know? You can see it on their faces. "No! Geez! Another fat one comin' through. What am I gonna tell this one?" It's not like they look at me as an individual and say, "You know, this is your weight. This is your height." You know, it's not like they're looking at . . . at . . . at ***me*** . . . as a ***person***, and all my medical factors that go around it, and saying something from that. They're just looking at my appearance and saying, "Sister, you're ***fat***!" It's like I lose my individuality when they say, "Yeah, your problems are because you're fat."

I [have] physician-hopped because they've upset me so badly about my weight. I'm looking for one that will not make me feel worse about myself than what I already feel. And I'm hoping this [new] physician will be that person.

[But] maybe there's no way for a physician to talk to me about my weight that would make it acceptable for me. I'd *say* I would listen, if they could approach it from

the standpoint of, “Diana, you’re not a bad person. We all struggle with different things, and some of us struggle with weight more than others. It really would be healthier for you if you could lose weight and . . . ”

(*Shakes head in recognition that even this will not work for her*.) But then no matter what, no matter what . . . and . . . and my family tells me this all the time. No matter what, when someone says something about my weight, I’m instantly—change my attitude or my demeanor. Or the defense-y thing comes up in me, and I’m thinking, “I don’t want to talk about it. I don’t want to talk about it. I don’t want to talk about it. I know what I am. Just leave me alone.”

So I ***think*** I would listen and from a cognitive standpoint understand what it was they were telling me, but it’s always . . . it’s just . . . I just *hate* it. I . . . I ***hate*** it! [Because they’re implying] that I’m ***not good enough***. That I’m ***less human***. I’m not ***worth*** as much.

I don’t think that I’ve ever found a physician where I could have the conversation that you and I are having, to tell them, “I know what you’re telling me. But it’s just such an emotional subject for me, and it’s not superficial. It goes down to my deepest core.” And really, what physician would take that time with me? What physician would let me sit across from them and tell them why I think I’m fat? And the history of why. And what I think the difference is between fat, pudgy and skinny. And how I feel on a daily basis. I just don’t really see that anyone would ever give me that much time.

If they would let me be vulnerable, without judging me. And let me cry. And let me say “I know I’m overweight. I know I don’t always eat the healthiest. I realize that

I'm an adult, and that I have to suffer the consequences from those choices." And just let me go on and say whatever it is I want to say. And then, maybe, if they would say back to me, "You know that there are options out there for you, and if you want me to help you with that, I'll find you some resources. If you need someone to talk to—a professional someone—I think we probably have some resources." Because they want to tell you you're overweight and they want you to lose weight, but they don't want to engage in the dialogue and everything that goes on with weight.

And they don't want to treat us like [they would treat] someone who has cancer. You know, they pay a lot of attention to people who have cancer: "My, what can we do for you? And here's this and here's that." They're seen as "Poor souls, something happened to them that was out of their control." Fat people? "That's in their control. They can control how much they eat. Just say 'No' to that cookie or that candy. They can have the willpower." Willpower: I get so ***sick*** of that word!!

I've never told anyone this much ***ever*** about how I feel about weight or going to the doctor. And frankly, it feels kind of good to get some of it off my chest. Just to be able to say it out loud: That there's not the support there.

My conversation [with you] has sounded like I blame [doctors]. I know it's me as well. I know that the way I feel about myself and my weight is my responsibility as well. I'm not here just to bad-mouth them. There's just a level of ignorance—not stupidity; just ignorance—with how to treat patients like me.

Narrator: Arthur Frank says that Chaos stories are hard to hear, and I think he's right. I have a couple of other stories to share with you that aren't quite so wrenching. But first, I think it is probably time for us to take a brief respite from all of this serious talk, maybe grab something to drink . . . and if there are any cookies left, by all means help yourselves. I'm going to take a break myself, and let's gather again in (*time specified*).

(*Intermission*)

Narrator: I hope everyone is refreshed. I have a confession to make. I had saved back one of those cookies to make sure I had one on my break. So I have to plead "Guilty" to Premeditated Caloric Ingestion. And you know what's worse? I don't feel the least bit remorseful!

Which is bad, because our culture has definitely framed overweight/obesity as a moral issue. There is plenty of precedence for that, too. Back in the early Christian era, when the church fathers outlined the Seven Deadly Sins, one of them was gluttony. Being fat, then, was a clear sign that you were not "right with God." And we really have never escaped that. Oh, sure, there have been times in history when being heavy was not regarded as a bad thing. For example, during periods of prolonged famine, being plump was an indicator of one's economic success. And we have all stared at the paintings of the "Rubenesque" woman—some viewers wondering how *that* could have *ever* been considered attractive, and the rest of us longing for a return to that era.

Generally, though, as one scholar has noted, "things pleasing to the eye usually connote moral goodness."[10] And in our culture, thin is pleasing, ergo "good." Fat is displeasing, ergo "bad." Dieting women are familiar with this, when they moan to each other, "I was *good* all day, and then when I got home and started fixing dinner, I lost all control and I was *so bad*! I actually ate ***two*** hummingbird tongues!"

A lot of women have weight histories that can only be described as "chaotic." They have lived the phenomenon that is often called "yo-yo" dieting. This takes a toll on women, both physically and emotionally. And somewhere along the way, many women have to take a hard look at where they have been trying to go and whether that journey is even feasible.

Some women, then, decide to re-story their lives. They adopt what I have termed a Reorientation story, the plot line of which goes like this: "I was headed to my destination, but the road washed away. Now I must head in a new direction, perhaps to a new destination."

They have not given up. They have simply decided on a new goal that seems more realistically achievable. Their stories are not as optimistic as those of the Restitution narrative. They are wary, because they have been unsuccessful on too many occasions. Six of the 23 women I talked to had decided to chart a new course.

AnnaMarie said, "I'm not going to be able to be thin, but there's about 50-70 pounds that I need to be able to [lose] to go on with whatever the Lord wants me to do. If

[10] See Jutel, 2003, pp. 68-69.

He has plans for me, how am I going to carry them out if I'm carrying too much? Your body is going to fail anyway, but you don't have to hasten it with being overweight."

Mary Lou had only been overweight since menopause, but she was very unhappy about it. She was used to being a size 2, after all, and weighing 96 pounds, and now she weighed 175. But she had decided to set her goals just to a level where she could be healthier, so instead of 80 pounds, she was thinking in terms of perhaps 35 pounds that she wanted to lose. In some ways, she thought that having become overweight was a benefit. She said, "I've gotten more involved in actually *trying* to be fit than I would have before."

Megan had been overweight since the birth of her now16 year old son. She had gained and lost and regained repeatedly. She remembered that one time she thought, "Forget it. I'm meant to be who I am, so I'm just going to live with it." She even expressed admiration for women who are, as she said, "bigger, and they're completely happy and content being that way. And more power to them!" But she had finally concluded, "I don't think I'm meant to be overweight," and she was now focusing on simply getting to a point where she could feel "comfortable in my own skin."

Ruth had a number of health issues—including a serious problem with diabetes—that made it very important to lose a significant amount of weight. After years of dieting, resulting in some modest success followed by even greater re-gain, she opted for Lap Band® surgery. Her experiences over the years had led her to comment that doctors need to understand that, as she put it, "Obesity is kind of a mask. It covers up who a person really is. And [they need to] try to see past the mask and find out who that

person really is. Sometimes we put the masks on ourselves, and sometimes the masks are just kind of built up without our intention of building them up. [They need to] be willing to find out who a person is rather than just a body type. A lot of times, labels tend to confine people rather than opening them up to things. Saying someone is obese or morbidly obese—it kind of puts them in a pigeonhole, and then you look at everything else as, "Does this reinforce this?" rather than finding out the information and then finding out where a person fits. [They need to] get to know people, because there's no one diet recommendation that's going to work for everybody. And if you know who the patient is—who the ***person*** is—then you would be able to make a more appropriate recommendation."

Sherry had actually been anorexic for much of her life, but a series of serious health problems made it necessary to gain weight in order to be healthy enough for a heart transplant. She ended up gaining 30-35 pounds too much. She had lost some of it, and now she was under doctor's orders to lose 10 more pounds and stay at that level. She doubted she could be happy living the rest of her life even at that weight, much less at the weight she was at now. She said, "If someone had told me 3 years ago, prior to all this health issue that I was going to have to gain the weight, I would've said, 'There ain't no way I'm gonna gain that weight. ***No way***!'" So she was working at reorienting, but only because she knew: "I ***have*** to do it."

Victoria was very familiar with the dieting yo-yo, and she had decided to give it one last try before opting for surgery. But she conceded that she no longer thought in terms of becoming thin. "Being thin is not the option. If I can just get to a weight that

I'm healthy at and look better, I'm sold." Her motivation for continuing to make the effort was "all those things that you X'ed off the list that you don't want to do because you're overweight . . . You could be living this life, you know, all these different experiences and you're not. You're living a sub-life that is not as good as the other one, because you don't want to try all these things because you're overweight."

All of these women have mapped a different weight-loss journey than the one they have been on, recognizing that they weren't going to be able to get to where they had longed to be. The more detailed story of Reorientation that I want to tell you about, though, is told by Mary Frances.

Mary Frances: First of all, I was a fat kid, and I had this round face, so that even when I weighed 106 [as an adult], I still had a little fat face with chipmunk cheeks.

My grandmother and my mother had this sort of—I don't know how to describe their relationship—pretty screwed up. And my mother left me with my grandmother. And I had sort of soft, lovely, curly hair, and she told my grandmother not to do anything to it. And when she came back, my grandmother had given me like a "bowl" haircut—you know? The little Dutch girl? So that every little fat part of my face was just . . . I looked like I had a giant balloon on. And there must have been some discussion about that, because I remember my mother was ***furious***! I think probably she said "It makes her look ***fat!***" And she wasn't saying it to me, [but] parents never think you can hear anything. And when I looked in the mirror, I saw, "Oh! I ***do*** have a fat face!"

Then, after 5th grade, I started to sort of thin out. I just got more active. And then my mother was real intense about it when I became a teenager. So I really worked at getting a waist and ankles. I can remember doing exercises, like the ones where you think you're going to build your bust (*laughs)*. Or the twist (*demonstrates*) where you're going to try and get more of a waist. She didn't want me to sort of suffer through being an overweight teenager. (*shrugs*) So I wasn't.

She would promise me new clothes, like a particular kind of a dress for a fancy cotillion. And then, you know, it's sort of self-enforcing when you're a teenager. You see the kids around you who are chubby, and they don't get asked out, or people make fun of them or talk about them. Did **not** want to be in **that** group!

I'm between 5'3" and 5'4", and [in high school] I probably varied from 104, which was the lowest, and that was a little too low, to maybe 115. And when I hit 115-116, that was too much and I would dive down [and immediately lose it.] [College]: the same. After that, I had a first marriage. I was thin and well-dressed for that. And then I got divorced and went back to graduate school. Still fine. [More grad school]: I gained maybe 10 pounds, 15 pounds. I was no longer at 106, but I was still in the 110-120 range.

[And, actually], it's great camouflage. I found that [being] just a little overweight—5 to 10 pounds overweight, enough to look soft—and having a southern accent: That was camouflage for how really smart and ambitious I was. I think it made the other grad students more comfortable; it made me look less threatening. [It was like]

protective coloring. [But] I think it was more useful when I was just 10 or 20 pounds overweight. (*grimaces*) I seem to have gone to a little bit [of an] extreme.

But I've got to tell you. I still think of myself as ***fat*** during that period. I don't know. I have a complete body—is it "dysmorphia" they call it? I thought I was fat when I wasn't, and haven't realized how fat I was when I was.

I go back and I look at pictures and—this is a weird thing: [My daughter] wanted to try on my wedding dress. I said, "Sure." (*pause*) She couldn't zip it up. And she's ***little!*** But when I look at my wedding pictures . . . I thought of myself as chubby and I couldn't have weighed more than 116. I was wearing a size 4! It's very bizarre.

[After grad school and re-marriage], I started gaining weight. So maybe I was weighing 130. I thought of myself as horribly fat, but when I look back, I'd be really happy to be at 130 now. I had a miscarriage. I had two miscarriages. And it was years before my thyroid got diagnosed, and I had gained 70 pounds by then. And I would go on diets and I would ***gain*** weight! There was no amount of food I could eat and ***not*** gain weight.

And I talked to this physician I was going to about it, and it's clear that he believed I was cheating. Because he would say, "Well, if you ***really*** follow this diet, you ***will*** lose weight." [But] I had this friend, and we went for walks together every morning, and I would religiously follow the diet.

So finally, I decided I had some kind of psychological problem that was keeping me from losing weight. So I joined this group of overweight women who were trying to address the issues of their weight. We sat there and they described what they ate. And

there were things like they would eat a whole pecan pie in a sitting. And a whole bag of chips. And I said, “My God! If I ate like that, I wouldn’t have been able to walk through the door!” I remember this woman telling me that she would hide pecan pie tins under her chair. It was amazing!

[There was another doctor besides the one who thought I was cheating. One time I had a health issue and had to be referred to a rheumatologist for some tests], and so we finished, and I said, “You know, I’m starting to have some real problems, I think, with arthritis.” And he said to me in this extremely curt way, “Well, with your weight, I’m not surprised. It’s going to get your knees and your hips.” (*long pause*) And I looked, and I said, “But it’s my ***hands*** that I’ve got it in.” (*pause*) And, you know, your hands aren’t really a weight bearing part of your body. And that was the first time I encountered a physician that clearly . . . you know? I mean . . . I just think he didn’t like fat people.

(*Reflecting for a moment*) But, you know, that was my assumption. I think that if people don’t like me, I often assume it’s because of my weight. I think it’s less how the docs react to me than . . . like, I don’t go to get Pap smears as often as I should. You know, when they do the thing to see if you’ve got tumors? I know they can’t feel through all that flab, and it’s just embarrassing! It’s embarrassing being that overweight!

I do mammograms. I ***hate*** mammograms! If I had a chance to get at Picker! You know, Picker invented the mammogram machine. And I think if any man ever had to put his balls in a mammogram machine, somebody would find a better way to do a mammogram!

[So], I get mammograms; I just don't do the Pap smears. And I know I should. So I've now found a woman doc—a nurse practitioner—so I'm going to go to her. I hope it'll be better. [But really], it was never anybody's reaction; it's just mine. I'm just embarrassed. I'm surprised now that I think about it, because that one negative experience really stood out for me. And the one where he didn't believe that I was on my diet and that I would gain weight on that diet.

See, it's **my** behavior—not anybody else's. I tend to blame things on my weight. (*pause; reflects*) Maybe the burden I need to drop is shame. (*pause; reflects*) I mean, maybe there really is a psychic burden that I need to drop along with weight.

