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**Women-Centred Sensitive Practice Guidelines for Weight Issues:
A Proactive Primary Prevention Approach**

by

Patricia H. Thille

Submitted in partial fulfillment of the requirements
for the degree of Master of Arts
in the Joint Women's Studies Programme

at

Mount Saint Vincent University
Dalhousie University
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requirements for the degree of Master of Arts.

Dated: _____

Supervisor: Dr. Catrina G. Brown

Committee Member: Dr. Mary Delaney

Examiner: Dr. Audrey MacNevin

MOUNT SAINT VINCENT UNIVERSITY
DALHOUSIE UNIVERSITY
SAINT MARY'S UNIVERSITY

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ABSTRACT

Weight preoccupation and body dissatisfaction affect the majority of Canadian women and can foster behaviours that adversely affect their well-being. Rather than understanding these attitudes and behaviours as the problems of individuals, socio-cultural models argue that the environments in which we live influence these experiences. The cultural institution of Western medicine has been named as one socio-cultural contributor to the idealization of thinness and weight discrimination. The purpose of this research is to highlight how the behaviours of health care professionals influence women's sense of body satisfaction and weight preoccupation as well as their health care access and health outcomes. This study critically examines the discursive patterns in fifteen women's stories of weight-related discussions with health care professionals, and presents an alternative model for clinical care ("sensitive practice guidelines") that responds to concerns articulated by the 'health at every size' approach and by broader critiques of the culture of medicine.

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Introduction

The idealization of thinness and related weight discrimination in North America, now several decades old, fuels weight preoccupation and body dissatisfaction among the majority of Canadian women. These attitudes are harmful and can foster many behaviours among women that adversely affect their well-being. This idealization of thinness persists through a variety of discursive mechanisms, including meta-narratives such as ‘the obesity epidemic’, ‘individuals are responsible for their health’, ‘dietary and body fat are bad’, ‘dieting is effective’, and ‘thin is healthy, fat is unhealthy’ (with related assumptions of ‘weight reflects health’ and ‘fat people lack willpower, overeat and/or are mentally ill’). Rather than understanding problematic eating attitudes and behaviours as individual problems, I agree with socio-cultural models that argue that these experiences are influenced by the environments in which we live. These weight and health discourses are expressed in a range of cultural institutions, such as our media systems, dieting/fitness/fashion industries and medical science. The cultural institution of Western medicine (herein medicine) has been named as one socio-cultural contributor to the idealization of thinness for women (Austin, 1999; Germov & Williams, 1996), one that is authoritative and legitimized by its underlying construction of medical knowledge as “Truth”. The purpose of this research is to highlight how the behaviours of health professionals, shaped by the knowledge base and culture of medicine, can, positively or negatively, influence some women’s experiences of body dissatisfaction and weight preoccupation as well as their health care access and health outcomes. The central aim of this project is to develop a vision of ‘sensitive practice’ for women-centred clinical care.

Critiques of the culture of medicine recognize that health professionals are influenced by the same cultural discourses as their clients. The culture of medicine is also critiqued for its tendency to individualize patients and subsequent failure to recognize the role of social and physical environments on the health of the individuals they treat. By understanding the problems of each individual in this decontextualized and isolated fashion, and reducing health to primarily biology, medicine has no mechanism by which to understand the role of environments on health. As a result, medicine does nothing to change these environments. Recognizing that some dominant cultural discourses are harmful for women means that medicine needs to critically examine its discursive practices, or risks reinforcing normative social reality. The cumulative effect of these critiques is the assertion that medicine fails to live up to its credo 'above all, do no harm'.

Philosophical and ethical arguments, discursive analyses and empirical methods have all been employed to frame feminist conceptualizations of body weight and shape. Some feminists have focused on exposing the dominant cultural ideologies and contentious myths reinforced by medical practice, which include: (a) the responsibilities of individuals to control their own weight; (b) the physical body is infinitely malleable; (c) people who are overweight overeat; (d) people who are overweight have psychological problems; and (e) dieting is an efficacious strategy to control body size (Brownell & Rodin, 1994; Ciliska, 1993; Wooley & Garner, 1991). Measures of 'healthy weight' used clinically by health professionals have been examined and critiqued; body mass index, one such measure used in one-on-one clinical exchanges, is a population-based measure that is problematic when used at the level of individuals, as it does not account for body composition (Brownell & Rodin, 1994; Ciliska, 1993; Ernsberger, 1999;

Kline, 2001). These critiques expose the 'weight-centred' assumptions that shape medical practices.

Well-intentioned health professionals can reinforce harmful cultural discourses and assumptions through clinical practice (Austin, 1999; Germov & Williams, 1996). Health professionals live in the same cultural settings as the rest of us, thus are influenced by many of the same cultural discourses. Secondly, these beliefs about weight have shaped the development of medical knowledge, which forms the foundation of clinical medicine. Health professionals reinforce these ideological assumptions implicit in the medical model through daily clinical practice. The absorption of these assumptions into clinical practice affects the quality of care provided, and risks reinforcing weight preoccupation and body dissatisfaction among women. For example, the 'obesity epidemic' is a socially constructed discourse heavily shaped by medicine that adds to North American cultural fear of fatness, fostering weight discrimination in our society.¹ Schwartz and colleagues (2003) highlight how pervasive weight or 'anti-fat' bias continues to be among health professionals specializing in 'obesity'. They suggest that these specialists know the complex theoretical models of 'obesity' causation, but most still intrinsically believe in stereotypes that portray larger people as lazy, stupid or worthless (Schwartz et al., 2003). That is, people are large because they do not work hard enough, do not know enough or fail to take responsibility for their own health. When experienced by clients, weight prejudice affects future willingness of larger people to access health care (Ciliska, 1993, Yanovski, 1998). These findings speak to the strength

¹ The problematic construction of 'the obesity epidemic' used heavily by medicine and the media is the topic of new book *The Obesity Myth: Why America's Obsession with Weight is Hazardous to your Health* by Paul Campos.

of the hegemonic weight myths and the need for concern about the role of medicine in perpetuation of these beliefs.

What would clinical health care practice look like if hegemonic beliefs about weight were no longer reinforced? That is the central concern for this research study. My work builds upon the critiques and concerns about both the 'weight-centred' medical paradigm and general critiques of the culture of medicine in order to be able to explore an alternative for clinical practice. The majority of published arguments for alternatives are constructed primarily through application of ethical principles. Multiple feminist authors agree that while the current system is problematic, feminist efforts should focus on reconfiguring the system so that practitioners are sensitive to how environments and life roles affect a person's health (Foster, 1989; Garry, 2001; Hamilton, 1994; Miers, 2002; Purdy, 2001; Reissman, 1998). Building upon these arguments, my research explores women's experiences to construct another view of medical practice, one that can emphasize contextualized understandings of women's experiences of weight preoccupation and body (dis)satisfaction. In this study, women's stories of their experiences exemplify problematic medical practices and highlight alternative modes of clinical care, where weight prejudice is not a factor.