And, you know, it's funny. When I take it off and I feel better (I mean, I feel not so much ***physically*** better; it's like ***psychically*** better) and I look a little better, and I can wear things that I haven't been able to wear for awhile—I think: "Man if I gain ***2 pounds***, I'll go back on this diet." But you just don't. And, I've lost a lot of weight. I've probably lost 10,000 pounds, but it's the same 30 over and over and over. It isn't that I can't do it. But, I mean, I need to lose a hundred and—well, maybe 140's a little high, but I need to lose 130 pounds anyway. That's a ***lot!***

I know now I have to eat around 800 calories a day—I've got to be under 1,000 to lose weight. And it's hard to do that for more than a month or two, but I don't want to stay like this! I don't want to go into retirement like this! You know, [even if I were only] 60 pounds overweight, I can still SCUBA dive and I can still ride a horse without breaking its back. But (*laughs*) I'm past that now. They'd have to bring me a Clydesdale, and you just don't find those around!

[So] I made a commitment. I don't know how long I can stay on an 800 calorie diet. But if I don't [lose a significant amount of weight in 6 months], I'm going to go ahead and have surgery. Part of the qualifications—you have to go through a lot of criteria in order to be approved for the surgery—you have to give [the diet] a 6-months try. And you [have] to show you [have] had some health effect. And I haven't had any health effect. I don't have high blood pressure, I don't have high cholesterol, my triglycerides are fine, I'm not diabetic. I mean . . . thanking my grandmother! Thank God for genes! But the [spine problems I am having right now] might do it, because [when I asked the doctor about alternatives to having spinal surgery], he said, "You could try losing weight, but it's really hard, I know."

[So], I think because I've sort of mentally agreed that I'll do Lap Band® if I don't [lose the weight on the diet], it *probably* is [realistic to think I can lose what I need to lose and keep it off]. But most people tell me it's not realistic to lose this amount of weight at my age and keep it off. That's what the literature says, and that's what Oprah lives. So, I don't know. Ask me again in 8 months.

[I do think physicians could be more helpful to overweight women], and I think the number one thing would be instead of assuming that weight is a problem for people, to ask them, and let what their lived experience is come out of their mouths so that you could help them with what ***they*** perceive as the problem. That doesn't mean that if somebody's diabetic you shouldn't talk to them about, you know, "Here's the kind of diet that you want to eat." [And], I think, just not making an assumption that every overweight person has the same problems, or even the same causes for being

overweight. I think there's probably more variability in the causes of overweight than we understand. And I guess the third thing would be not holding a sense of blame. Not holding a sense of "This is a weak, failed person. There's no point in my even talking to them about a diet because they won't follow it." I don't want you giving up on your patients! And you've got to help people be realistic without being defeatist.

[And about the shame] . . . I think I've reached a point where I've just got to say to this new [nurse] practitioner, "Okay, this is what I'm concerned about. I haven't had a Pap smear for 5 years and this is why." If the doc I had before, instead of not saying anything, had said something about, "I know this is uncomfortable; here's maybe something that we could do about it," or "Don't worry about it." If somebody gave me permission to say, "I feel really bad about this." You know, you've got to do something to allow people to talk about their sort of deepest fears.

I don't know if it would work. I think it would work with me.

Narrator: Mary Frances has adjusted her expectations about how much she can realistically lose. Like many others, she had experienced the ups and downs of dieting. Ruth commented that she thought most overweight women eventually feel like they are "hitting their head up against a wall." After years and years of losing and re-gaining, there is a certain sense of futility that develops. Some of my informants talked about dieting feeling like a "hopeless," "valueless," and "pointless" enterprise.

Is it any wonder that some overweight women eventually come to a place where the thing they most want in their lives is some peace?

I think this is particularly true in cases where the woman has not experienced any real health issues that she can attribute to being overweight. Certainly they have heard the litany of all the health problems that are associated with being overweight. You'd pretty much have to have lived in a cave for the past decade not to have heard that news, as so many media stories have been generated about the obesity "epidemic." And no doubt there is validity to much of those health concerns.

And yet, there are people who do not develop those problems, for whatever reason, so for the moment, they may not see being overweight as a health problem. They may choose to resist the medicalization of overweight, maybe with some suspicion about whose interests are served by promoting the overweight-as-disease model.

Some of them decide to adopt what I call the Acceptance story for their lives. It's not so much that they have "given up," though I am sure that sometimes is the case. For now, though, their plot line is: "I took a trip. The destination seemed inviting, but the cost of getting there was high. Moreover, I found that I missed the comforts of home. So I am back, at least for the time being."

Angel had a gastric bypass. She lost 135 pounds, which, she reminded herself, is "like losing a person!" All of her health problems had been improved or eliminated after her weight loss. She admitted that she would like to lose another 30 or 40 pounds, but she had reached the point where she realized that to do so would mean further reductions in what she ate, and she had pretty well reached the point where it was unlikely that that would happen. She was happy that she had lost as much as she had, and was now primarily intent on keeping that off.

Lisa had Polycystic Ovary Syndrome, an endocrine disorder that often makes weight loss difficult. It ran in her family, and she had observed that in most instances, once her female relatives who had PCOS went through menopause, "they turned back skinny." The potential that she would also experience this reversal of her weight was something that appeared to reduce any sense of urgency to lose weight. In our interview she said, "It occurs to me just now: Maybe not being in a certain weight range that you expect for my height might be a normal size for me. And not that killing for me."

Susan had overcome alcoholism about 6 years before our conversation, and she had also given up a heavy smoking habit a few years after that. Frankly, her doctor was so thrilled with those changes that he was not that concerned with the 60 pounds she had gained in the aftermath of those two positive health outcomes. So Susan wasn't either. When I asked her what she would do if her doctor told her that she really needed to lose weight, she responded, "I would want to know, "What's the least I can get away with?"

Maggie, who had never had a weight problem until menopause, and who was only 20 pounds heavier than her ideal, had a high level of body acceptance. She did not judge others by their body size, so she assumed that others did not judge her that way either. About her weight, she said, "I don't particularly like it, but obviously, because I haven't done a whole lot of work to prevent that, it's not too big a deal. It's a little bit of a big deal, but not much." She said that once she learned that weight gain was a normal part of menopause, she thought, "(*shrugs*) That was your new weight."

Raquel and her daughter **Vanessa** expressed nearly identical attitudes about their bodies. Raquel said she got it from her grandmother who had raised her, and Vanessa

said she got her attitude from Raquel. That attitude was summed up by Raquel when she said that, despite being 70 pounds overweight, "I guess I've never felt bad about being overweight. I've just always known I'm just, you know, I'm just a big girl." Vanessa, who regards herself to be 100 pounds overweight, said, "You know, I may be bigger than the next skinny girl, but I know I look good. This is what works for me. This is how I am. This is what makes me ***me***."

The acceptance story I want to share with you in some detail, is GiGi's. Like Angel, GiGi had undergone the gastric bypass, largely because of the life-saving results of that surgery for someone else in her life. Here is her story:

GiGi: [I have been overweight] my entire life. My mother gained a lot of her self-esteem from being the perfect homemaker, which meant continually baking and cooking. And she was an absolutely over-the-top fantastic cook. So there was always an abundance of phenomenally wonderful food in our house. And it was always very available. Food was love in our family, and it showed caring.

I can tell you exactly when [I first thought of myself as overweight]. Happened in 4th grade. We were being measured for caps and gowns that we had to wear for [our] confirmation ceremony. And we had to do it right there in front of the class. I mean, it's like every female comedienne's plot, you know? And I remember that in 4th grade I weighed 100 pounds. And I'm not sure that it hit me—it's so weird—when they first weighed me, but my whole class was ***overwhelmed*** that I weighed 100 pounds. I knew there were girls that were smaller than me, but I was the tallest in the class, too. But I

remember that everyone was just “Oh, my gosh! She weighs ***100 pounds***!”And that’s when I first thought, “Oh, evidently this means I’m fat.”

I went to a parochial school. And there wasn’t a lot of pressure to date or have a full-time boyfriend or any of those kinds of things. The cheerleaders were the ones who dated people and the rest of us kind of didn’t! And part of that was probably just the culture, too. We all were very close and we were more like brothers and sisters. I mean, it was evident that there were some girls in our classes who the boys were all going to go for. But I never thought to flirt with boys because I always thought, “Well, I’m not the kind of girl they’re looking to date.” I really didn’t necessarily think it was going to hold me back as much as . . . I just thought, “Well, I’m probably not going to be prom queen.”

All the way through high school, I played sports. And whether it’s a good thing or bad thing, for years and years and years, my weight really didn’t interrupt or stop me from being able to work really hard or to do manual labor, or to do the things that at that time I wanted to do physically. I think if there had been something that it had stopped early on, there might have been more warning bells. But, you know, I always said I was strong as a horse, and I was. But that was a lot of horse!

I haven’t gone through a lot of career changes. I never really saw my weight as a factor in my first interview, because I was coming right out of grad school and didn’t see myself as really being severely overweight at that point. And then the second job I got—I still felt like I could buy professional clothes and look pretty good. But then I stayed at that job—it’s the job I’m in presently; I’m going on 22 years in that career. So I didn’t have to go out at my heaviest and try to take on a job.

My initial [college] degree was in theatre. [So] I have stage presence and stuff like that. You can really delude yourself to think, "I'm really not as heavy as . . . " And you know, I would even have people say, "Wow, you don't *look* that heavy!" And I go, "I'm really not!" (*laughs*) But coming from theatre, and knowing how to disguise certain things—you can hide it from ***yourself*** for a long time. I did it with clothes. I just started wearing more and more jumper/smock type looking things. So if you don't ever have to see how big your thighs are getting and your butt's getting, then you kind of forget that it's getting bigger and bigger.

My daughter suffers from obesity as well. And I see a lot of the same struggles that I had. I think about what would my daughter possibly be like if her mother had not been severely overweight? You know? Were my children ashamed of me? They've never expressed that, but on the other hand, I'm thinking, "Well, when all their friends' mothers might have looked normal or might have looked very attractive or younger . . . "

The worst thing about being overweight is not being able to do things in society that other people do. I mean, you don't think about walking into a restaurant and not being able to sit in a chair. You don't think about—my suitcase didn't get to the convention, and a lot of women go, "Oh, great! I'll just go buy a new wardrobe!" Well, you just can't, if you're obese. You can't just go to K-Mart® and just pick up a pair of pants, or you just can't go to the mall and go into any store and find clothes that fit you. And those are real issues that mean—that show you—you're not normal.

[As for doctors], I've been just religious about going to a gynecologist every year. I mean, I go have my Pap, all that kind of stuff. I've always been very good about

that from young woman on. I always felt like I was a healthy person, and this is what a healthy person did.

And you know, I think it's interesting, because I never once had a doctor who said, "You know what? You are really overweight and you should do something about it." It might have been [beneficial to me if any of them had brought the topic up], if they had approached it from "Here are the things that this can develop into, and here is a real plan of action to approach it."

The journey [to my gastric bypass] started with my husband because he had severe obesity, severe sleep apnea, severe high blood pressure . . . literally I have to say tied to die twice. So [the surgery] was really his only choice.

He was very encouraging for me to do it. [But I had a lot of responsibilities with children in college and taking care of him]. I tell people, I think that eventually everybody's got to get into their head: "Okay, I have been successful in a lot of avenues in my life, but . . . " Sometimes, I think you just have to get to a point that says: "I can't." You know, it's a surrendering to a certain extent. It's an "I'm a real failure on this. I have fought this for 50 years and I have never won this battle, so I don't have the ***tool*** evidently I need to control this. So I'm going to admit that and now I'm going to try to get the tool that will help me because nothing else has." So that's how I came to it.

I [feel like I have been successful]. I do. I did not lose as much weight as I—I didn't lose 170 pounds. But I lost 100 pounds. And I could probably lose the rest of that if I would exercise! (*laughs*). And be more physically active than I am, which I'm not opposed to. But I [would] have to get out from behind the computer and [quit] working

long hours. I believe I could if that could be my main focus. (*shakes head and shrugs*) But it's very rewarding to have lost at least 100 pounds and in four years not gained any of them back.

I'm not sorry I did [the surgery]. I really don't think I would have ever achieved losing [100] pounds by diet and exercise—and *maintaining* it. I wish I could say I did, but statistics do not bear that out. I think statistics say 3% lose that kind of weight and keep it off.

But here's the truth. I think if my doctor had written me a prescription and said, "You ***must*** walk three miles a day" or whatever, or if he had . . . or if she had said, "I'm going to prescribe a physical regimen" . . . I might have. I can't say I ***would***, but I ***might*** have. Because it would have been a prescribed plan of action type thing. I always thought, "I want to be a good patient. And I want to do what they told me to do."

If they had said—you know, like they do with blood pressure medicine: "Okay, you've got high blood pressure, so I'm going to give you this medication. We're going to try it. I want to see you in two weeks and let's see if this is doing it. And if not, then we're going to make an adjustment." I don't know. I'm not in the medical profession. But I bet a lot of people don't *blow* that off.

It's an investment. It feels like your doctor is investing in you as a patient. And I think that makes a difference. I feel very fortunate. I've had a lot of supportive people around me. I just feel like there are a lot of women that suffer from obesity, [and] I think a lot of them don't necessarily feel support of other people or an investment of other people. They give a lot.

I have a niece that suffers from severe obesity—***severe*** obesity. And she gives 99.9% of herself to other people ***all the time***. And very rarely do I see any of that come back into her. I'm really sad [for her]. I mean, I know her lifestyle, and I know her struggles; I've been there. And I know: "There, but for the grace of God, go I." I fought it for 50 years.

Narrator: Of the women who told me Acceptance stories, none were very close to their ideal weight. Maggie was the closest—just 20 pounds away. The others were anywhere from 40-100 pounds away. Yet all had decided that, for the time being, they were going to retreat from the battle. It may be an uneasy truce, but it's at least some peace.

I have told you a little about the two story types that I call Reorientation and Acceptance. Before that I told you about Arthur Frank's story types that he calls Restitution and Chaos. I want to conclude by telling you about Frank's third story type: Quest.

In Quest stories, the protagonist meets "suffering head on" and they have found that "something is to be gained from the experience." [11] In the struggle, the hero prevails, is transformed, and receives what Frank calls a "boon" at the end, "usually some insight that must be passed on to others."[12] Frank says that sometimes the teller of

[11] See Frank, 1995, p. 115.

[12] See Frank, 1995, p. 118.

a Quest story will make "significant vocational and personal changes" in their life, perhaps related to "patient advocacy."[13]

Of the women I talked to, the only one whose story fits this type at all was **Naomi**. In her case, the struggle with her weight was only part of the story. She had suffered sexual abuse as a child, and she felt that her disregard of her body for her whole life was related to that. She said, "I didn't think that much of myself. I didn't think I was anything special." But through a series of events, she experienced a religious transformation which, she believed, had paved the way for her to begin caring for her body. Losing the 40 extra pounds she had always carried was part of that process. She explained it to other people this way: "You start loving yourself . . . [It all changed] when I realized, 'God loves me! I am the daughter of the Almighty God!'"

As I said, Naomi's was the only Quest story among my women. But I have one more story to tell. It is a Quest story. It is my story.