I enter into this research as a woman who has experienced weight preoccupation and body dissatisfaction, and also as a health care professional. What started as my complaining about a general practitioner to friends and colleagues evolved into a thesis when most of the women who heard my story retorted with their own. Over the course of two years, I realized how common it was that women's conversations with health professionals about weight reinforced myths about weight and reflected weight prejudice.

At the same time, while working on an interdisciplinary treatment team, I observed how my colleagues and I talked about our client's weight and body size, the measures that we relied on to do so, and how some applied body weight as a 'catch-all' explanation for health problems. My ability to challenge my colleagues was limited by my inability to pull all the components of my argument together. This thesis has been a process for me to do just that.

I conceptualize my approach as a 'proactive primary prevention' strategy. Primary prevention indicates preventing the development of problematic attitudes, behaviours and/or experiences. Austin (2000) delineates between reactive and proactive strategies: reactive prevention strategies may recognize influential socio-cultural factors but do not work to change them. Instead, reactive strategies target the 'at risk' individuals in the hope that they can "improve coping responses and...augment the individual's resistance to potentially harmful stressors" (Austin, 2000, p. 1250). Proactive strategies are those that try to eliminate causal environmental agents. She argues that this is a much more appropriate focus, as "we must recognize...the fact that no mass disorder affecting large numbers of human beings has ever been controlled or eliminated by attempts at treating each affected individual or by training enough professionals as interventionists" (Albee, 1982, quoted in Austin, 2000, p. 1250). If the powerful cultural institution of medicine plays a major role in both producing and reproducing weight myths in our society, a proactive strategy needs to reduce/eliminate this contribution to the dominant weight discourses. Compared to some of the other known socio-cultural contributors to the reification of thinness, medicine can be held accountable to change because of its own articulated ethical principles.

More specifically, my thesis research highlights how the behaviours of health professionals can influence women's experiences of body dissatisfaction and weight preoccupation as well as their health care access and health outcomes. My project involved collecting stories from women about their experiences discussing weight, food and exercise issues with health care practitioners. Presented in this thesis are the stories gathered through fifteen semi-structured, open-ended individual interviews with women and my analysis of these stories through both a critical discursive method and a conversation analysis method. The conversation analysis highlights the social/interactional context of this 'data', helping me re-examine transcripts for signs of trust, hesitation and co-construction of ideas that give clues to interpretation (Cameron, 2001; Chase, 1995, 1996; Speer, 2002; Widdicombe, 1995). The critical discourse analysis method allows me to highlight hegemonic and alternative discourses about weight and health (Cameron, 2001; Chase, 1995; DeVault, 1990).

While it was my original intention to explore the themes and tensions that emerged in the interviews further through a focus group with initial interviewees interested in participating, this was not possible due to scheduling difficulties. Instead, I sent a summary of the stories, one perspective on an alternative model of clinical care, and an earlier draft of my 'changing clinical practice' chapter to all participants, with a set of open-ended questions to elicit responses about their comfort with how I represented and used their stories to frame my recommendations for clinical practice. This step allows for a more 'participatory' framework for this research, which I value, and which was obvious that some of the women interviewed value. The end result is sensitive practice

guidelines that build upon both the pre-existing literature and reflect the concerns of the women who spoke with me.

In chapter one, I elaborate upon three inter-related bodies of theory that frame this project. These include: (a) feminist critiques and visions of alternatives to the culture of mainstream medicine, (b) debates and conceptualizations of 'healthy weight', eating problems, weight preoccupation and body dissatisfaction, and (c) feminist critiques and conceptualizations of prevention of health related problems. Chapter two is a detailed description of my epistemological and methodological approach to this project. Chapter three presents the results of the conversation analysis to situate the interviews in their social/interactional contexts before offering my summaries of the women's stories of experiences with health care providers. I then offer and discuss the results of my critical discourse analysis. Chapter four reviews one alternative conceptualization of clinical practice (Kratina, 2003) before presenting my own alternative, the sensitive practice guidelines. My response addresses the concerns about culture of medicine and outlines how clinical practice can be structured when a health professional works in a 'health at every size' approach. The concluding chapter will offer final insights and ideas for future directions.

This project highlights how the behaviours of health professionals influence some women's experiences of body dissatisfaction and weight preoccupation as well as their health care access and health outcomes. As illustrated by women's stories, well-intentioned health professionals can and do reinforce harmful cultural discourses through clinical practice. This study builds upon women's stories of experiences to construct another view of medical practice, one that can open up the dialogue about alternative

modes of clinical care. I believe that health care practitioners have an ethical obligation to attempt to minimize potential harms arising from clinical interactions, and as such, sensitive health care should not be impeded by a priori weight prejudiced beliefs.

Chapter 1: Critiques and Visions for Medicine

Western medicine functions within the present dominant scientific paradigm. The scientific paradigm constructs boundaries on what can be known, the methods by which 'legitimate' knowledge is developed, and who is a credible knower. The ontological and epistemological assumptions of this scientific paradigm influence medicine in ways that can be detrimental to those in need of care. Lorber (1997) describes medicine as "...the term used for a system of health care whose knowledge base is modern science and whose practitioners are licensed by the government of the country in which they practice" (p. 11). Medicine relies on specific constructions of health and the body that remove the individual from their socio-cultural, economic and physical environments, as well as assuming that patients possess complete rationality and freedom of choice; that is, given the information, people will make the 'right' choice. The constraints to our choices imposed by socio-cultural, economic, and political factors as well as physical environments are not taken into account. Hence, these constructions overemphasize personal responsibility for health and risk reproducing harmful stereotypes. Following a detailed review of the medical scientific paradigm, this chapter will illustrate how these assumptions affect prevention and treatment of 'illness' and outline how these constructions and assumptions act specifically in relation to women and body weight, concluding with the development of a feminist theoretical space upon which to conceptualize change.

The Medical Paradigm

A review of the epistemological and ontological foundations of medicine is necessary to situate my thesis. Medicine operates within the dominant knowledge paradigm, called positivism, absolutism or objectivism. Positivism assumes that reality has a structure that is unaffected by human investigations; fact is mind-independent. Humans can ‘uncover’ the structure of reality (that is, “The Truth”) through application of reason and adherence to a particular method. To uncover ‘Truth’, humans must enter into the knowledge production process as solitary beings, unaffected by their membership in social groups (Jaggar & Bordo, 1989). All humans are considered capable of the same faculties of reason, regardless of differences. Differences merely create impediments to understanding “The Truth”. Objectivism assumes that ‘Truth’ has only natural causes and that human interests blind us to the real regularities of the world (Harding, 1991). “Truth” is that which holds across local boundaries; that is, local and global are assumed to be virtually interchangeable (Code, 2000).