Bonnie: I am told that I was tiny when I was born. When I was maybe 6 or 7 months old, my grandparents, who lived across the state from my parents, had to assume my care as my mother was hospitalized for the last few months of her second pregnancy. My mom told me that my grandmother fed me every time I cried—and apparently I cried a lot—so that when Mom reclaimed me, she was handed a pudgy toddler.

And pudgy I remained.

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[13] See Frank, 1995, p. 116.

I don't remember being particularly conscious of my weight except that I realized by the time I was in first or second grade that buying clothing for me was really frustrating for my mother, and I felt bad about that. I remember thinking that my sister always had pretty clothes while I had whatever fit.

The first time being heavy really posed a problem for me was when I was not allowed to take ballet—which I desperately wanted to do—because I was too chubby to look good in a leotard. Over the years, I have often thought back to how passionately I wanted to take dance—and really, it bordered on an obsession—and I wonder: Why didn't I just lose the weight? And I don't have an answer. Except that I remember that I didn't really have any conception of what that would take. I ate what was put in front of me. I didn't have a big enough allowance to buy extra treats. I just didn't know what it meant to "diet."

I did occasionally hear references to some elusive commodity known as "willpower." It was something that was hard to define but it was easily spotted. Thin people had willpower. You might never have observed them in a situation where they seemed to need to use it, but their thinness was all the evidence you needed to know that they had it. Fat people, on the other hand, clearly "lacked willpower," even if most of the time you could see them clearly depriving themselves. Like I said: I never quite figured it out.

By the time I was in junior high I was no longer wearing shorts or going swimming with friends because I knew my body was not slender and lovely like those of my friends. I was never part of the "in" group. I was never part of ***any*** group—always

just on the periphery. I knew that my body would not allow me full membership in any group that I would care to belong to.

So I found other ways to make my way in the world. I made good grades, but I wasn't part of the "intelligentsia" at my high school—the ones taking physics and trigonometry and vying for valedictorian and National Merit scholarships. I was in choir, but I wasn't a soloist. I was in speech and drama, and I loved theatre, so I got to play most of the mothers and grandmothers in the school plays.

My mother, though, thought I was very smart and talented. She often told me: "If you could just lose weight, you could be anything you want to be."

If you could just lose weight, you could be anything you want to be.

I know she meant that as praise, and as an attempt to be encouraging and motivating. But—though I know this is not what she meant—here's what I heard: Since you are fat, you cannot be anything you want to be. You can be something. But you can't be anything you'd really ***want*** to be.

It explained a lot to me: Because I'm fat. That's why I can't . . .

In a weird sort of way, being heavy was both the bane of my existence and my ultimate protection. It did, indeed, keep me from doing-and-being some of the things I thought I wanted to do-and-be. But it also allowed me a convenient explanation for anything at which I failed.

Didn't get chosen for homeroom rep to the Student Council? Because I'm fat.

Didn't get invited to the dance? Because I'm fat.

Didn't get chosen to be a cheerleader? Because I'm fat. Though really, that was because at the end of the last cheer, in the final round of the competition, I decided, at the last second, not to do the last jump. The cheerleading sponsor told me that was the reason I wasn't chosen; she asked, sadly, "Why didn't you do that last jump?!!" But you know what? Here's the truth. I remember it very clearly. At the moment when I was to do that jump, this is what I thought: "What's the point? I'll never be chosen. I'm fat."

I won't even bore you by detailing all the diets I've been on in my adult life. Like my friend Mary Frances, I, too, "have lost 10,000 pounds, but it's the same 30 over and over and over." Only in my case it was 30 at first, then 50, then 75, then 100. No kidding. I did manage to become very thin once, basically flirting with anorexia. I often joke that "I was thin once. It was on May 23, 1973, from about 6:35 a.m. until I ate breakfast. But I may be a day off on that."

I also won't bore you by detailing all the emotional struggle that being overweight and obese has meant to me. Or all the friendships I have not pursued because I knew I was unacceptable for human companionship. Or the relationships I've fractured because I couldn't believe anyone could actually love me: I'm ***fat! Can't you see? I'm FAT!!!***

I will tell you this: For most of my life, I have felt that I owe everyone an apology for taking up so much space on the planet.

One year, early in my teaching career, I got a student evaluation that has stuck with me. There was a question on the form that said something like, "What could this instructor do to improve his or her teaching?" And this student wrote: "Loose weight."

Of course, it was a misspelling. But really, isn't that the problem? "Loose" weight? How dare me allow all this *loose weight* to offend anyone's sensibilities, to infringe on anyone's otherwise serene life?

And so, I feel the need to apologize. To family. To friends. To strangers. Even to doctors.

I can think of several times I have felt that way during a medical visit, but one that stands out in my mind was about spring of, maybe, 1995? Somewhere around there. And I realized that I had been procrastinating in getting a well-woman check for several years. I don't know how long it had been since I'd had one. Several years. And we had had a change in our insurance coverage at work, so I had to find a new ob-gyn. And I'd been thinking for some time that it might be something that I would like, to have a female ob-gyn. I'm not exactly sure why I thought that would be an improvement. I think I was expecting that perhaps a woman would understand a professional woman, and the stresses and challenges of being a professional woman, and balancing family and career and all that sort of thing. And somehow that seemed important to me that my doctor be someone who could empathize with those kinds of issues. So I got a referral to a woman ob-gyn from my general practitioner, and she was very highly regarded by the medical community in our city, and by other patients that I talked to later.

And I was really excited! I was looking forward to the appointment. I was feeling good about finally getting this done, and feeling good about having a new doctor, and thinking that maybe there would be some change that would happen, you know, after I talked to her, that I would somehow get some sort of help that I needed.

So I went to the appointment and, of course, first the nurse comes in and takes your history and does your blood pressure and all of that sort of preliminary thing. And when she was taking my blood pressure she came up with a higher reading than was typical for me. And I was kind of surprised by that, so she took it another time or two and then—the whole time she was acting very frustrated, kind of, "hhhh", making little, sounds that made me think that she was really kind of distressed. And she left the room for a few minutes and then she came back and she said, "Well, we're just going to have to go with the reading that we've got, because I can't find the blood pressure cuff that we have—we don't use it very often so I'm not sure where it is—but it's especially designed for large women. So I think maybe the reading is because this blood pressure cuff that we're using for you is really too small, and maybe it's because you're nervous since you haven't seen a doctor in some time."

And I remember thinking that I felt like a freak. I was heavy; there's no question about that. But I had never felt freakishly heavy. But I did at that moment. *I was so big that a normal blood pressure cuff would not fit around my arm*.

So then the doctor came into the room and she was performing the exam. And the whole time she was performing it, she was kind of, "hh." I don't know how to describe it. She wasn't rude. But there came a point during the exam where I had the sense from the kind of sounds she was making—the kind of sounds that people make when they're doing something physical that requires a lot of effort, so they have these little kind of "unhhh, unhhh," little exhaled breaths that you do when you're exerting a

lot of effort on something? And then she said, “I’m afraid I’m not going to be able to do a very good exam on you, because it’s very difficult to palpate fat.”

And I remember when she said that, that I felt so terribly sorry that I was putting her through that. I realized that touching me was disgusting to her. I felt like I was an unpleasant object that she had to deal with. And that she was doing her best to be nice about it but really, deep down, she was just terribly disgusted to have to be touching me. And I don’t really know that it was anything that she did. I couldn’t even say that I think now that she necessarily was. But that’s how I felt at the time. I felt like she was disgusted with me. Or not disgusted with *me*, but disgusted with having to *touch* me.

So, the next time I had a well-woman check was five years later in the summer of 2000. My general practitioner’s nurse practitioner did my well-woman check and she was very good. But it came back with a suspicious result on my Pap smear. So I had to take some medication for several months and then go back for a follow-up Pap smear, and this time I had to have another doctor because of insurance carrier issues. And I really couldn’t stand him. And I had a very definite impression when I left his office that he was very worried. There were things that he said and things that he didn’t say that made it sound like he was very deeply concerned.

So for several weeks while I waited for the results of that Pap smear, that follow-up Pap smear, I remember thinking, “It’s my own fault. I didn’t get a well-woman check for so many years, and if this Pap smear comes back bad, it’s my own fault, because I didn’t go to the doctor.” But then I thought, “It’s so hard to go to the doctor. Because you feel like you’re so disgusting.” . . . But the Pap smear came back okay.

I'd like to tell you that since that visit I have been much more diligent in making sure that I have my screenings at the recommended intervals. And really, I have improved some. But not enough. For example: Right now, it has been 2 years since my last Pap and closer to 3 since my last mammogram. What am I waiting for? Well, I need to lose some weight first. I was doing so well the last time I went. My doctor congratulated me on the weight I had lost since the previous visit. I can't disappoint him by showing up now having gained what I've gained. Don't you know?

If you were an overweight or obese woman, you'd know.

So yes, I have fought this battle for most of 60 years. My experiences have been the catalyst for my curiosity about how other overweight and obese women feel about themselves, about their weight, about their bodies, and about interacting with others—particularly the healthcare practitioners whom we are supposed to be looking to for help in remaining healthy.

I talked to 23 amazing women in my formal research, and many others informally who expressed interest in what I was doing, sometimes because of their own weight history and other times because of the struggles of someone they cared about. I have emerged from this process having experienced a type of transformation, and with the conviction that what I have learned must now direct what I do in my future. I do not know yet precisely what shape that might take, but "advocacy" might capture some of it.

Here's something interesting. Many years ago, my mother enclosed in a letter the horoscope that had appeared in her local newspaper on my birthday. It said something about "If you were born on this day," and it went on to claim that I was a natural teacher,

that I had a particular affinity for communication and the arts, and that in my future I would do something that would be helpful especially for women.

I don't believe in horoscopes, but I have remembered that all these years. And now, as a result of what I have learned from my 23 courageous ladies, I want to take a message to other overweight women, to the people who live with them, to the people who merely encounter them, and to the people who help them take care of their health. That message will undoubtedly become sharper in the months and years ahead, but for now, here is part of what I want to say to all of them. It is most succinctly captured in this statement by two scholars, Lynn McAfee and Miriam Berg:[14]

1. Diets don't work. There is no successful treatment for individuals that takes off weight and keeps it off.
2. Ideas of attractiveness change throughout history. Today's cultural obsession with extreme thinness is damaging to people's self-esteem and, indeed, to their physical health.
3. People should be judged on the basis of their actions and their character, not on the basis of their weight.

As for me, I have decided to embrace some form of acceptance so I can move on with my quest. I choose to be mindful of my health but not obsessed with weight. I thank my 23 beautiful ladies for helping me get there. In sharing their pain with me, they helped me to recognize the senselessness of allowing myself to go through life feeling perpetually "othered." I learned that I share a great deal with them and with all of our

[14] See McAfee & Berg, 2005, p. 286.

"sisters" who are struggling to feel worthy in a society that demeans and discriminates on the basis of any physical difference. I know my ladies are worthy; so I must conclude that perhaps I am as well.

I don't know if I'll ever lose another pound. I've decided, though, that I don't really need to be thin to do anything I want to do. True: I didn't get to be a ballerina. But it turns out my neck was too short anyway.

I think I will adopt the attitude of Ruth Raymond Thone, the former First Lady of Nebraska and author of the book *Fat—A Fate Worse Than Death?*[15] She writes:

> I may be self-justifying, but I am also following the passionate urgings within myself to rail against the pain and injustice caused in this world by defining women by what they look like, by judging others by a narrow, ridiculous, random, irrational standard of what is attractive, by trying to arrange a world that shows only what our eyes have been trained to like and approve of.
>
> The long road for me is obviously to love this old, heavy body, to clothe it happily and comfortably, and, as we say, "get on with it," not leaving anything out of the living of this strange awkward journey. I accept no paeans to my beautiful spirit, as a way of ignoring my body or making up for its failings. My spirit may be beautiful, but I live in this physical body and need to discover what it has to teach me in this lifetime, especially, I hope, gratitude for its longevity and power---and beauty.

[15] See Thone, 1995, p. 85.

REFERENCES

Abid, O., Galuska, D. A., Khan, L. K., Gillespie, C., Ford, E. S., & Serdula, M. K. (2005). Are healthcare professionals advising obese patients to lose weight: A trend analysis [Abstract]. *Medscape General Medicine, 7* (4), 10. Retrieved June 15, 2009 from http://cme.medscape.com/viewarticle/514048

Adams, C. H., Smith, N. J., Wilbur, D. C., & Grady, K. E. (1993). The relationship of obesity to the frequency of pelvic examinations: Do physician and patient attitudes make a difference? *Women & Health, 20* (2), 45-57. doi**:**10.1300/J013v20n02_04

Adeghate, E., Schattner, P., & Dunn, E. (2006). An update on the etiology and epidemiology of diabetes mellitus [Abstract]. *Annals of the New York Academy of Sciences, 1084*, 1-29.

Adelman, M. B., & Frey, L. R. (1997). *The fragile community: Living together with AIDS*. Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Ahmed, S., Lemkau. J., & Birt, S. (2002). Toward sensitive treatment of obese patients [Electronic version]. *Family Practice Management, 9* (1), 25-28.

Albright, A. C. (1997). *Choreographing difference: The body and identity in contemporary dance*. Hanover, NH: University Press of New England.

American Heart Association (2010). *Women and cardiovascular diseases—Statistics 2010*. Retrieved from http://www.americanheart.org/downloadable/heart/ 1260905040318F S10 WM10.pdf

Anderson, D. A., & Wadden, T. A. (2004). Bariatric surgery patients' views of their physicians' weight-related attitudes and practices. *Obesity Research, 12* (10), 1587-1595.

Arterburn, D. E., Maciejewski, M. L., & Tsevat, J. (2005). Impact of morbid obesity on medical expenditures in adults. *International Journal of Obesity, 29* (3), 334-339. doi:10.1038/sj.ijo.0802896

Aruguete, M. S., Yates, A., & Edman, J. (2006). Gender differences in attitudes about fat. *North American Journal of Psychology, 8* (1), 183-192.

Asplin, J. R. (2009). Obesity and urolithiasis [Abstract]. *Advances in Chronic Kidney Disease, 16* (1), 11-20.

Atkinson, P. (1997). Narrative turn or blind alley? *Qualitative Health Research, 7* (3), 325-344.

Bailey, J. M., Gaulin, S., Agyei, Y., & Gladue, B. A. (1994). Effects of gender and sexual orientation on evolutionarily relevant aspects of human mating psychology. *Journal of Personality and Social Psychology, 66* (6), 1081-1093.

Barker, J. (2003, December 2). Ho Ho? Large belly's no joke; Santa Claus may look better the rounder he is around the middle, but no one else does. And someone should tell him he's setting himself up for diabetes and hypertension. *The Gazette* (Montreal, Quebec), p. D5.