The positivist paradigm is dominant and privileged in contemporary medical/scientific knowledge. “Kuhn used the term ‘paradigm’ to describe the belief system that underpins puzzle-solving in science” (Sardar, 2000, p. 26). Paradigms relate to ‘normal’ science: “those who work within a dogmatic, shared paradigm use its resources to refine theories, explain puzzling data, establish increasingly precise measures of standards, and do other necessary work to expand the boundaries of normal science” (Sardar, 2000, p. 26). Scientists are puzzle-solvers working within an established belief system. Foucault (1970) described a similar concept. His idea of an ‘episteme’ is that of the underlying network through which thought is organized. An episteme “limits the

totality of experience, knowledge and truth, and governs each science in one period” (Horrocks & Jetvic, 1997, p. 65). In both conceptualizations, science is an ideological practice.

In Kuhn’s notion of paradigms, the invisibility of ideology is a function of the dominance of the paradigm; the dominant ideology *is* ‘normal science’. At any time, the dominant paradigm affects which questions are asked, what is assumed in question and hypothesis formation and who is deemed capable of discerning and knowing ‘The Truth’. It also influences perceptions of what is knowable and by whom, which in turn relates to ontological assumptions about ‘reality’.

The current paradigm builds upon several of Descartes’ epistemological and ontological assumptions. Cartesian dualisms have had a lasting impact on positivism. These are either/or constructions, such as reason/passion, mind/body, culture/nature, subject/object and objective/subjective, where typically one is privileged over the other (Ramazanoglu & Holland, 2002). The Cartesian framework assumes that reality has a structure that is unaffected by human investigations. It is believed to be possible for humans to know the structure of reality, primarily attained by application of reason, sometimes in combination with empiricism (systematic sensory observation). Adhering to a particular method allows one to discover ‘true’ or ‘reliable’ knowledge (Jaggar & Bordo, 1989). In this process, humans can be ‘objective’, that is, transcend subjective historical and political locations, if they follow the rules.

Scheman (2001) highlights how objectivity is an instrumental good; in practice, it must function in a way that produces the good promised. Positivism relies upon a construction of objectivity that Harding (1991) considers weak. This construction of

objectivity as value-free and neutral considers knowledge and knowers as abstract, not affected by their personal locations in concrete historical, political and social contexts. Harding (1991) contends that this conceptualization of objectivity is both too narrow and too broad in its operationalization. It is too narrow in the sense that the only social values and interests identified and eliminated are those that differ from those held by 'normal science'. Weak objectivity fails to consider how the exclusion of certain groups of people from scientific knowledge production affects question and hypothesis formation and definition of key concepts. It is too broad in that it calls for the elimination of all social values and interests from science. Some social values and interests have positive effects on research, generating less partial or distorted beliefs (Harding, 1991). Code (1988) highlights constraints to the actual possibility of the dominant construction of objectivity through an illustrative example from the research world: "by now it is well known that the presence of an observer affects the nature of what is observed" (p. 73). Preconceptions of what is expected affect the behaviours of those studied, the methods used to study them and the interpretative framework used in analysis. Objectivity, as described by the current dominant paradigm, is not possible or desirable.

"The best as well as the worst of the history of the natural sciences has been shaped by – or, more accurately, constructed through and within – political desires, interests, and values" (Harding, 1991, p. 146). As Kuhn described, achieving paradigmatic status means that the beliefs and ideologies shaping the paradigm are assumed, not visible. If all knowledge is shaped by ideologies, one must ask why this impossible constructed version of objectivity persists. This 'weak' construct endures because it serves the interests of those with privilege. The construction of scientific

knowledge as non-ideological and innocent means that any challengers risk being labelled as dogmatic, intolerant or 'subjective' if they do not demonstrate the flaws in 'the facts' (Code, 1996). Hence, the construction of scientific knowledge as developed through this privileged but obscured-from-view ideology works to maintain the status quo. The dogmatic rejection of subjectivity and the invisibility of ideology in hegemonic science creates the opportunity to discredit knowledges shaped by alternative ideologies. Additionally, this promise of value-free knowledge production allows practitioners to distance themselves from both the origins and the consequences of their theories, absolving the knowers of limits and responsibilities (Haraway, 1991; Harding, 1991).

The androcentric positivist paradigm fails to live up to the promise of neutrality in practice. Stereotypes of women and men are built on dichotomies such as reason/emotion, mind/body and public/private. These essentialist stereotypes have been supported by empiricist 'evidence' (Code, 1988). Such evidence is problematic in that it relies on a priori assumptions about innate differences. This process, often ignored by positivists, underlies the false construction of scientific knowledge as abstract, theoretical and neutral.

The development of prejudicial, androcentric knowledge relies on both epistemological and methodological devices. The dependence on essentialist dichotomies and belief in 'universal truths' limits what questions are asked, the methodological approach to data collection, and the lenses through which data is analyzed. Discrediting of counter-examples and labelling outlying data as 'aberrant' exemplify androcentric research practices (Code, 1988). Animal behavioural studies, where sex differences are the focus, have excluded counter-examples to sex stereotyping, even though ignoring

counter-evidence runs contrary to the scientific model. Another practice used to discredit counter-examples is the act of labelling a finding 'aberrant'. The inability of these theories to include the broad spectrum of animal behaviour points to the ideological underpinnings of such work (Code, 1988). This is how stereotypes are strengthened through science: counter-examples are ignored or dismissed as aberrant, while confirming findings are given undue attention (Code, 1988). Gender stereotypes are reproduced by studies exploring male and female natures that assume male to be the human norm, female the aberrant condition. Such prejudicial, ideologically driven practices reinforce discrimination through strengthening stereotypes.

This dominant paradigm relies on the construction of the 'knower' as a rational, autonomous actor detached from socio-cultural influences and ideologies. Haraway (1991) describes this socially constructed concept of the knower as one who is able to see everything from nowhere, with the ability to mark others while remaining unmarked. The 'true' knower is understood as protected from the 'polluting interests' of the world (Harding, 1991). In this sense, the knower in positivism transcends their body and their social location. Code (1996) argues that this assumes

knowers worthy of the title can act as 'surrogate knowers' who are able to put themselves in anyone else's place and know her or his circumstances and interests in just the same way as she or he would know them. Hence those circumstances and interests are deemed epistemologically irrelevant (p. 192).

This construction of being able to transcend one's own social location in this dominant construction of objectivity is both irrational and impossible (Haraway, 1991).

Code (1996) contends that this assumed context-independence is legislated, not found. She challenges positivism by illustrating how what is called 'normal' or 'typical' in science hides the subjectivities of the knowers from view and scrutiny. The subject is one who concludes what 'any normal individual' would conclude upon reflection (Code, 1996). She asks, 'normal or typical to whom?' to illustrate the problem in this assumption. The application of the label 'normal' naturalizes the idea of 'aberrance' or 'deviance'. In application, this normal/deviant dichotomy serves to create and reinforce discriminatory forces such as sexism and racism (Code, 1996).

This paradigm constructs a false dichotomization between knowledge and experience (Code, 1988). This is false because empiricism, one of the primary tools through which positivists develop knowledge, is sensory observation, a form of experience. The issue becomes what type of experience is privileged as knowledge, and who is granted the credibility to know. A credible knower must present knowledge in an acceptable form (Code, 1988).

Working within the positivist paradigm, as medicine does, means taking on these epistemological assumptions. In contemporary mainstream medicine, the health professional is deemed the knower, the one whom is granted credibility and exercises power, while the patient is the puzzle, the object waiting to be pieced together. Subjective symptoms can be disregarded if the objective signs tell a different story. How the health professional interprets the signs and symptoms of the patient relies on a body of positivistic scientific literature that replicates discriminatory biases based upon dualistic thought. Clinical medicine risks reproducing discrimination and prejudice because it relies on a biased knowledge base while it ironically works behind the façade of this

impossible yet persistent construction of objectivity. This dominant construction of objectivity allows health care practitioners to distance their actions from negative consequences of their knowledge.

This study builds upon the problematization of positivism, the dominant epistemological foundation used in the construction of the medical paradigm and its clinical practices. I argue that the positivist assumptions of medical practice have implications for women, their health, and their health care.

Social Constructionism: Critiques of 'Health', Medicalization and the Culture of Medicine

While there are several theoretical approaches to the sociology of health, the body and illness, social constructionist approaches engage best with the questions raised in this study. Social constructionist approaches to health, medicine and the body question the claims of essential truths and explore power within hegemonic frameworks. Hence, “what is asserted to be ‘truth’ should be considered the product of power relations, and as such, is never neutral, but always acting in the interests of someone” (Lupton, 1994, p.11).

Social constructionism is criticized for questioning the reality of disease or illness experiences. Lupton (1994) argues that these critiques are misguided; social constructionism “...emphasizes that these states and experiences are known and interpreted via social activity and therefore should be examined using cultural and social analysis” (p. 11). Bodies are physical entities, but what we perceive and how we understand our body is socially mediated (Lupton, 1995; Malson, 1995, 1998, 1999).

What a social constructionist approach offers to the study of medicine, health and illness

is an avenue by which to examine the claims to truth held by medicine and recognize multiple interests and sites of power within this system. A social constructionist perspective allows for an anti-essentialist examination of the issues of agency and difference. The goal of such an approach is to not reconstruct “The Truth” but to assemble alternate versions that can be evaluated for their insights and contributions.

Foucault’s understanding of the relationship between power and knowledge has been particularly influential.

There can be no possible exercise of power without a certain economy of discourses of truth which operates through and on the basis of this association. We are subjected to the production of truth through power and we cannot exercise power except through the production of truth (Foucault, 1980, p. 83).

He argues that power is everywhere, and is exercised, not possessed (Foucault, 1984). Further, power is not always negative or repressive; rather, “power produces; it produces reality; it produces domains of objects and rituals of truth” (Foucault, 1984, p. 205).

Foucault’s works focus on the strategies by which power is exercised. Through this focus, he was able to illustrate how domains of knowledge are domains of power. In the late 18th century, a shift in education, workplace, medical and disciplinary systems occurred in Western societies. Prior to this period, subjection was accomplished often through violence and ideology, and in the case of slavery, relied on the notion of ownership of bodies. Societal changes created the need for other technologies of power that were less costly economically, less visible, and less open to resistance. New strategies of power increased aptitude for action while simultaneously reducing resistance (Foucault, 1984).

These new strategies of power were inter-related with knowledge, demonstrable in the modes of objectification. Foucault describes this nexus as 'power/knowledge' (Foucault, 1984, 1995). Foucault described three inter-related modes of objectification of subjects: dividing practices, where part of a group is removed from the whole; scientific classification, a systematic approach to separation; and subjectification, where the self-understanding of individuals is mediated by an external authority (Rabinow, 1984). "In the modern age...a great deal of power and social control is exercised not by brute forces or even by economic coercion, but by the activities of 'experts' who are licensed to define, describe and clarify things and people" (Cameron, 2001, p. 16). The implications of this argument impact upon how medical knowledge and practices are understood. Medical experts, relying on this nexus and strategies of 'power/knowledge', mediate how we understand our health, our bodies and illness.

These evolving disciplinary strategies of power, exercised in a range of social institutions through the knowledge claims of experts, serve to normalize certain behaviours and foster a system of self-surveillance. This occurs through both a sense of constant supervision and 'punishment' for non-conformity (Foucault, 1984). The ideal disciplinary apparatus would be one where a single gaze can see all constantly, while remaining unseen.

Disciplinary power...is exercised through its invisibility; at the same time, it imposes on those whom it subjects a principle of compulsory visibility. In discipline, it is the subjects who have to be seen. Their visibility assures the hold of power that is exercised over them. It is the fact of being constantly seen, of

being able always to be seen, that maintains the disciplined individual in his subjection” (Foucault, 1984, p. 199).

The sense of always being monitored and compared, combined with privilege for those who fit the expectations and punishment for those who do not, ‘encourages’ individuals to conform. Hence, the ‘norm’ becomes a principle of coercion (Foucault, 1984). The ‘norm’, an effect of these strategies of power, is produced and reproduced through knowledge.

Medicine is one of the institutions Foucault discusses in his study of ‘disciplinary power’. The medical examination is a key technique in individualization and training ‘correct’ behaviour (Foucault, 1984). In the examination, the person and his/her symptoms are subject to a normalizing gaze that differentiates, classifies, and judges. The results of this surveillance are then ‘captured’ in writing by the health professional, a process that further objectifies patients. In the examination and documentation process, the health professional exercises power through this normalizing gaze and surveillance of the patient.

Foucault’s work on power and medicine continues to be central to social constructionist approaches to health and the body. Lupton (1995) draws on the work of Foucault to explain power: power is neither external to nor independent of the body, but influences how we understand the body. Power/knowledge disciplines populations, reproduced through extra-local discourses and local interpersonal relations in medical encounters. This power has the potential to be coercive:

In the interests of health, one is largely self-policed and no force is necessary.

Individuals are rarely incarcerated or fined for their failure to conform; however

they are punished through the mechanisms of self-surveillance, evoking feelings of guilt, anxiety and repulsion towards the self (Lupton, 1995, p.10).