Baumeister, H., & Harter, M. (2007). Mental disorders in patients with obesity in comparison with healthy probands. *International Journal of Obesity, 31*, 1155–1164. doi:10.1038/sj.ijo.0803556

Befort, C. A., Greiner, A., Hall, S., Pulvers, K. M., Nollen, N. L., Charbonneau, A., et al. (2006). Weight-related perceptions among patients and physicians: How well do physicians judge patients' motivations to lose weight? *Journal of General Internal Medicine, 21* (10), 1086-1090.

Befort, C. A., Thomas, J. L., Daley, C. M., Rhode, P. C., & Ahluwalia, J. S. (2008). Perceptions and beliefs about body size, weight, and weight loss among obese African-American women: A qualitative inquiry. *Health Education & Behavior, 35* (3), 410-426.

Belenky, M. F., Clinchy, B. M., Goldberger, N. R., & Tarule, J. M. (1997). *Women's ways of knowing* (10th anniversary edition). New York, NY: Basic Books.

Berger, P. L., & Luckmann, T. (1966). *The social construction of reality: A treatise in the sociology of knowledge*. New York, NY: Doubleday.

Bertakis, K. D., & Azari, R. (2005). The impact of obesity on primary care visits. *Obesity Research, 13* (9), 1615-1623. doi:10.1038/oby.2005.198

Block, J. P., DeSalvo, K. B., & Fisher, W. P. (2003). Are physicians equipped to address the obesity epidemic?: Knowledge and attitudes of internal medicine residents. *Preventive Medicine, 36* (6), 669-675. doi:10.1016/S0091-7435(03)00055-0

Bloom, L. R. (1996). Stories of one's own: Nonunitary subjectivity in narrative representation. *Qualitative Inquiry, 2* (2), 176-197.

Blumberg, P., & Mellis, L. P. (1985). Medical students' attitudes toward the obese and the morbidly obese. *International Journal of Eating Disorders, 14* (2), 169-175. doi:10.1002/1098-108X(198505)4:2<169::AID-EAT2260040204>3.0.CO;2-F

Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Berkeley, CA: University of California Press.

Bordo, S. (1993). *Unbearable weight: Feminism, western culture, and the body*. Berkeley, CA: University of California Press.

Bowman, M. (1998). Toward a curriculum in performance studies. In S.J. Dailey (Ed.), *The future of performance studies: Visions and revisions* (pp. 189-194). Annandale, VA: National Communication Association.

Brannen, C., & Petite, K. (2008). An alternative framework for understanding women's caregiving stress: A qualitative application of the ways of coping model. *Journal of Health Psychology, 13* (3), 355-365. doi:10.1177/1359105307088140

Brody, H. (1987). *Stories of sickness*. New Haven, CT: Yale University Press.

Brown, C., & Jasper, K. (1993). Preface. In C. Brown and K. Jasper (Eds.), *Consuming passions: Feminist approaches to weight preoccupation and eating disorders* (pp. 11-14). Toronto, ON: Second Story Press.

Brownell, K. D., Puhl, R. M., Schwartz, M. B., & Rudd, L. (Eds.). (2005). *Weight bias: Nature, consequences, and remedies.* New York, NY: The Guilford Press.

Brownmiller, S. (1984). *Femininity*. New York, NY: Linden Press/Simon & Schuster.

Bruner, J. (1990). *Acts of meaning*. Cambridge, MA: Harvard University Press.

Bruner, J. (2002). Narratives of human plight: A conversation with Jerome Bruner. In R. Charon & M. Montello (Eds.), *Stories matter: The role of narrative in medical ethics* (pp. 3-9). New York, NY: Routledge.

Buchanan, K. S. (1993). Creating beauty in blackness. In C. Brown & K. Jasper (Eds.), *Consuming passions: Feminist approaches to weight preoccupation and eating disorders* (pp. 36-51). Toronto, ON: Second Story Press.

Bullis, C., & Bach, B. W. (1996). Feminism and the disenfranchised: Listening beyond the "other". In E. B. Ray (Ed.), *Communication and disenfranchisement: Social health issues and implications* (pp. 3-28). Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Cachelin, F. M., Rebeck, R. M., Chung, G. H., & Pelayo, E. (2002). Does ethnicity influence body-size preference?: A comparison of body image and body size. *Obesity Research, 10* (3), 158-166. doi:10.1038/oby.2002.25

Cahill, S. E., Eggleston, R. (1995). Reconsidering the stigma of physical disability: Wheelchair use and public kindness. *Sociological Quarterly, 36* (4). 681-698. Stable URL: http://www.jstor.org/stable/4121347

Calle, E. E., Rodriguez, C., Walker-Thurmond, K., & Thun, M. J. (2003). Overweight, obesity, and mortality from cancer in a prospective cohort of US adults. *New England Journal of Medicine, 348* (17), 1625-1638.

Carmichael, A. R. (2006). Obesity as a risk factor for development and poor prognosis of breast cancer. *BJOG: An International Journal of Obstetrics and Gynaecology. 113* (10), 1160-1166.

Carpenter, K. M., Hasin, D. S., Allison, D. B., & Faith, M. S. (2000). Relationship between obesity and DSM-IV major depression disorder, suicide ideation, and suicide ideation and suicide attempts: Results from a general population study. *American Journal of Public Health, 90* (2), 251-257.

Carter, R., & Watenpaugh, D. E. (2008). Obesity and obstructive sleep apnea: Or is it OSA and obesity? *Pathophysiology, 15* (2), 71-77. doi:10.1016/j.pathophys.2008 .04.009

Centers for Disease Control and Prevention (2009). *Defining overweight and obesity.* Retrieved from http://www.cdc.gov/obesity/defining.html

Chang, H. (2008). *Autoethnography as method*. Walnut Creek, CA: Left Coast Press.

Charmaz, K. (1994). Identity dilemmas of chronically ill men. *Sociological Quarterly, 35* (2), 269-288. Stable URL: http://www.jstor.org/stable/4121547

Charmaz, K. (1999). Stories of suffering: Subjective tales and research narratives. *Qualitative Health Research, 9* (3), 362-382. doi:10.1177/104973239900900306

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 509-535). Thousand Oaks, CA: Sage.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage.

Charmaz, K., & Rosenfeld, D. (2006). Reflections of the body, images of self: Visibility and invisibility in chronic illness and disability. In D. D. Waskul & P. Vannini (Eds.), *Body/embodiment: Symbolic interaction and the sociology of the body* (pp. 35-49). Hampshire, England: Ashgate Publishing Limited.

Charon, R., & Montello, M. (Eds.). (2002). *Stories matter: The role of narrative in medical ethics.* New York, NY: Routledge.

Chernin, K. (1981). *The obsession: Reflections on the tyranny of slenderness*. New York, NY: Harper and Row.

Chung, S. J., Kim, D., Park, M. J., Kim, Y. S., Jung, H. C., & Song, I. S. (2008). Metabolic syndrome and visceral obesity as risk factors for reflux oesophagitis: A cross-sectional case–control study of 7078 Koreans undergoing health check-ups. *Gut: An International Journal of Gastroenterology and Hepatology, 54* (10), 1360-1365. doi:10.1136/gut.2007.147090

Clark, M. C., & Sharf, B. F. (2007). The dark side of truth(s): Ethical dilemmas in researching the personal. *Qualitative Inquiry, 13* (3), 399-416.

Coles, R. (1989). *The call of stories: Teaching and the moral imagination*. Boston, MA: Houghton Mifflin.

Conquergood, D. (2002). Performance studies: Interventions and radical research. *The Drama Review, 46* (2), 145-156.

Conrad, P., & Schneider, J. W. (1992). *Deviance and medicalization: From badness to sickness*. Philadelphia, PA: Temple University Press.

Cooley, C. H. (1922). *Human nature and the social order*. New York, NY: Charles Scribner's Sons.

Crandall, C. S., & Reser, A. H. (2005). Attributions and weight-based prejudice. In K. D. Brownell, R. M. Puhl, M. B. Schwartz, and L. Rudd (Eds.), *Weight bias: Nature, consequences, and remedies* (pp. 83-96). New York, NY: The Guilford Press.

Cuengros, J. A., Christensen, A. J., Cunningham, C., Hillis, S. L., & Kaboli, P. J. (2009). Patient preferences for and reports of provider behavior: Impact of symmetry on patient outcomes. *Health Psychology, 28* (6), 660-667.

Davis, N. J., Emerenini, A., & Wylie-Rosett, J. (2006). Obesity management: Physician practice patterns and patient preference. *The Diabetes Educator, 32* (4), 557-561. doi:10.1177/0145721706290437

Danaei, G., VanderHoorn, S., Lopez, A. D., Murray, C. J. L., & Ezzati, M. (2005). Causes of cancer in the world: Comparative risk assessment of nine behavioural and environmental risk factors. *Lancet, 366*, 1784-1793. doi:10.1016/S0140-6736(05)67725-2

Daviglus, M. L. (2005). Health care costs in old age are related to overweight and obesity earlier in life. *Health Affair (Web Exclusive Supplement 2), 24*, R97-R100. doi:10.1377/hlthaff.W5.R97

Davis, N., Emerenini, A., & Wylie-Rosett, J. (2006). Obesity management: Physician practice patterns and patient preference. *Diabetes Educator, 32* (4), 557-561.

Dennis, L. K., Lowe, J. B., Lynch, C. F., & Alavanja, M. C. R. (2008). Cutaneous melanoma and obesity in the Agricultural Health Study. *Annals of Epidemiology, 18* (3), 214-221. doi:10.1016/j.annepidem.2007.09.003

Denzin, N. K. (2000). The practices and politics of interpretation. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 897-922). Thousand Oaks, CA: Sage.

Dobbins, J. F. (2007). Connections of care: Relationships and family caregiver narratives. In R. Josselson, A. Lieblich, & D. McAdams (Eds.), *The meaning of others: Narrative studies of relationships* (pp. 189-211). Washington, DC: American Psychological Association. doi:10.1037/11580-008

Dong, C., Li, W. D., Li, D., & Price, R. A. (2006). Extreme obesity is associated with attempted suicides. *International Journal of Obesity, 30* (2), 388-390. doi:10.1038/sj.ijo.0803119

Downey, M, & Stern, J. S. (2003). The importance of being earnest. *The Lancet, 362* (Supplement 1), S42-S43.

Durant, N. H., Bartman, B., Person, S. D., Collins, F., & Austin, S. B. (2009). Patient provider communication about the health effects of obesity. *Patient Education and Counseling, 75* (1), 53-57. doi:10.1016/j.pec.2008.09.021

Early, J. L., & Johnston, J. A. (2005). Improving medical practice. In K. D. Brownell, R. M. Puhl, M. B. Schwartz, & L. Rudd (Eds.), *Weight bias: Nature, consequences, and remedies* (pp. 223-233). New York, NY: The Guilford Press.

Edgley, C. (2006). The fit and healthy body: Consumer narratives and the management of postmodern corporeity. In D. D. Waskul & P. Vannini (Eds.), *Body/embodiment: Symbolic interaction and the sociology of the body* (pp. 231-246). Hampshire, England: Ashgate Publishing Limited.

Ellingson, L. L. (1998). "Then you know how I feel": Empathy, identification, and reflexivity in field work. *Qualitative Inquiry, 4* (4), 492-514.

Ellingson, L. L. (2002). The roles of companions in the geriatric oncology patient-interdisciplinary health care provider interaction. *Journal of Aging Studies, 16* (4), 361-382.

Ellingson, L. L. (2005). *Communicating in the clinic: Negotiating frontstage and backstage teamwork.* Cresskill, NJ: Hampton Press.

Ellingson, L. L. (2008a). Communication within the comprehensive geriatric assessment. In K. Wright & S. Moore (Eds.), *Applied communication: A sourcebook* (pp. 229-254). Creskill, NJ: Hampton Press.

Ellingson, L. L. (2008b). Patients' inclusion of spirituality within the comprehensive geriatric assessment process. In M. Wills (Ed.), *Spirituality and health communication* (pp.67-85). Creskill, NJ: Hampton Press.

Ellingson, L. L. (2009). *Engaging crystallization in qualitative research: An introduction*. Thousand Oaks, CA: Sage.

Ellis, C. (1995). *Final negotiations: A story of love, loss and chronic illness*. Philadelphia, PA: Temple University Press.

Ellis, C. (2004). *The ethnographic I: A methodological novel about autoethnography*. Walnut Creek, CA: AltaMira Press.

Ellis, C., & Bochner, A. P. (2000). Autoethnography, personal narrative, reflexivity: Researcher as subject. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 733-768). Thousand Oaks, CA: Sage.

Elmer-DeWitt, P. (2004). A summit on obesity. *Time, 163* (18), 8. Retrieved from: http://www.time.com/time/magazine/0,9263,1101040503,00.html

Ensler, E. (2004). *The good body*. New York, NY: Villard.

Epstein, L., & Ogden, J. (2005). A qualitative study of GPs' views of treating obesity. *The British Journal of General Practice: The Journal of the Royal College of General Practitioners, 55* (519), 750-754.

Estroff, S. E. (1995). Whose story is it anyway?: Authority, voice, and responsibility in narratives of chronic illness. In S. K. Toombs, D. Barnard, & R. A. Carson (Eds.), *Chronic illness: From experience to policy* (pp. 77-104). Bloomington, IN: Indiana University Press.

Evans, E. (1999). Why should obesity be managed? The obese individual's perspective. *International Journal of Obesity, 23* (5), 3.

Fabricatore, A. N., Wadden, D. A., & Foster, G. D. (2005). Bias in healthcare settings. In K. D. Brownell, R. M. Puhl, M. A. Schwartz, and L. Rudd (Eds.), *Weight bias: Nature, consequences, and remedies* (pp. 29-41). New York, NY: The Guilford Press.

Fadiman, A. (1997). *The spirit catches you and you fall down: A Hmong child, her American doctors, and the collision of two cultures.* New York, NY: Farrar, Straus & Giroux.

Feingold, A., & Mazzella, R. (1998). Gender differences in body image are increasing. *Psychological Science, 9* (3), 190-195. doi:10.1111/1467-9280.00036

Field, A., Coakley, E., Must, A., Spadano, J., Laird, N., Dietz, W., et al. (2001). Impact of overweight on the risk of developing chronic diseases during a 10-year period. *Archives of Internal Medicine, 161* (3), 1581-1586.

Fleury, J., Thomas, T., & Ratledge, K. (1997). Promoting wellness in individuals with coronary heart disease. *Journal of Cardiovascular Nursing, 11* (3), 26-42.

Fontaine, K., Faith, M., Allison, D., & Cheskin, I. J. (1998). Body weight and health care among women in the general population. *Archives of Family Medicine, 7* (4), 381-384.

Fontaine, K. R., Heo, M., & Allison, D. B. (2001). Body weight and cancer screening among women. *Journal of Women's Health and Gender-Based Medicine, 10* (5), 463-470.

Foreyt, J. P. (1995). Weight loss programs for minority populations. In K. D. Brownell & C. G. Fairburn (Eds.), *Eating disorders and obesity: A comprehensive handbook* (pp. 536-540). New York, NY: The Guilford Press.