In the clinical encounter, this self-surveillance is compounded by one obvious power differential: that of a supplicant asking another for assistance or guidance (Stevens, 1996). That is, a power differential exists between the physician and the patient simply because the patient seeks assistance from the doctor. While the identities of the health professional and the patient may involve many nuanced power inequalities, this one remains constant. This position does not assume that patients are without agency; they can seek other opinions, challenge the physician or disregard the advice. However, the health professional, granted the status of expert, is the one who controls access to services and medications.

Medical discourse in Western society relies on a specific social construction of the term 'health' (Lupton, 1995). Health is synonymous with physical health, set up as a dichotomous entity of 'healthy' or 'ill'. Tied to this is the present issue of 'healthiness', the new measure of proper or morally good living. Focus on diet and other 'lifestyle choices' has become a primary mechanism by which we understand life and death (Lupton, 1995). This tyranny of health is also called 'healthism' (Lupton, 1995). This concept of health, as well as the knowledges and practices of different medical disciplines (such as public health or medicine), are embedded in broader socio-cultural, historical and political settings. What is understood as 'healthy' is not static historically and is defined by dominant social discourses.

Social constructionist approaches have been used to explore gender and illness in Western medicine specifically. Lorber (1997) suggests that experiences of illness

symptoms are noted for how they disrupt our social lives. Our evaluations that something is 'wrong' and our guesses as to potential causes are experienced in social contexts. Some experiences are legitimized as symptoms while others are ignored or deemed irrelevant; power shapes these processes. The medical encounter itself is a social exchange in which experts transform symptoms into one or more diagnoses. At least two actors are involved in the process of assigning meaning to illness symptoms: the health care practitioner and the patient. However, with this system, the interpretation of the health care practitioner is deemed 'true'.

Both past and present examples of dominant androcentric bias challenge medical claims of scientific objectivity. In the nineteenth century, constructions of gender influenced the application of the 'conservation of energy' theory (Ehrenreich & English, 1973). This physiological theory was that human organs and systems compete for a fixed quantity of energy available in a human body. Women's reproductive roles were central to their lives, while men's central concern was intellectual function. Hence, women's energy was to be concentrated internally, particularly during menstruation and pregnancy, which translated into recommendations of bed rest during these phases of their reproductive cycles (Ehrenreich & English, 1973). This theory was extended beyond visible reproductive processes. The uterus and ovaries, theorized as the control centres of women's bodies, were considered the source of most ailments (headaches and sore throats, for example). Hence, these organs became the focus for treatment, which included acts such as applying leeches to women's reproductive organs and surgically removing the ovaries. Not only physical symptoms were understood as linked to women's reproductive organs; many of these insidious treatments aimed to change women's

behaviours into ones understood as congruent with women's 'natural state'. What was defined as 'natural' was a socially constructed version of femininity encompassing passivity and dependence (Ehrenreich & English, 1973).

For a contemporary example, consider how medical investigation and treatment differ between an elite male athlete and a female office worker complaining of back pain. The athlete will be asked about mechanism of injury, interference with activities and multiple diagnostic tests will be arranged. The office worker will be asked questions about her 'stress' levels and enjoyment of work. Few tests, if any, will be ordered. She may be offered anxiety or anti-depressant medications and told that her back pain will resolve without intervention (Lorber, 1997). This example oversimplifies the variables involved, but gender and social status affect how the clinical exchange unfolds. These examples illustrate the failure of medicine to live up to the promise of objectivity. Medical practices, like those of other institutions, are historically and culturally located.

Health professionals providing clinical care are oriented to look at disease through a positivistic scientific lens that tends to conceptualize individuals and their illnesses as separate from their social or physical environmental contexts. This process of decontextualization fuels reductionism, where the complaints of individuals are examined through only or primarily a biological lens. The individualization and decontextualization of illness renders invisible the social and political context that may be central in producing, defining and classifying illness.

The process of medicalization is an example of the reductionism inherent in the positivistic scientific paradigm. This is a process by which the social aspects of a problem are ignored; a problem of social origin is labelled and subsequently treated as a biological

disease. By conceptually removing people from their social worlds, all are treated as patients or 'almost' ('at-risk') patients (deSwaan, 1989; Verweij, 1999). A medicalized social problem obscures political and social inequalities. Those deploying a medical model do not leave space for social critique.

Medical approaches to 'eating disorders' exemplify medicalization in contemporary society. Diagnostic criteria for anorexia nervosa and bulimia nervosa (outlined in Appendix A) are specific and measurable, but have changed over time, suggesting that these disease categories are socially defined and overly inclusive. Under these static criteria used by medicine, one can only be ill or healthy. This dichotomy fails to account for the majority of women who express dissatisfaction with their body weight (Allaz, Bernstein, Rouget, Archinard & Morabia, 1998; Jones, Bennett, Olmstead, Lawson & Rodin, 2001), an attitude fuelled by demonstrable weight bias and discrimination in Western societies. The medical approach removes women's fear of fat from its social contexts. Brown (1993b) argues that the diagnostic criteria applied by medical practitioners "reflect a poor understanding of the degree of desperation and anxiety the average woman in our society experiences around eating and her body shape and size" (p. 58). These criteria cannot respond to questions about why this 'illness' disproportionately affects women in Western countries, why the problems are more prevalent now compared to a century ago, or why eating problems are increasing in prevalence around the world. Typical of the medicalization of women's experiences, relatively normative eating attitudes (such as 'fat is bad') and behaviours (such as caloric restriction) are classified as 'illness' and treated as a problem affecting an individual woman. Brown (1993b) suggests that this process illustrates the distance of medicine

from women's experiences in our society. It also fails to operate with the widely accepted World Health Organization definition of 'health', which encompasses physical, emotional, mental and spiritual well-being.

Biological factors in illness often are identified, correctly or incorrectly, as causal even when social or physical environmental factors are recognized by medicine. Hamilton (1994) calls this implicit theory of medicine 'biological primacy'. She argues that this reductionistic theory is implicit because the broader culture of medicine projects itself as apolitical and ahistorical. Inevitably, this biological primacy leads to reductionism. Reductionism risks misattributing, underestimating or overestimating the roles of various factors in illness. She argues that it is the overly simplistic nature of this assumption that is the crux of the problem of medicalization.

Feminists are concerned with the medicalization of women's social experiences because it not only erases the oppressive context of women's lives, but also often contributes to it. Unlike non-feminist writers such as deSwaan (1989) and Verweij (1999), feminists look to the overall professional dominance of medicine, the practices of individual practitioners and women themselves in fostering medicalization of women's lives. Findlay and Miller (1994), Garry (2001), Morgan (1998), Purdy (2001), and Reissman (1998) all agree that power inequalities in the clinical medical encounter are central to medicalization.

The culture of medicine affects interpersonal relations between health care practitioners and patients. Lorber (1997) describes the social aspects and power dynamics of the medical encounter in detail. The typical clinical exchange is one where the physician asks the questions, while the patient provides answers. This question/answer

dynamic may be verbal or non-verbal. Verbal answers may be dismissed as irrelevant by the health care professional, as the dominant view in the medical model is that the 'truth' is inscribed on the physical body. Certain features warrant monitoring, while others do not; the medical practitioner is the one with the power to decipher symptoms and signs, and to decide what is of relevance.

Exploring this dynamic in the medical encounter means being attentive to what is asked and not asked, as well as what is validated and what is ignored by the involved parties (Cohn, 1997; Fisher, 1994; Lorber, 1997). Cohn (1997) analyzed clinical exchanges between patients and nurses in a diabetes treatment centre. In the example he provides, the patient vocalizes her belief that stressors and personal concerns are affecting her blood sugar levels, which is subsequently ignored by the nurse. The nurse emphasizes diet as the method to control blood sugar levels, even though other effective options exist to address the problem, such as changing the medication dose. The nurse validates the medical discursive construct of diabetes as a biological condition caused by poor 'lifestyle' choices. This focus on 'lifestyle' reduces the illness to factors under individual control. This discursive construction of diabetes as a lifestyle disease over-emphasizes individual agency and de-emphasizes the interaction of social, political and economic factors with biology.

These assumptions have direct ramifications for treatment/management. After the exchange between the nurse and patient, Cohn interviewed the patient and found that she had an understanding of her symptoms that ran counter to the medical one. With this different understanding, she acts in ways that are highly discouraged by the nurse. The interplay between the woman's beliefs and social influences with biology is left

unexamined by the nurse. Instead, the patient is labelled non-compliant. There is no reason to believe that the patient will stop acting in ways that exacerbate her diabetes. The medical treatment paradigm focuses on behaviour change without contextualizing the behaviours, thus fails to provide patients with support that is relevant to their beliefs, understandings and life stresses. This often results in disempowering relationships with health care practitioners (Brown, 1993a).

Feminist Perspectives on Weight Preoccupation, Body Dissatisfaction and Eating Problems

Social contexts must be considered in any examination of the culture of medicine. Many feminist authors have named popular discourse, which incorporates medical discourse, as primary in perpetuating the tyranny of thinness² (Austin, 1999; Bordo, 1993; Chernin, 1981; Germov & Williams, 1996; Wolf, 1990). In the 1990's, more focused attention was paid to the contributions of medicine to this dominant discourse. Western societies construct the citizen as a rational actor who has freedom of choice, an assumption evident in medicine. In such a culture, "the civilized body is controlled, rationalized and individualized, subject to conscious restraint of impulse, bodily processes, urges and desires" (Lupton, 1995, p. 8). Medicine in these societies assumes that individuals just need the right knowledge, skills and socialization to act rationally, and hence, produce a 'healthy body'. Health, an idealized notion, is believed attainable

² Influential earlier works by feminists such as Orbach's (1978) *Fat is a feminist issue* and Chernin's (1981) *The obsession: reflections on the tyranny of slenderness* set up the fat/thin issue as political, and were important in fostering the discursive shift from 'dieting' to 'balanced eating'. Comparing these earlier reviews of the issue to contemporary critiques highlight how we are still dealing with the same general issues, though the language and focus has changed somewhat.

solely through the actions of an individual; the pursuit of good health becomes an end in itself as opposed to a means to an end.

The body is understood as reflecting the morality and personality of the inner self (Lupton, 1995; Malson, 1999). ‘Good health’ is assumed to be inscribed on the physical body, mirroring inner self-control, strength and weakness. “Fatness thus stood as a tangible sign of lack of control, impulsiveness, self-indulgence, while the thin body was a testament to the power of self-discipline” (Lupton, 1995, p. 139). Body shape and bodily fat as well as food assume moral qualities: “Certainly these days, when I hear people talking about temptation and sin, guilt and shame, I know they’re referring to food rather than sex” (Rothblum, 1994, quoted in Germov & Williams, 1996, p. 103). If a person does not behave in a ‘rational’ manner, they are either considered to have insufficient knowledge or be irrational. Western medicine generally assumes the patient to be a rational actor and ignores the social and physical environmental contexts that shape individuals’ choices. “The focus on individual lifestyles not only reinforces a blame the victim approach, but does nothing to mitigate the environment in which individual lifestyles are *lived*” (Germov & Williams, 1996, p. 104). This, in turn, constrains choices.

Medicine assumes that medical knowledge is objective and ideologically neutral, delivered by rational, autonomous health care practitioners. Several authors have contested these assumptions by exploring the dominant ideologies in medical training and providing examples of the inability of health care professionals to divorce their own subjectivities from practice. Studies of weight bias highlight how dominant cultural beliefs influence health professionals. Like the general population, health professionals view ‘overweight’ people as less successful and less intelligent (Melcher & Bostwick

1998; Szekely & DeFazio, 1993; Yanovski, 1998) and adhere to the belief that an inability to maintain a 'healthy' body weight is related to a lack of willpower (Austin, 1999; Germov & Williams, 1996; Schwartz et al., 2003). Schwartz and colleagues (2003) recently reproduced these results in health professionals and researchers specializing in 'obesity'. These types of findings directly challenge the notion that health professionals are neutral and objective. Assuming that they are ignores that health care practitioners and their patients are influenced by the same dominant culture (Austin, 2000; Germov & Williams, 1996). Health care professionals hold attitudes and biases similar to the rest of society. While they may not intend to reinforce a culture of slimness, through their practice, they can and often do (Berg, 1999b; Germov & Williams, 1996). This is problematic as it reproduces the status quo, which is, in this case, discourses that foster harmful weight preoccupation and body dissatisfaction attitudes and behaviours among women.

Additionally, there are practices in medicine that profit directly from individuals believing that they are ugly and/or fat. The discipline of cosmetic surgery (not to be confused with plastic surgery that specializes in treatment of trauma and burn victims) reduces healthy, able bodies to those in need of correction (Wolf, 1990). This medical discipline tends to cultural needs, and relies upon the vulnerability and insecurity of patients to be lucrative. In this sense, at least one branch of medicine profits from reinforcing, perpetuating or even furthering harmful cultural discourses about weight (Wolf, 1990).

Similarly, Austin (1999) raises suspicion, in her discursive examination of public health and nutritional science literature, about the legitimacy of claims of neutrality and

truth made by various health disciplines. This non-neutrality constructs a version of reality where personal failing is the explanation assigned for larger body size and higher body weight. In Western culture, where physical thinness promises (and often delivers) both social and psychological rewards (Wolf, 1990), being 'overweight' is understood as reflecting personal character flaws (Brownell & Rodin, 1994). This constructed reality relates to the widespread belief that self-control, via dieting, will prevent people from being 'overweight', even though this ignores or minimizes the role of genetics, socio-economic status and physical environment on body weight and composition. Hence, an individual whose weight is above the 'healthy' range (defined as a body mass index greater than 27) is assumed to lack discipline or self-control. This myth is both affected and perpetuated by medical practices.