Frank, A. (1998). A multidisciplinary approach to obesity management: The physician's role and team care alternatives. *Journal of the American Dietetic Association, 10* (Supplement 1), S44-S48.

Frank, A. W. (1991). *At the will of the body: Reflections on illness.* Boston, MA: Houghton Mifflin Company.

Frank, A. W. (1995). *The wounded storyteller*. Chicago, IL: University of Chicago Press.

Frank, A. W. (2002). “How can they act like that?”: Clinicians and patients as characters in each other’s stories. *The Hastings Center Report, 32* (6), 14-22.

Freedland, S. J., Wen, J., Wuerstle, M., Shah, A., Lai, D., Moalej, B., et al. (2008). Obesity is a significant risk factor for prostate cancer at the time of biopsy. *Urology, 72* (5), 1102-1105. doi:10.1016/j.urology.2008.05. 044

Freedman, R. (1986). *Beauty bound*. Lexington, MA: Lexington Books.

Freedman, R. E. K., Carter, M. M., Sbrocco, T., & Gray, J. J. (2004). Ethnic differences in preferences for female weight and waist-to-hip ratio: A comparison of African-American and White American college and community samples. *Eating Behaviors, 5* (3), 191-198.

Frey, W. C., & Pilcher, J. (2003). Obstructive sleep-related breathing disorders in patients evaluated for bariatric surgery [Abstract]. *Obesity Surgery, 13* (5), 676-683. doi**:**10.1381/096089203322509228

Geist-Martin, P., Ray, E. B., and Sharf, B. F. (2002). *Communicating health: Personal, political, and cultural complexities*. Belmont, CA: Wadsworth.

Gergen, M. M., & Gergen, K. J. (2000). Qualitative inquiry: Tensions and transformations. In N. K. Denzin & Y. S. Lincoln (Eds.) *Handbook of qualitative research* (2nd ed., pp. 1025-1046). Thousand Oaks, CA: Sage.

Ghandehari, H., Le, V., Kamal-Bahl, S., Bassin, S. L., & Wong, N. D. (2009). Abdominal obesity and the spectrum of global cardiometabolic risks in US adults. *International Journal of Obesity, 33* (2), 239–248. doi:10.1038/ijo.2008.252

Glaser, B. G. (1998). *Doing grounded theory: Issues and discussions*. Mill Valley, CA: The Sociology Press.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago, IL: Aldine.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice Hall.

Goodall, Jr., H. L. (1998, November). *Notes for the autoethnography and autobiography panel, NCA.* A paper presented at the National Communication Association Convention in New York City.

Goode, E. (1969). Marijuana and the politics of reality. *Journal of Health and Social Behavior, 10* (2), 83-94.

Grabe, S., & Hyde, J. S. (2006). Ethnicity and body dissatisfaction among women in the United States: A meta-analysis. *Psychological Bulletin, 132* (4), 622-640.

Grainge, M. J., West, J., Solaymani-Dodaran, M., Aithal, G. P., & Card, T. R. (2009). The antecedents of biliary cancer: A primary case-control study in the United Kingdom. *British Journal of Cancer, 100* (1), 178-180. doi:10.1038/sj.bjc.6604765

Grover, V. P., Keel, P. K., & Mitchell, J. P. (2003). Gender differences in implicit weight identity. *The International Journal of Eating Disorders, 34* (1), 125-135.

Gupta, S. (2004a, September 6). Feeling the pressure? One out of three American adults has hypertension. What you need to know. *Time*, p. 102.

Gupta, S. (2004b, December 6). Body and mind: Brain scans suggest a link between dementia and long-term obesity. *Time*, p. 122.

Hall, J. A., Epstein, A. M., DeCiantis, M. L., & McNeil, B. J. (1993). Physicians' liking for their patients: More evidence for the role of affect in medical care. *Health Psychology, 12* (2), 140-146.

Harter, L. M., Japp, P. M., & Beck, C. S. (Eds.). (2005). *Narratives, health, and healing: Communication theory, research, and practice.* New York, NY: Routledge.

Harter, L. M., & Bochner, A. P. (2009). Healing through stories: A special issue on narrative medicine. *Journal of Applied Communication Research, 37* (2), 113-117.

Harvey, E. L., & Hill, A. J. (2001). Health professionals' views of overweight people and smokers. *International Journal of Obesity, 25* (8), 1253-1261.

Hayden, M. J., Dixon, J. B., Piterman, L., & O'Brien, P. E. (2008). Physician attitudes, beliefs and barriers towards the management and treatment of adult obesity: A literature review. *Australian Journal of Primary Health, 14* (3), 9-18. doi:10.1071.PY08031

Hebl, M. R., & Heatherton, T. F. (1998). The stigma of obesity in women: The difference is Black and White. *Personality and Social Psychology Bulletin, 24* (4), 417-426.

Hebl, M. R., & Xu, J. (2001). Weighing the care: Physicians' reactions to the size of the patient. *International Journal of Obesity, 25* (8), 1246-1252.

Hellmich, N. (2003, February 26). Belly full of danger. *USA Today*, p. 1D.

Heron, M. P., Hoyert, D. L., Murphy, S. L., Xu, J. Q., Kochanek, K. D., Tejada-Vera, B. (2009) Deaths: Final data for 2006. *National Vital Statistics Reports, 57* (14). Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_14.pdf

Hirshkowitz, M. (2008). The clinical consequences of obstructive sleep apnea and associated excessive sleepiness. *Journal of Family Practice (Aug 2008 Supplement), 57*, S9-S16.

Hoffman, J. L., Dundes, L., & Lemke, D. C. (2007). Reflections of the self: Comparing pressures on men and women to lose weight. *Agro Food Industry Hi-Tech, 18* (1), 27-28.

Holstein, J. A., & Gubrium, J. F. (1995). *The active interview*. Thousand Oaks, CA: Sage.

Houston, D. K., Ding, J., Nicklas, B. J., Harris, T. B., Lee, J. S., Nevitt, M. C., et al. (2009). Overweight and obesity over the adult life course and incident mobility limitations in older adults: The health, aging, and body composition study. *American Journal of Epidemiology, 169* (8), 927. doi:10.1093/aje/kwp007

Huff, J. L. (2001). A "horror of corpulence": Interrogating Bantingism and mid-nineteenth century fat-phobia. In J. E. Braziel & K. LeBesco (Eds.), *Bodies out of bounds: Fatness and transgression*. Berkeley, CA: University of California Press.

Janesick, V. J. (2000). The choreography of qualitative research design: Minuets, improvisations, and crystallization. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research*, (2nd ed., pp. 379-399). Thousand Oaks, CA: Sage.

Japp, P. M. & Japp, D. K. (2005). Desperately seeking legitimacy: Narratives of a biomedically invisible disease. In L. M. Harter, P. M. Japp, & C. S. Beck (Eds.), *Narratives, health, and healing: Communication theory, research, and practice* (pp. 107-130). Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Jutel, A. (2003). Pretty is as pretty does: An historical explanation for fat fixation. *Healthy Weight Journal, 17* (5), 68-72.

Klein, S., Burke, L. E., Bray, G. A., Blair, S., Allison, D. B., Pi-Sunyer, X., et al. (2004). Clinical implications of obesity with specific focus on cardiovascular disease: A statement for professionals from the American Heart Association Council on Nutrition, Physical Activity and Metabolism. *Circulation, 110*, 2952-2967. doi:10.1161/01.CIR.0000145546.97738.1E

Kleinman, A. (1988). *The illness narratives: Suffering, healing and the human condition*. New York, NY: Basic Books.

Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness, and care: Clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine, 88* (2), 251-258.

Ko, J. Y., Galuska, D. A., Zhang, J., Blanck, H. M., & Ainsworth, B. E. (2008). Weight loss advice US obese adults receive from health care professionals [Abstract]. *Preventive Medicine, 47* (6), 587-592. doi:10/1016/j.ypmed.2008.09.007

Koplan, J. P. (2005, April 29). Attempts to downplay obesity ignore dangers (editorial). *The Atlanta Journal-Constitution*, p. 19A.

Kral, J. G. (1995). Surgical interventions for obesity. In K. D. Brownell & C. G. Fairburn (Eds.), *Eating disorders and obesity: A comprehensive handbook* (pp. 510-515). New York, NY: The Guilford Press.

Kuhn, T. S. (1962). *The structure of scientific revolutions*. Chicago, IL: University of Chicago Press.

Labov, W., & Waletzky, J. (1997). Narrative analysis: Oral versions of personal experience. *Journal of Narrative and Life History, 7* (1), 3-38.

Lakdawalla, D. N., Goldman, D. P., & Shang, B. (2005). The health and cost consequences of obesity among the future elderly. *Health Affairs (Web Exclusive Supplement 2), 24*, R30-R41.

Lamm, N. (2001). It's a big fat revolution. In B. Findlen (Ed.), *Listen up: Voices from the next feminist generation* (New expanded edition, pp. 133-141). New York, NY: Seal Press.

Langellier, K. M. (1999). Personal narrative, performance, performativity: Two or three things I know for sure. *Text & Performance Quarterly, 19* (2), 125-144.

Langellier, K. M. (2009). Performing narrative medicine. *Journal of Applied Communication Research, 37* (2), 151-158.

Langellier, K. M., & Peterson, E. E. (2006). Shifting contexts in personal narrative performance. In D. S. Madison & J. Hamera (Eds.), *The Sage handbook of performance studies* (pp. 151-168). Thousand Oaks, CA: Sage.

Leavy, P. (2009). *Method meets art: Arts-based research practice*. New York, NY: The Guilford Press.

LeBesco, K., & Braziel, J. E. (2001). Editors' introduction. In J. E. Braziel & K. LeBesco (Eds.), *Bodies out of bounds: Fatness and transgression* (pp. 1-15). Berkeley, CA: University of California Press.

Leitzman, M. F., Koebnick, C., Danforth, K. N., Brinton, L. A., Moore, S. C., Hollenbeck, A. R., et al. (2009). Body mass index and risk of ovarian cancer. *Cancer, 115* (4), 812-822. doi:10.1002/cncr.24086

Lemonick, M. D. (2004, December 27). The year of obesity. *Time,* p. 186.

Lincoln, Y. S. & Guba, E. G. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 163-188). Thousand Oaks, CA: Sage.

Linde, C. (1993). *Life stories: The creation of coherence*. New York, NY: Oxford University Press.

Lindlof, T. R. (1995). *Qualitative communication research methods*. Thousand Oaks, CA: Sage.

Lokken, K., Ferraro, F. R., Kirchner, T., & Bowling, M. (2003). Gender differences in body size dissatisfaction among individuals with low, medium, or high levels of body focus. *Journal of General Psychology, 139* (3), 305-310.

Loureiro, M. L., & Nayga, R. M., Jr. (2006). Obesity, weight loss, and physician's advice. *Social Science & Medicine, 62* (10), 2458-2468. doi:10.1016/j.socscimed.2005.1 1.011

Luo, J., Margolis, K. L., Adami, H., LaCroix, A., & Ye, W. (2008). Obesity and risk of pancreatic cancer among postmenopausal women: The Women's Health Initiative (United States). *British Journal of Cancer, 99* (3), 527-531. doi:10.1038/sj.bjc.6604487

Macdonald, M. (1995). *Representing women: Myths of femininity in the popular media*. London, England: Edward Arnold.

MacInnis, B. (1993). Fat oppression. In C. Brown & K. Jasper (Eds.), *Consuming passions: Feminist approaches to weight preoccupation and eating disorders* (pp. 69-79). Toronto, ON: Second Story Press.

Madison, D. S. (1999). Performing theory/embodied writing. *Text & Performance Quarterly, 19* (2), 107-124.

Madison, D. S., & Hamera, J. (2006). Performance studies at the intersections. In D. S. Madison & J. Hamera (Eds.), *The Sage handbook of performance studies* (pp. xi-xxv). Thousand Oaks, CA: Sage.

Mather, A. A., Cox, B. J., Enns, M. W., & Sareen, J. (2008). Associations between body weight and personality disorders in a nationally representative sample. *Psychosomatic Medicine, 70* (9), 1012-1019. doi:10.1097/psy.0b013e318189a 930

Mather, A. A., Cox, B. J., Enns, M. W., & Sareen, J. (2009). Associations of obesity with psychiatric disorders and suicidal behavior in a nationally representative sample. *Journal of Psychosomatic Research, 66* (4), 277-285. doi:10.1016/j/jpsychores. 2008.09.008

McAfee, L. M., & Berg, M. (2005). Advocacy. In K. D. Brownell, R. M. Puhl, M. B. Schwartz, & L. Rudd (Eds.), *Weight bias: Nature, consequences, and remedies* (pp. 285-293). New York, NY: The Guilford Press.

Mead, G. H. (1962). *Mind, self, and society: From the standpoint of a social behaviorist.* Chicago, IL: University of Chicago Press.

Miller, K. I. (2005). *Communication theories: Perspectives, processes, and contexts* (2nd ed.). New York, NY: McGraw-Hill.

Miller, K. I., Shoemaker, M. M., Willyard, J., & Addison, P. (2008). Providing care for elderly parents: A structurational approach to family caregiver identity. *Journal of Family Communication, 8* (1), 19-43. doi:10.1080/15267430701389947

Miller, L. C., & Taylor, J. (2006). The constructed self: Strategic and aesthetic choices in autobiographical performance. In D. S. Madison & J. Hamera (Eds.), *The Sage handbook of performance studies* (pp. 169-187). Thousand Oaks, CA: Sage.

Mishler, E. G. (1986). *Research interviewing: Context and narrative*. Cambridge, MA: Harvard University Press.

Monaghan, L. F. (2006). Corporeal indeterminancy: The value of embodied, interpretive sociology. In D. D.Waskul & P. Vannini (Eds.), *Body/embodiment: Symbolic interaction and the sociology of the body* (pp. 125-140). Hampshire, England: Ashgate Publishing Limited.

Morgan, J. F. (2000). From Charles Atlas to Adonis complex—Fat is more than a feminist issue. *The Lancet, 356* (9239), 1372-1373.

Morrow, G. (2004). Metabolic syndrome identified as another danger of obesity. *The Columbus Dispatch*, July 6, 7A.

Must, A., Spadano, J., Coakley, E. H., Field, A. E., Colditz, G., & Dietz, W. (1999). The disease burden associated with overweight and obesity. *The Journal of the American Medical Association, 282* (16), 1523-1529.

National Institutes of Health (2008). Obesity. In *Medline Plus Medical Encyclopedia*. Retrieved from http://www.nlm.nih.gov/medlineplus/ency/article/007297.htm

Nguyen, N. T., Magno, C. P., Lane, K. T., Hinojosa, M. W., & Lane, J. S. (2008). Association of hypertension, diabetes, dyslipidemia, and metabolic syndrome with obesity: Findings from the National Health and Nutrition Examination Survey, 1996-2004 [Abstract]. *Journal of the American College of Surgeons, 207* (6), 928-934.

Oddy, W. H., DeKlerk, N. H., Miller, M., Payne, J., & Bower, C. (2009). Association of maternal pre-pregnancy weight with birth defects: Evidence from a case-control study in Western Australia. *Australian and New Zealand Journal of Obstetrics and Gynaecology, 49* (1), 11-15. doi:10.1111/j.1479-828X.2008.00934.x

Obesity cancels health advantage of affluent (2008, March 13). *USA Today*, p. 7D.

Ogden, J., Bandara, I., Cohen, H., Farmer, D., Hardie, J., Minas, H., et al. (2001). General practitioners' and patients' models of obesity: Whose problem is it? *Patient Education and Counseling, 44* (3), 227-233.

Olson, C., Schumaker, H., & Yawn, B. (1994). Overweight women delay medical care. *Archives of Family Medicine, 3* (10), 888-892.

Orbach, S. (1978). *Fat is a feminist issue: The anti-diet guide to permanent weight loss*. New York, NY: Berkley.

Patel, R., Blackwell, T., Redline, S., Ancoli-Israel, S., Cauley, J. A., Hillier, T. A., et al. (2005). The association between sleep duration and obesity in older adults. *International Journal of Obesity, 33* (12), 1825-1834. doi:10.1038/ijo.2008.198

Peplau, L. A., Frederick, D. A., Yee, C., Maisel, N., Lever, J., & Ghavami, N. (2009). Body image satisfaction in heterosexual, gay, and lesbian adults. *Archives of Sexual Behavior, 38* (5), 713-725. doi: 10.1007/S10508-008-9378-1/

Pilner, P., Chaiken, S., & Flett, G. L. (1990). Gender differences in concern with body weight and physical appearance over the life span. *Personality and Social Psychology Bulletin, 16* (2), 263-273.

Pirisi, A. (1998). Obesity in women presents extra health barrier. *Lancet, 352* (9192), 712. doi:10.1016/S0140-6736(05)60831-8

Pompper, D., & Koenig, J. (2004). Cross-cultural-generational perceptions of ideal body image: Hispanic women and magazine standards. *Journalism & Mass Communication Quarterly, 81* (1), 89-107.

Potter, M. B., Vu, J. D., & Croughan-Minihane, J. (2001). Weight management: What patients want from their primary care physicians. *The Journal of Family Practice, 50* (6), 513-518.

Prevalence of overweight and obesity among adults: United States, 2003-2004 (2006). Centers for Disease Control and Prevention/National Center for Health Statistics. Retrieved from http://www.cdc.gov/nchs/products/pubs/pubd/hestats/overweight/overwght_adult_03.htm

Puhl, R. M. (2005). Coping with weight stigma. In K. D. Brownell, R. M. Puhl, M. B. Schwartz, & L. Rudd (Eds.), *Weight bias: Nature, consequences, and remedies* (pp. 275-284). New York, NY: The Guilford Press.

Rand, C. S. W., & MacGregor, A. M. C. (1990). Morbidly obese patients' perceptions of social discrimination before and after surgery for obesity. *Southern Medical Journal, 83* (12), 1390-1395.

Redland, A. R., & Stuifbergen, A. K. (1993). Strategies for maintenance of health-promoting behaviors [Abstract]. *Nursing Clinics of North America, 28,* (2), 427-442.

Reis, J. P., Araneta, M. R., Wingard, D. L., Macera, C.A., Lindsay, S. P., & Marshall, S. J. (2009). Overall obesity and abdominal adiposity as predictors of mortality in U.S. white and black adults. *Annals of Epidemiology, 19* (2), 134-142. doi:10.1016/j.annepidem.2008.10.008

Resta, O., Foschino, B., Bonfitto, P., Gilberti, T., DePalo, A., Pannacciulli, N., & DePergola, G. (2003). Low sleep quality and daytime sleepiness in obese patients without obstructive sleep apnea syndrome. *Journal of Internal Medicine, 253* (5), 536-543. doi:10.1046/j.1365-2796.2003.01133.x

Richardson, L. (1994). Writing: A method of inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 516-529). Thousand Oaks, CA: Sage.

Richardson, L. (2000). Writing: A method of inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research*, (2nd. ed., pp. 923-948). Thousand Oaks, CA: Sage.

Riessman, C. K. (1992). Women and medicalization: A new perspective. In G. Kirkup & L. S. Keller (Eds.), *Inventing women: Science, technology and gender* (pp. 123-144). Malden, MA: Blackwell Publishers, Inc. (Polity Press).

Riessman, C. K. (1993). *Narrative analysis*. Newbury Park, CA: Sage.

Roman-Diaz, M. A. (1993). Futility and avoidance: Medical professionals in the treatment of obesity. *The Journal of the American Medical Association, 270* (12), 1422.

Roter, D. L., & Hall, J. A. (1993). *Doctors talking with patients/patients talking with doctors: Improving communication in medical visits.* Westport, CT: Auburn House.

Ruhl, C. E., & Everhart, J. E. (2001). Relationship of serum leptin concentrations and other measures of adiposity with gallbladder disease. *Hepatology, 34* (5), 877-883. doi:10.1053/jhep.2001.29005

Ruhm, C. J. (2007). Current and future prevalence of obesity and severe obesity in the United States [Electronic version]. *Forum for Health Economics & Policy, 10* (2), 1-26.

Schutz, A. (1967). *The phenomenology of the social world* (G. Walsh & F. Lehnert, Trans.). Evanston, IL: Northwestern University Press.

Schwartz, M. B., Chambliss, H. O., Brownell, K. D., Blair, S. N., & Billington, C. (2003). Weight bias among health professionals specializing in obesity. *Obesity Research, 11* (9), 1033-1039. doi:10.1038/oby.2003.142

Sharf, B. F. (1990). Physician-patient communication as interpersonal rhetoric: A narrative approach. *Health Communication, 2*, 217-231. doi:10.1207/s15327027hc0204_2

Sharf, B. F. (2001). Out of the closet and into the legislature: The impact of communicating breast cancer narratives on health policy. *Health Affairs, 20* (1), 213-218.

Simoes, E. J., Newschaffer, C. J., Hagdrup, N., Ali-Abarghoui, F., Tao, X., Mack, N., & Brownson, R. C. (1999). Predictors of compliance with recommended cervical cancer screening schedule: A population-based study. *Journal of Community Health, 24* (2), 115-130. doi:10.1023/A:1018754307718

Smith, D. (1979). A sociology for women. In J. Sherman & E. Beck (Eds.), *The prism of sex: Essays in the sociology of knowledge* (pp. 135-187). Madison, WI: University of Wisconsin Press.

Sobal, J. (1995). The medicalization and demedicalization of obesity. In D. Maurer & J. Sobal (Eds.), *Eating agendas: Food and nutrition as social problems* (pp. 67-90). New York, NY: Aldine deGruyter.

Sontag, S. (1978). *Illness as metaphor*. New York, NY: Vintage.

Spry, T. (2006). Performing autoethnography: An embodied methodological praxis. In S. N. Hesse-Biber & P. Leavy (Eds.), *Emergent methods in sociological research* (pp. 183-211). Thousand Oaks, CA: Sage.

Stein, R. (2003, July 15). Study links excess weight to likelihood of Alzheimer's. *The Washington Post*, p. AO1.

Steiner, J. F. (2005). The use of stories in clinical research and health policy. *The Journal of the American Medical Association, 294* (22), 2901-2904.

Strate, L. L., Liu, Y. L., Aldoori, W. H., Syngal, S., & Giovannucci, E. L. (2009). Obesity increases the risk of diverticulitis and diverticular bleeding. *Gastroenterology, 36* (1), 115-122. doi:10.1053/j.gastro.2008.09.025

Strauss, A. L., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Thousand Oaks, CA: Sage.

Strecher, V. J., Seijts, G. H., Kok, G. J., Latham, G. P., Glasgow, R., DeVellis, B., et al. (1995). Goal setting as a strategy for health behavior change. *Health Education Quarterly, 22* (2), 190-200. doi:10.1177/109019819502200207

Street, R. L., Jr., Gordon, H., & Haidet, P. (2007). Physicians' communication and perceptions of patients: Is it how they look, how they talk, or is it just the doctor? *Social Science and Medicine, 65* (3), 586-598. doi:10.1016/j.socscimed.2007.03.036

Street, R. L., Krupat, E., Bell, R. A., Kravitz, R. L., & Haidet, P. (2003). Beliefs about control in the physician-patient relationship. *Journal of General Internal Medicine, 18* (8), 609-616.

Sturm, R. (2003). Increases in clinically severe obesity in the United States, 1986-2000. *Archives of Internal Medicine, 163* (18), 2146-2148.

Sturm, R., & Wells, K. B. (2001). Does obesity contribute as much to morbidity as poverty or smoking? *Public Health, 115* (3), 229-235. doi:10.1038/sj.ph.1900764

Tan, D., Zwar, N. A., Dennis, S. M., &Vagholkar, S. (2006). Weight management in general practice: What do patients want? [Electronic version]. *The Medical Journal of Australia, 185* (2), 73-75.

Teachman, B. A., & Brownell, K. D. (2001). Implicit anti-fat bias among health professionals: Is anyone immune? *International Journal of Obesity, 25* (10), 1525-1531.

Thone, R. R. (1995). *Fat—a fate worse than death?: Women, weight, and appearance*. New York, NY: The Haworth Press.

Timmerman, G. M., Reifsnider, E., & Allan, J. (2000). Weight management practices among primary care providers. *Journal of the American Academy of Nurse Practitioners, 12* (4), 113-116. doi:10.1111/j.1745-7599.2000.tb00289.x

Vanderford, M. L., Jenks, E. B., & Sharf, B. F. (1997). Exploring patients' experiences as a primary source of meaning. *Health Communication, 9* (1), 13-26. doi:10.1207/s15327027hc0901_2

Vanderford, M. L., & Smith, D. H. (1996). *The silicone breast implant story: Communication and uncertainty*. Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

VanMaanen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy.* Albany, NY: State University of New York Press.

Vgontzas, A. N., Bixler, E. O., & Chrousos, G. P. (2006). Obesity-related sleepiness and fatigue: The role of the stress system and cytokines. *Annals of the New York Academy of Sciences, 1083*, 329-344. doi:10.1196/annals.1367.023

Wadden, T. A., Anderson, D. A., Foster, G. D., Bennett, A., Steinberg, C., Sarwer, D. B. (2000). Obese women's perceptions of their physicians' weight management attitudes and practices. *Archives of Family Medicine, 9* (9), 854-860.

Waskul, D. D., & Vannini, P. (2006). Introduction: The body in symbolic interaction. In D. D. Waskul & P. Vannini. (Eds.), *Body/embodiment: Symbolic interaction and the sociology of the body* (pp. 1-18). Hampshire, England: Ashgate Publishing Limited.

Watkins, M. L., Rasmussen, S. A., Honein, M. A., Botto, L. D., & Moore, C. A. (2003). Maternal obesity and risk for birth defects. *Pediatrics, 111* (5), 1152-1158.

Wear, D., Aultman, J. M., Varley, J. D., & Zarconi, J. (2006). Making fun of patients: Medical students' perceptions and use of derogatory and cynical humor in clinical settings. *Academic Medicine: Journal of the Association of American Medical Colleges, 81* (5), 454-462. doi: 10.1097/01.ACM.0000222277.21200.a1

Wee, C. C., Phillips, R. S., Legedza, A. T. R., Davis, R. B., Soukup, J. R., Colditz, G. A., & Hamel, M. B. (2005). Health care expenditures associated with overweight and obesity among U.S. adults: Importance of age and race. *American Journal of Public Health, 95* (1), 159-165. doi:10.2105/AJPH.2003.027946

Weiner, B. (1993). On sin versus sickness: A theory of perceived responsibility and social motivation. *American Psychologist, 48* (9), 957-965.

Weir, H., Thun, M., Hankey, B., Ries, L., Howe, H., Wingo, P., et al. (2003). Annual report to the nation on the status of cancer, 1975-2000, featuring the uses of surveillance data for cancer prevention and control. *Journal of the National Cancer Institute, 95* (17), 1276-1299. doi:10.1093/jnci/djg040

Weitz, R. (2001). *The sociology of health, illness, and health care: A critical approach* (2nd ed.). Belmont, CA: Wadsworth/Thomson Learning.

Wilson, J. A., & Clark, J. J. (2003). Obesity: Impediment to wound healing [Abstract]. *Critical Care Nursing Quarterly, 26* (2), 119-132.

Wysoker, A. (2002). A conceptual model of weight loss and weight regain: An intervention for change. *Journal of the American Psychiatric Nurses Association, 8* (5), 168-173.

Ylostalo, P., Suominen-Taipale, L., Reunanen, A., & Knuuttila, M. (2008). Association between body weight and periodontal infection. *Journal of Clinical Periodontology,35* (4), 297-304. doi:10.1111/j.1600-051X.2008.01203.x

Yang, Z., & Hall, A. G. (2008). The financial burden of overweight and obesity among elderly Americans: The dynamics of weight, longevity, and health care cost [Abstract]. *Health Services Research, 43* (3), 849-868.

Zalesin, K. C., Franklin, B. A., Miller, W. M., Peterson, E. D., & McCullough, P. A. (2008). Impact of obesity on cardiovascular disease. *Metabolism Clinics of North America, 37* (3), 663-684. doi: 10.1016/j.ecl.2008.06.004

Zhao, G., Ford, E. S., Dhingra, S., Li, C., Strine, T. W., & Mokdad, A. H. (2009). Depression and anxiety among US adults: Associations with body mass index. *International Journal of Obesity, 33* (2), 257-266. doi:10.1038/ijo.2008.268

APPENDIX A

INTERVIEW SCHEDULE: QUESTIONS AND POSSIBLE PROBES

(FINAL VERSION)

Initial Demographic Information: "First I would like to ask you some brief questions to get a little background about you."

_____ Age?
_____ Race/ethnic or cultural group with which you identify?
_____ Highest level of education attained?
_____ Relationship and parenting status
_____ Occupation
_____ For how much of your life have you considered yourself overweight?
_____ How many serious efforts have you made to lose weight?
_____ Do you have any medical conditions for which you have been told that your weight is a contributing or complicating factor? Specifically?
_____ How would you describe your overall health status?
_____ At your heaviest, about how many pounds would you have wanted to lose to achieve what you consider to be normal weight?

I. Questions Related to Weight and Identity: "Now I'm going to ask you some questions about how your weight affects how you see yourself."

1. Tell me a little about who (*insert pseudonym*) is.
   - (*Probe for personal traits and other characteristics beyond physical appearance.*)
   - One writer has said that a person's body is an outward expression of their inner self. Do you think this is true for you? If so, in what way? If not, in what way do you see yourself as different from what your body expresses?
   - One woman I talked to has said that she feels she is a thin person in a fat person's body? Does this seem true for you?