While medical discourse is not the only discourse reinforcing Western cultural idealization of thinness, it wields significant influence on popular understandings of food, weight and size. Findlay and Miller (1994) argue that women's physical appearance has come to be governed by medical control through the dominance of medical discourse. They examine the reliance on quantification of modern medical/scientific discourse and explore how this has been internalized by individuals, such that people now self-police their actions. It is not uncommon to hear someone say 'That's really high in fat, I can't eat it', or 'I really shouldn't eat that'. This type of language demonstrates the disciplinary strategy of self-surveillance (as described by Foucault, 1984 and Lupton, 1995) in regard to weight.

A conceptual framework for both 'obesity' and 'eating disorders' that places responsibility for weight and health solely on the individual shapes the strategies for

prevention and treatment, assuming that only the individual is in need of change. This approach ignores strategies to change the adverse health influences of social, physical, and economic environments. This approach over-emphasizes the agency of individuals and does not acknowledge the multiple influences that constrain and shape our choices. Hence, the medical approach to prevention and treatment, which focuses solely or primarily on individuals, risks blaming the individual for a situation beyond her control. Medical weight loss programs typically focus on behavioural causes of 'obesity', rather than contextualizing the choices of individuals in our societies.

Wooley and Garner (1991) take issue with the assumptions underscoring current medical practices around weight control issues. In this model, 'obese' people eat more, exercise less, are less disciplined and emotionally underdeveloped or unstable, with potential concurrent psychopathology, such as binge eating (Wooley & Garner, 1991). This operates on a number of assumptions, including that weight is changed easily, that permanent weight loss to a body mass index value of 25 or less is possible or healthy for everyone, that dieting is effective and that fat is unhealthy (Berg, 1999b; Cogan, 2000; Gaesser, 2003). There is a body of literature that demonstrates that those many of those who are 'overweight' do not eat more than those who are thin (see Rothblum, 2001 for a comprehensive review). The model employed for 'obesity' is problematic in the same way that the psychiatric model of 'eating disorders' is problematic (Cooksey & Brown, 1998): by defining the problem at the level of the individual and naming their behaviours as the cause of larger body size, treatment and prevention can only be understood at an individual level. The lack of incorporation of the biological, social, cultural and

environmental factors related to 'obesity' illustrates an inherent disjuncture between the causation models and approaches to prevention and treatment (Austin, 2000).

The efficacy of dieting and diet drugs as treatment tools for 'obesity' is debatable (see Berg, 1999b for a comprehensive review). The word is used to denote practices including both severe caloric restriction and changes in food selection. Some of these practices are health promoting while others cause deterioration in health status. Generally, 'dieting' indicates a reduction in caloric intake (Brownell & Rodin, 1994) and is recommended for 'overweight' and 'obese' people. However, the definitions of 'overweight' or 'obese' are contentious. Body mass index, the most popular measure used to judge weight, fails to consider body build and relies on the assumption that 'excessive' weight causes poorer health (Brownell & Rodin, 1994; Ciliska, 1993). This assumption is problematic, as much of the research exploring effects of body weight on morbidity and mortality is inconclusive and rife with methodological flaws (Ernsberger & Koletsky, 2000b; Marchessault, 2000). Such data usually is generated by large epidemiological studies, where weight loss is self-reported and fails to account for possible mediating factors, such as body fat distribution, fitness levels, use of dangerous diet drugs, weight cycling or weight loss attributable to smoking or disease (Brownell & Rodin, 1994; Ernsberger & Kotskey, 2000a; Gaesser, 2003). A number of studies with a range of specific populations have demonstrated the limitations of assuming 'healthy' BMI is 18-25 (Bedogni et al, 2001; Kline, 2001; Malina, 1999; White & Parham, 2000). As Ernsberger (1999) and Kline (2001) point out, BMI has poor predictive ability for body fat and health risk when applied directly to individuals; that is, it is not a valid or reliable measure when applied to an individual person. Despite all this contradictory evidence, the

BMI-based definitions of 'overweight' and 'obese' used in many research and clinical settings remain unchanged.

Individuals are often adversely affected by the inadequacy of medical weight loss programs. Both the stigmatization of 'obesity' and the recommended treatments can unfavourably affect health (Berg, 1999b). The dominant discourse implies that failure to achieve or maintain a specific weight indicates a personal flaw and ignores the psychological consequences of under- or mal-nutrition (Berg, 1999b; Wooley & Garner, 1991). That is, the psychological concerns are attributed to a primary mental health disorder rather than as consequences of poor nutrition. In terms of physical health, short-term weight loss followed by weight gain adversely affects many metabolic and cardiac conditions (Berg, 1999b). Furthermore, calorie-restrictive dieting usually produces a sense of deprivation, obsession with food, and trigger behaviours like binge eating (Berg, 1999a; Ernsberger, 1999). In order to approach the issue ethically, health professionals must not assume that the psychological presentation of a person with an eating problem existed prior to the under- or mal-nutrition (Wooley & Garner, 1991).

Women and girls are risking their health to be thin. The sheer numbers of North American female adolescents exhibiting signs of weight preoccupation or 'dysfunctional eating' implies that this experience is the rule rather than the exception. In Canada, 80% of adolescent girls of 'normal' weight reported a desire to weigh less (Jones, Bennett, Olmsted, Lawson & Rodin, 2001). Dieting, binge eating and purging behaviours are observable in 27% of adolescent females (aged 12-18), increasing in prevalence throughout adolescence (Jones et al., 2001). In a comparison of more than 2,000 male and female adolescents with chronic illness to more than 1,300 without, those with illness

reported more body dissatisfaction and engaged in more dangerous weight loss behaviours than those without (Neumark-Sztainer, Story, Resnick, Garwick & Blum, 1995). The weight preoccupation/body dissatisfaction trend is observable beyond adolescence. Allaz, Bernstein, Rouget, Archinard and Morabia (1998) found that 71% of a sample of 30-74 year old women reported a desire to thinner, even though 73% of these were of 'normal' weight. Of these, almost half had dieted for weight control reasons in the previous five years. Dieting, defined as chronic dietary restraint, is a recognized risk factor for many health problems, including slowed basal metabolic rate, long term weight gain and 'obesity' as well as eating problems (Dae, Robinson, Lawson, Turpin, Gregory & Tobias, 2002; Jones et al., 2001). Yet, in spite of the evidence that suggests that chronic dietary restraint is harmful, women in our society continue to engage in the behaviours, and some health professionals continue to emphasize dieting as a weight control strategy. This speaks both to the strength of dominant weight myths and the material expressions of weight discrimination in our society, where stereotypical beliefs about body weight are operationalized by social and economic rewards and sanctions. By situating the behaviour within influential socio-cultural contexts, it becomes apparent that striving to be thin in this society is a 'rational' response to weight discrimination (Wolf, 1990). Our societal focus on weight is not just about pressure to be thin; it is a strategy of control (Wolf, 1990). "The social obsession with dieting and weight control is yet another example of the body politic...whereby controlling women's bodies has ensured social control of women" (Brown, 1987).