2. Tell me a little about your history with weight and your efforts to lose weight.
   - Tell me about the first time you became aware that you were overweight.
   - To what do you attribute your problems with weight?
   - What word would you use to characterize your efforts to lose weight? Why?

3. How does/did being overweight affect you?
   - How you see yourself? How you see others? How you see other overweight people?
   - Lifestyle?
   - Interactions with others? Has there been any time that you felt that another person's reaction to you was affected by your weight?
   - In what way, if any, do you think any of these things are or would be different if/when you are at "normal" weight?

4. When you attempt/ed to lose weight, what are/were your motivations for doing so?
   - (If "health") Do/did you see your weight as an "illness," or do/did you see yourself as a "well" person despite being overweight? Explain.
   - (If "appearance") How would you describe your appearance when you are overweight? How would you describe your appearance at normal weight?
   - (If "relationships") Describe how your relationships would be/are different at "normal" weight. (If not answered in #2)
   - Do you believe that losing weight and maintaining the weight loss is a realistic goal for you?
   - What is the worst thing about being overweight?
   - Is there anything positive about being overweight?
   - If there were absolutely no stigma attached to being overweight, do you think you would still want to lose weight?

II. Question Related to Identity and Medical Interactions: "Now let's move to how the way you think about being overweight is related to past medical visits."

1. Tell me about how being overweight has affected your interactions with a physician, nurse, or other health practitioner during a medical visit?
   - How has it affected your decision-making about whether to seek healthcare?
   - How has it affected the way you see yourself?
   - How has it affected the way you communicated with the health practitioner?
   - How has it affected your perception of the care you received?

2. What is your perception of how medical practitioners react to overweight patients?
   - In what ways have these attitudes been communicated to you?
   - How accurate do you think those perceptions are?

III. Questions Related to Medical Interactions: "Now I'd like to know a little about specific things that have happened in past medical visits."

1. Have you ever consulted a health practitioner specifically about losing weight?
   - Who initiated the topic?
   - (If by subject) What made you feel comfortable about initiating the topic?
   - (If by practitioner) How did you feel about her/his introduction of the topic?
   - Was the interaction helpful? Why/why not? What were your expectations or hopes for the interaction?

2. Tell me about a time that being overweight affected how you felt during a medical visit? (If not well-covered in II.1.)
   - Describe what happened.
   - How did you feel?
   - How did it affect how you see yourself?
   - What effect, if any, did this encounter have on later decisions about seeking healthcare?
   - (*If respondent has had surgery*): In what ways, if any, have your interactions with practitioners involved in your surgery been different from interactions with other practitioners in the past?

3. Tell me about specific things that healthcare practitioners have done during medical interactions that have been encouraging in helping you to lose weight? Discouraging?
   - Can you think of a particular incident in which something encouraging happened?
   - Can you think of a particular incident that was discouraging?

4. Other than the things you have mentioned previously, are there other factors in a typical medical visit that have created problems for you with respect to being overweight?

5. I want you to pretend that I am a newly-graduated doctor or nurse, and I am about to go into my first medical practice. I know I am going to encounter a lot of female patients who are dealing with weight issues.
   - What would you want me to know about the experience of being an overweight woman in daily life?
   - What do you think I should do to be as effective as possible in working with my overweight female patients?
   - What do you think I should avoid doing to be as effective as possible in working with my overweight female patients?

APPENDIX B

RECRUITMENT FLYER

A Fellow ******® Member Needs Your Help!

Bonnie Creel, who is a member at the ***** ******® location, is working to complete her Ph.D. in Health Communication at Texas A&M University. Her dissertation topic relates to how women who are or have been overweight see themselves and how their interactions with doctors or other health professionals are affected by their weight.

She is looking for adult women who consider themselves to be or to have been moderately-to-seriously overweight. You may be someone for whom weight is your only health issue, or someone for whom weight is a contributing or complicating factor in other health conditions (for example, diabetes, hypertension, orthopedic problems, etc.).

Volunteers will be asked to participate in an interview for approximately 60 minutes with Bonnie, arranged at your mutual convenience. Your participation and your responses will be entirely confidential.

The study is being conducted with the approval of the Texas A&M Institutional Review Board, which only approves studies that are designed to absolutely safeguard the rights of participants. If you have questions about this, or about anything else related to your possible participation in the study, Bonnie will be glad to talk to you and answer those questions. Her phone # is xxx-xxx-xxxx, and her email is bonniecreel@gmail.com. (Note: To insure your privacy, if you contact her by email, please use an account to which only you have access. Only Bonnie has access to her email address. Please type "weight study" into subject line.)

If you would be interested in considering participation in Bonnie's study, please fill out the form below, tear it off, and place it in one of the envelopes provided and seal the envelope. Place the sealed envelope in the large manila envelope that is being kept at the front desk. Keep this part of this flyer for your own information. If you prefer, you can contact Bonnie directly instead of leaving this form for her to pick up.

Bonnie will greatly appreciate any help you can give her!

……

(Note: Identifying information removed to protect confidentiality of some participants.)

Yes, Bonnie, I would be interested in helping you earn your Ph.D.!
(****® member: Please choose only one option below.)**

Name

_____

Option 1 _____ I prefer that you contact me at:
Phone(s) _____

Email (legible, please!) _____

Option 2 _____ I will contact you, Bonnie.

APPENDIX C

PARTICIPANT PROFILES

(*The respondents are listed alphabetically according to their pseudonyms, which they selected for themselves.)*

Angel: Angel is a 52 year old Caucasian woman. She is single with no children. She has completed the 12th grade and has had "a little" training after high school. When asked about her occupation, she replied, "Aerospace." She traces the onset of her problems with overweight to her 20's. She estimates that she has made 5 or 6 serious attempts to lose weight, but acknowledges that she has been on "Oh, heavens! Countless!" diets. "Whatever was new that was out, you know, it seems we always tried it." Her latest serious attempt was a gastric bypass, and it was during the preparations for that surgery that she learned she was diabetic. Now that she has had the gastric bypass and has lost a substantial amount of weight, she regards her overall health status to be "great," and she reports that she is now able to manage her diabetes solely through diet and exercise. Health and appearance are her main motivators for wanting to lose. She has lost 135 pounds since her surgery four years ago, but still considers herself to be overweight, admitting that she is still well over 200 pounds, wants to be under 200 pounds, but doubts she can get there.

Ann: Ann is a 57 year old married Caucasian female with one adult child. She has a Bachelor's degree and works in insurance. She traces her history with

weight problems to a visit to a "weight doctor" when she was 13 years old. "It's very interesting to go back and look. I don't think I was—I was heavier than most, but not by today's terms, you know?" She thinks she might have weighed about 145 pounds at the time of that medical encounter. Unlike many of the women I interviewed, she does not seem to view the extremely thin body of celebrities and fashion models to be the contemporary ideal; rather, she apparently regards the healthy, athletic body as the standard of the day. She estimates that she has made "hundreds—lots!" of serious efforts to lose weight, and in the course of the interview it became clear that she had, indeed, tried almost every imaginable method of managing her weight. She has no health issues except high blood pressure, which she controls with medication. She describes her health status as "definitely not very good, because of the weight," drawing on her professional experience to add, "By an insurance standard I'm not the best risk." She believes that at her heaviest she was "probably about a hundred" pounds over what would be normal for her. The theme of our interview was that she has "beaten this horse" and "whipped this dog" incessantly, referring to the perpetual struggle of her adult years to lose weight. She notes that "if I had a brain in my head" health would be a motivator, but she acknowledges that her problem is that she can't seem to find any motivation at all. She expresses a high degree of doubt that she will ever find the answer.

AnnaMarie: AnnaMarie is a 41 year old African-American woman who has recently completed her Master's degree. She works as a pre-school teacher in a college

"lab school" while she looks for other positions for which she is now qualified. She is single and has no children. She has been overweight all of her life and figures that, since middle school, she has been almost perpetually on some sort of weight loss program. Her only complicating health issue is that her blood pressure has recently become elevated, and she is on medication for that. At her heaviest she was 70 pounds overweight. She feels there is some biochemical explanation for why she is overweight and is currently intrigued by the theories that link blood type to weight. Being overweight has been the source of a great deal of emotional struggle for her over the years, and she reports that she always felt she was not well treated by others, including family members, because "I didn't look cute enough." She is working on trying to "appreciate myself more," and she has reconciled herself to the fact that she is never "going to be that skinny person." Her primary motivation for losing weight is that she wants to be able to do "whatever the Lord wants me to do," and "If He has plans for me, how am I going to carry them out if I'm carrying too much?" She seems uncertain about the likelihood that she will be successful in weight loss.

Charlotte: Charlotte is a 56 year old Caucasian woman who has a Bachelor's degree and is now a retired administrative assistant. She is married and has two adult children and grandchildren. She estimates that she has been overweight at least "90%" of her life, tracing the beginning of her weight problems to first grade. At her heaviest, she would have needed to lose 110 pounds to be at normal weight. She underwent a gastric banding procedure over 20 years ago, when it was

"revolutionary to have it done." Her primary reason for doing so was that she wanted a "nice, practical way for me not to be so attached to food." Her most serious health problem is that she has been diagnosed with advanced breast cancer; she has had a mastectomy and is now using alternative medical approaches in the post-surgical phase. Her experiences in medical encounters, particularly those related to HMOs, have been very frustrating to her as she has dealt with the decisions related to her cancer. Her strict religious upbringing from childhood had resulted in her "denying the importance of my body," and she admits that over the years she has been prone to postponing medical visits and health screenings as a consequence. Her lifelong attitude toward her body is something she is struggling to overcome in the effort to regain health and survive after her cancer diagnosis. She has lost some weight and would like to lose more, but when asked what she thought would be realistic for her to lose, she responded ruefully, "Apparently nothing." Understandably, her efforts are more directed at her overall health at the moment.

Diana: Diana is a 42 year old woman who identifies herself as "Mexican." She is divorced and has no children. She is in a committed relationship, living with her partner. She has a Master's degree and is a teacher. She states that she has been overweight "all my life." She describes a lifetime of battling her weight, but only counts the three times when she was able to become truly thin as "serious efforts" to lose. She has experienced a series of major gynecological problems, so she has interacted a great deal with the medical profession. She voices

significant frustration with the way she has been treated by doctors, nurses, and other medical personnel over the years, and she strongly relates that treatment to what she perceives as negative attitudes toward her because of her weight. However, she also acknowledges her own role, admitting that she is hyper-sensitive, and wondering if anyone could ever have a productive conversation with her about it due to her near-obsession with her weight. She tries to remain hopeful that someday she will find a doctor who will be able to be helpful to her in her quest to lose weight permanently, but she also expresses great doubt that this will ever happen: “I just don’t really see that anyone would ever give me that much time.”

Gabby: Gabby is a 50 year old Caucasian woman who has attended college and is a housekeeper. She is married and has three adult children. She considers herself to have been overweight for about 25 years, probably beginning with the birth of her first child, and she estimates that she has made five serious attempts to lose weight. She has a number of health issues, mostly orthopedic and circulatory in nature, highly problematic because of her occupation. She is at her heaviest and would like to lose 44 pounds so she can fall below what is for her a meaningful marker. She is a person who derives a great deal of satisfaction from being helpful to other people. However, she has had a number of personal relationships in her family that have been disappointing to her because of the criticism she feels, much of it directed at her weight. She attributes the majority of her struggle to overeating due to the stresses caused by life circumstances. Her primary

motivations to lose are health and appearance. She wants to be hopeful that she can lose weight, saying, “Yes, it is realistically possible,” and then shortly after expressing doubt because of her repeated “failure.” She fervently decries the obsessive attention to diet and exercise that characterizes the attitudes of people she has known who have been successful in losing weight, stating that “I don’t want to live that way! I want to be who I am, all the time. Whether I’m heavy or skinny, it just doesn’t matter.” Despite her occasional optimistic statements, the overwhelming tenor of our interview is that she is doubtful of her ability to succeed at losing weight.

GiGi: GiGi is a 55 year old Caucasian college instructor with a Master’s degree. She is married and has adult children and several grandchildren. She has been overweight “my entire life,” noting that she comes from “pioneer stock women.” She thinks that she would have needed to lose 170 pounds when she was at her heaviest in order to be at an ideal weight for her. She made “countless attempts at Weight Watchers®” over the years, but never tried pills or any other “set program” in an attempt to lose. Initially her motivation to lose was primarily appearance, but she eventually began to develop high blood pressure and was borderline diabetic. At that point she decided to “surrender” and acknowledge that “I don’t have the tool, evidently,” and she opted for a gastric bypass. She has now lost over 100 pounds. Although she has not lost the other 70 pounds, she has come to see that losing and maintaining the 100 pound loss has been an accomplishment, and that to lose more would require her to make lifestyle

changes that she is not currently equipped to do. She seems content to just maintain at her current level for the moment.

Grace: Grace is a 43 year old Caucasian woman who works as a secretary. She is also at senior level in working toward her college degree. She is divorced, and she has three teen-aged children. She has no health conditions "other than weight." She is at her heaviest now, and she would like to lose 100 pounds. Her weight problems began with the birth of her first child. Her husband made it clear at that time that he was not happy with her weight gain, threatening to "do something" if she did not lose. Shortly after the birth of her third child, he followed through and left her, blaming her weight for his extra-marital relationships and for the dissolution of their marriage. Since that time, Grace has focused on raising her children, continuing as she always had to work outside the home, and returning to school once her children were at an age that allowed her to take that time away from them. She has virtually no extra time, her priorities being on work, school, and being as involved as she can be in the activities of her children. For that reason, focusing on losing weight has not been possible for her. She believes that she could lose weight if she were able to make that a priority, but does not see a time in the near future when she will be able to do that. She expresses considerable anguish with her weight, remarking that she feels like she is trapped in a "fat suit."

Lisa: Lisa is a 41 year old African-American woman who is single and has no children. She has a Bachelor's degree, and she is currently engaged in several

entrepreneurial enterprises. She estimates that she has been overweight for about 15 years, though she does make reference to her weight being an issue when she talks about earlier segments of her life a well. She thinks she has made 5-10 serious efforts to lose weight. She has problems with blood pressure and with Polycystic Ovary Syndrome, which she understands to be related to weight in that the condition makes it harder to lose. She derives much comfort in knowing that other women in her family who had also suffered from PCOS "turned back skinny" once they experienced the hormonal changes associated with menopause. She would like to lose 40-60 pounds, partly for health but also for appearance. She admits to having had problems in developing romantic relationships, though she has enjoyable Platonic relationships with men, largely because she is adept at talking "smack" while discussing sports and other similar topics. She attributes her problems with romantic relationships to her weight as well as to the fact that she is a dark-skinned African-American woman. Although she would like to lose weight, she does not seem to be currently very concerned about it. She is not presently doing anything actively toward that objective, and she does not have any concrete plans for the near future. The prospect of being able to lose the weight with little effort as a consequence of hormonal changes seems to encourage her to simply be patient.

Mae: Mae is a 56 year old Caucasian woman. She is married, and she has several children and step-children. She was in college at one time, attaining senior hours, but she had to discontinue her education when her husband

developed a serious health condition. She was a small-business owner, but she had to leave that when she developed her own health problems. She is suffering from end-stage kidney disease, a consequence of what appears to have been some degree of mismanagement of her diabetes. She recounts her repeated efforts to get her physician to consider putting her on insulin, but by the time that happened, her kidneys had been irrevocably affected. She is on a transplant list, and she has been told that it may be another two years before an organ becomes available. In the meantime, she is on a rigid and very limited diet of renal-friendly foods, most of which are not conducive to weight loss. Yet the doctors want her to lose 60 pounds. She regularly sees a nutritionist, and she keeps careful accounts of every morsel of food or drink she ingests. She is not frustrated because she is deprived of sweets; she would just love to have vegetables, but a great many of them are too hard on her kidneys and must be avoided. Her sense of frustration, of "just constant watching, and it doesn't seem like it does any good," is palpable throughout the interview. Health is obviously her motivator, though she also notes that she would love to be able to be more active than she can be at her current weight. Despite her struggles, she cheerfully describes herself as "pretty healthy," but there is little to no optimism that she is ever going to be able to get a handle on her weight.

Maggie: Maggie is a 58 year old Caucasian woman. She is married and has no children. She has a Bachelor's degree and is recently retired after having taught in the public schools for many years. She attributes her weight problems to

menopause, which she estimates she began to experience 10 years earlier. She weighs 20 pounds more than she would like to. She has some issues with cholesterol, but she does not see her weight as affecting any aspect of her health. She is aware that her health could be affected by weight at some point, so that is her primary reason for wishing to lose. She has not experienced any problems in any aspect of her life because of her weight, saying, “It’s not too big a deal; it’s a little bit of a big deal, but not much.” Any minor limitations she experiences are attributed more to age. She admits that at one time she was very thin—50 pounds lighter than she is today—so she figures people who knew her then would “wonder, ‘What happened to her?!’” But she does not judge others because of their weight, so she assumes no one judges her because of hers, either. Her doctor has not said anything to her about her weight, which, she says, “is a good thing; I’d cry.” Maggie has an extremely high degree of body acceptance and expresses no motivation to lose weight at the moment.

Marianne: Marianne is a 56 year old Caucasian woman who has a Bachelor’s degree and works in accounting. She is divorced and has several children; she recently assumed responsibility for raising her preschool-aged grandchild. She has been in a committed relationship with a “gentleman” for almost a decade. She has been overweight for “at least half” of her life, but the most significant weight-gain occurred in the aftermath of her divorce, a time she describes as “just very depressing.” Her weight had a profoundly negative effect on how she saw herself, and she confesses to having had a serious problem with emotional eating.

She also admits that her weight kept her from going to the doctor because she did not want to face the scales. “I wasn’t going to get on there and let anybody tell me that I was overweight!” Eventually, she developed several health conditions, including diabetes that she had difficulty controlling. Finally her boyfriend said, “I cannot live here watching you kill yourself.” With his encouragement and support, she opted for a gastric bypass. She has lost almost 90 pounds and is only 10-15 pounds from her goal. She is optimistic that she will attain this goal, as she is diligent about watching her diet and exercising four times a week with a personal trainer.

Mary Frances: Mary Frances is a 64 year old Caucasian woman. She is married and has a step-daughter, several grandchildren, and a great-grandchild. She has a Ph.D. and is a professor. She has been overweight since her mid-30s, and she estimates that she is about 140 pounds over her ideal weight. Her primary motivation to lose weight is that she wants to be physically able to do things she values in her upcoming retirement years. She has been blessed with good health up until fairly recently; she now has some orthopedic issues and is often limited in what she can physically endure. When asked how many serious efforts she thinks she might have made to lose weight, she said, “I couldn’t even count them. I’ve probably lost 10,000 pounds, but it’s the same 30 over and over and over.” Her weight does not appear to have had any significant impact on her personal or professional life, though she admits to feeling a certain amount of personal “shame” related to her weight. She is currently undertaking a strict eating

regimen of no more than 800 calories a day, and she is determined that if she has not been able to make meaningful progress toward losing weight within the next 6-8 months, she will opt for Lap Band® surgery. She no longer expects to lose all 140 pounds, stating that if she were just 60 pounds overweight she could manage to do most of the things she hopes to be able to do physically in her retirement. She initially says that she thinks it is "probably" realistic to think she can accomplish this goal, but then expresses doubt, suggesting, "Ask me again in eight months."

Mary Lou: Mary Lou turned 70 years old just a few days after our interview. She is a Caucasian woman who worked in the airline industry and is now retired. She has a Bachelor's degree, is divorced, and has one grown child and grandchildren. She states that her weight problems began about 15 years earlier with the onset of menopause. Prior to that time she had always been a petite woman who never had a problem buying fashionable clothing. Now she is 80 pounds over her previous weight, and nothing she has tried to help her lose the extra pounds has been successful. She has some health issues—primarily blood pressure and some orthopedic problems—but she considers her overall health to be "excellent." Her primary motivation for losing weight is clearly appearance, though she also says that health is important to her. She has been seeing holistic health practitioners for the past several years, and she hopes that weight loss will eventually occur, though the focus seems to be more on achieving chemical balance within her body than with weight. She does not like the body she now lives with, but she

seems to have come to the conclusion that she is not going to be able to lose back to her previous weight, so she is opting now for simply losing enough to maintain general health; she estimates that to be 35 pounds.

Megan: Megan is a 38 year old Hispanic woman who is married and the mother of three children, ranging in age from teenaged to toddler. She has an Associate's degree and works as a preschool teacher. She traces the beginning of her problems with weight to the birth of her first child and says that she has only made two serious attempts to lose weight since then. She would like to lose 80 pounds. She has hypoglycemia, requiring her to eat frequently, one of the factors that she believes contributes most to her struggles with weight; the other significant factor is a lack of time, given her work schedule and the demands associated with raising children. She and her husband are trying to do a workout program at home when the children are asleep, but she is not entirely confident that they will be able to keep it up. Megan realizes that she is not likely to ever lose all of her 80 pound goal and keep it off, but she would like to lose enough to be healthy for her children. Sometimes she finds herself wondering if she is just "meant to be who I am, so I'm just gonna live with it." In fact, she expresses admiration for overweight women who have come to some sort of acceptance of their bodies. However, she always ends up rejecting that idea because of her desire to "feel comfortable in my own skin," something that is not true of how she feels about herself at the weight she is currently carrying.

Naomi: Naomi is a 51 year old Caucasian woman who is single and has no children. She finished high school and has had some junior college education. In the past few years she has been undertaking study of the Bible in a religious study program. She is in sales. She says that she was always overweight, even as a small child. At her heaviest, she was 40 pounds overweight, but she never thought of her weight as a problem; in her mind she seemed to be about as heavy as everyone else around her. She went on a diet several years ago, mainly because her roommate was on it and was doing all the cooking. She lost weight, but gained it back after she stopped following the diet. Then several things happened that made her change her attitude about weight. She was told by a nurse that she was a candidate for a heart attack. Not long after, a neighbor died of a heart attack and a woman she knew had a stroke. Around this time period, she had started to undergo a religious transformation, getting "back with God," which caused her to decide to give up drinking and smoking and begin to take better care of her body. As part of her process of spiritual renewal, she confronted some past issues from her childhood, and this helped her to stop thinking of herself as "nothing special" and to see herself as "the daughter of the almighty God!" She began a diet and exercise program and lost all of the weight she wanted to lose. She has maintained that loss by healthy eating and regular exercise.

Raquel: Raquel is a 39 year old Hispanic woman who is divorced and the mother of two children, one in college and one in high school. She is nearing completion

of her Master's degree. She works on the staff at a community college. She estimates that she has been overweight at least 90% of her life. She would like to lose about 70 pounds. She has often been successful in losing weight by focusing on physical activity, but she invariably gains it back during the periods when she has no time for scheduled exercise. She has never attempted to lose weight through dietary modification, admitting to a fondness for the foods of her culture; however, she indicates that she has been willing to try to make some slight dietary modifications for the purposes of healthier eating. She enjoys good health; a recent checkup indicated no problems with cholesterol or any other health markers. In general, Raquel expresses a great deal of body acceptance, saying that she has "always known I'm just a big girl." She prides herself on carrying herself well and looking her best, and she has been told that she exudes confidence. She expresses some concern for the changes she is beginning to see in her body as a consequence of aging, and she thinks she might have to become more proactive in managing her weight. But overall, she is not unduly troubled by it, and she feels confident that she can lose weight any time she really wants to by simply increasing the emphasis on exercise.

Ruth: Ruth is a 52 year old Caucasian woman who is married and has two adult children and two grandchildren. She has two 2-year college degrees, and she works as a legal assistant. She has been overweight since childhood, and estimates that at her heaviest she needed to lose 150 pounds. She has a number of health issues, including diabetes (now controlled), neuropathy, and sleep apnea;

she describes her health status as “pretty good.” She attributes her problem with weight to a number of factors, including heredity, poor eating habits, the use of food for emotional comfort, and problems with weight management in dealing with other health issues. Her primary motivation for losing is health, although appearance also matters to her. She has tried several approaches to losing weight, including multiple attempts with Weight Watchers®. She has always regained and then gained even more with each effort. She has recently undergone Lap Band® surgery and lost about 45 pounds, but she has had cycles of slight regain and loss since then. She is continuing to try to achieve success with the gastric band by visiting her doctor for follow-up care, and he has been working to help her make the necessary adjustments. However, she expresses some doubt about how successful she will ultimately be.

Sasha: Sasha is a 49 year old African-American woman who has a Bachelor’s degree. She is in the process of divorcing her husband. She has two children, the younger of whom is about to leave home. She has recently re-entered the work world, and she is working at several varied jobs, most of which involve sales. She has been overweight since the birth of her first child, and her weight has been the source of some of the tension in her marriage. She thinks her health is “decent,” and she would like to lose about 50 pounds. Her primary motivation in losing is appearance, realizing that she needs to make a positive impression on people in her sales career. Her appearance also matters because she will soon be

re-entering the dating scene. She expresses complete confidence in her ability to reach her goal weight.

Sherry: Sherry is a 55 year old Caucasian woman who is divorced and has two children and several grandchildren. She finished high school and some trade school. She works in sales, dealing with very expensive products that are vastly more interesting to men than to women. For that reason, she feels that her appearance is of considerable importance in her career. However, her overriding concern with her weight is because of her health. She has experienced a number of serious health issues in the recent past, including high-stage cancer and then a heart attack that, it is believed, was due to damage to the heart caused by chemotherapy. She is also recovering from a foot injury and from surgery that she has undergone to correct the damage from a fractured face due to an incident of domestic violence that occurred many years ago. Her weight became an issue because her heart damage suggested that she would need to go on a transplant list. She had always been underweight, and her doctors insisted that she gain enough to be able to handle the anti-rejection drugs. Possibly as a result of the depression Sherry felt with all that life had been throwing at her, she gained too much weight, resulting in the doctor's insistence that she lose back to a narrow range. Her concern is that it is harder now than it has ever been to lose, but she knows she must lose the weight, and at the same time she is not sure she can really be happy at the new target weight since it is higher than what she was previously accustomed to. Sherry is working hard to adjust to the new realities.

Susan: Susan is a 52 year old Caucasian woman who is married and has two children. She has a Master's degree and works in programming. Her weight problems began in the last 6 years since she overcame alcoholism and, later, gave up smoking. She craves sugar as a result of the years of drinking, which makes management of her diet difficult. She has gained 60 pounds. She would like to lose it, but she has no serious medical conditions, and her doctor is so pleased with the positive things she has done for her health by giving up alcohol and nicotine that he is not pushing the issue of weight. This is fine with Susan, as she is doubtful about her willingness to give up more than she already has. She has a photograph of herself on her computer screen, but it is not so much as a motivator for her to lose weight as it is for her to remind herself that she is not as slender as she sees herself internally.

Vanessa: Vanessa is a 21 year old Hispanic college student. She is single and has no children. She goes to school full time and works part-time. She thinks of herself as having first struggled with her weight when she reached puberty. She was bullied about her size by a female classmate in middle school, as well as by her father (from whom her mother is now divorced and from whom Vanessa feels largely estranged). Although she describes herself as "fairly healthy for being overweight," Vanessa has in the last few years gone to her doctor frequently for a wide range of physical symptoms that she often assumes are due to her weight. She estimates that she is about 100 pounds overweight. Her doctor has reassured her that she does not have the health issues she imagines she has,

but she continues to be concerned. Like her mother, Raquel, she believes exercise is the key to losing weight and is not highly motivated to make significant dietary changes. She is confident that she can lose weight whenever she wants to by adding in exercise, though she admits that she has not been able to feel highly motivated for some time to do this. She has a high level of body acceptance, saying that she is "happy with who I am."

Victoria: Victoria is a 30 year old African-American woman who is single and has no children. She has a Master's degree and teaches. She says she feels like she has been overweight all her life, but it really first became a problem for her when she reached puberty. She is now about 130 pounds over her ideal weight. She has made four or five serious attempts to lose weight with some form of medical help, and she says that she has made "countless" attempts on her own. Other than some concerns about blood pressure, she feels that her health is "good outside of weight." Her motivations for losing include health, but she seems more concerned at the moment about her appearance, her ability to develop relationships, and her desire to be more able to participate in a variety of activities, all of which she sees as being detrimentally affected by her weight. She is currently on a weight loss plan, but she is doubtful about her ability to succeed. Therefore, she has decided that, if she is not successful, she is going to begin the process to undergo the Lap Band® procedure. She does not expect to ever be truly thin, but believes she can achieve an acceptable weight.

VITA

Bonnie R. Creel received her Bachelor of Fine Arts degree in speech education with a second teaching field in English from Texas Christian University in 1971. She completed her Master of Fine Arts degree in speech communication, also from TCU, in 1974. She taught speech and drama on the middle school level for five years in the Fort Worth Independent School District from 1972-1977. She was an adjunct instructor in the Radio-Television-Film department at TCU from 1983-1988, and also taught as an adjunct instructor in speech communication at TCU from 1985-1988. She held a one-year appointment as an instructor in the Speech Communication department at TCU for the academic year 1988-1989. From 1983-1988 she also taught a variety of courses for TCU's continuing education program. She is now an associate professor in the Communication Arts department at Tarrant County College in Fort Worth, Texas, where she has been teaching since the fall of 1989.

Bonnie entered the graduate program in Communication at Texas A&M University in the fall of 2000 and completed her doctoral work in December, 2010. Her research interests during the time she has pursued her Ph.D. have focused mainly on health communication, though her interests in the communication discipline are varied. As a result of her dissertation work, she plans to write and engage in advocacy efforts aimed at improving the health of overweight patients.

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