Another illustration of the failure of the medical professions to contextualize illness is found in the 'eating disorders' literature. The medical discipline of psychiatry

has a discrete way of diagnosing 'eating disorders' (see Appendix A), where one can only be 'healthy' or 'ill' (Brown, 1993a; Orbach, 1978). This fails to acknowledge social contexts in the development of the illness (Cooksey & Brown, 1993). This medical practice is reductionistic. Feminist perspectives on weight preoccupation, body dissatisfaction and eating problems do not use the same decontextualized approach. Instead, they visualize a continuum of attitudes and behaviours (Brown, 1993b) and consider socio-cultural contexts (including the current anti-obesity climate) as critical to developing an understanding of why these experiences are so common for women. Medical responses to socio-cultural models argue that while all women are exposed to the same socio-cultural messages, only some develop 'eating disorders'. Bordo (1993) points out the flaws in that argument; women are not all exposed to identical socio-cultural environments. What women in Western societies do have in common are exposures to images and ideologies that homogenize and normalize a specific construction of beauty and femininity.

While feminist authors typically contextualize women's struggles with the body and eating, there is no conceptual agreement as to how dominant discourses influence girls and women (Bordo, 1993). Some feminist authors emphasize that girls and women develop eating problems due to the overwhelming influence of cultural idealizations of thinness (Davis, 1990; Friedman, 1997; Mahowald, 1992). Others argue against this approach, allowing for eating problems to reflect a simultaneous submission to and struggle against social constructions of femininity (Bordo, 1993; Lester, 1997; Malson, 1995, 1998, 1999; Malson & Swann, 1999). These complex and contradictory conceptualizations of eating problems result from contradictions inherent in

contemporary discourses about the body and femininity. That is, multiple social discourses converge upon the body (Malson, 1995, 1998, 1999). In a society where the body is devalued *and* linked to the social construction of femininity, controlling the flesh can be understood as a rejection of the negative aspects of feminine identity. Malson and Swann (1999) describe how the curvaceous, hyper-sexualized female 'porn model' ideal body is discursively constructed as contemptible, and is vulnerable to 'consumption' by men. Thinness is, in this discourse, a representation of independence, assertiveness and self-determination (Lester, 1997). The paradox is that women's thinness is simultaneously interpreted as conformity to certain aspects of feminine gender stereotypes, such as vanity, approval/acceptance-seeking, vulnerability, irrationality, fragility and in need of protection, even if only from herself (Lester, 1997). "The 'anorexic body', like other bodies, is therefore, 'always already' caught up in systems of meanings, symbolic repressions and power relations" (Malson, 1995, p. 88). Women are agents, but limited to the spaces of available discourses (Lester, 1997). Hence, no universal meaning can be claimed for problematic eating behaviours.

For my work, I assume a nuanced position: while eating problems may be an active coping strategy used by a conscious actor, it is a coping strategy that engages in a 'conversation' with hegemonic discourses. The dominant discourse tells us that body weight is within our control, and it is a result of personal failing if we do not control our body size. Regardless of whether women 'manage' their body size and weight as resistance and/or submission to this discourse, their behaviour reflects the discourse. It is in this manner that behavioural expressions of weight preoccupation and body dissatisfaction are tied to socially dominant discourses.

While few are diagnosed as 'ill' by medicine, the continuum conceptualization of eating problems suggests that many women are adversely affected by weight preoccupation and body dissatisfaction (Brown, 1993b). The medical system response to these findings suggests that by normalizing problematic eating behaviours in this model, feminists are denying how debilitating anorexia or bulimia is to those affected by it (Bordo, 1993). Rather than acknowledge how normative obsession with body weight is in our society and considering body dissatisfaction/weight preoccupation as symptoms of a 'sick' society, the medical model further pathologizes women through the construction of 'subclinical' or 'partial' eating disorders (Bordo, 1993; for example, see Stein, Meged, Bar-Hanin, Blank, Elizur & Weizman, 1997). From this response, it becomes apparent that the range of women's eating problems with weight and weight control behaviours are medicalized, stripped of social context, by medicine.

The continuum approach to eating problems combined with an understanding of socio-cultural influences has implications for prevention. Austin (2000) delineates primary prevention (meaning prevention of the problematic experience altogether) efforts as reactive or proactive. Reactive prevention models may acknowledge the role of socio-cultural factors, but do not work to change these environments; they work to improve the coping responses of individuals to socio-cultural pressures. Workshops on body image given to 'susceptible' teens exemplify this approach. In reactive strategies, the environments are a given, assumed to be either unproblematic or unamenable to change. Proactive primary prevention efforts try to eliminate harmful environmental pressures. Such a position assumes that proactive primary prevention strategies are the most likely to minimize the harm of weight preoccupation and body dissatisfaction. In Brown and

Jasper (1993), several descriptions of initiatives exemplify this approach, from fitness classes for larger women, media campaigns, and peer support programmes that situate women's experiences in our weight prejudiced society. Proactive primary prevention strategies require that socio-cultural, political and economic structures be examined for their contributions to the idealization of thinness in Western culture.

In Austin's (2000) study of twenty different disordered eating prevention programs, none were found to adhere to a proactive primary prevention strategy. Most of the programs examined by Austin acknowledged socio-cultural pressures, such as media, fashion and dieting/fitness industries, in the development of disordered eating attitudes and behaviours, but none incorporated strategies to change the socio-cultural influences. This may not be surprising, considering that the psychiatric diagnostic criteria for eating disorders fail to consider mental illness diagnoses in any social context. Based on this medical conceptualization, there is no possible way to prevent eating problems (Cooksey & Brown, 1998). Some health care practitioners and researchers include socio-cultural influences in their conceptual models, but still approach prevention at the level of the 'susceptible' individual, exemplifying 'reactive' primary prevention. While not all the programs included evaluation components, those that had noted a lack of long-term success in preventing problematic eating behaviours. I agree with Austin's concern with the focus of these programs:

Expecting girls and boys to develop resilience to unhealthy pressures may prove to be a less successful strategy than searching out avenues to make significant changes in that environment....placing the burden of change on the individual

while leaving a toxic environment unchallenged may even be considered unethical (Austin, 2000, p. 1256).

Thus, proactive primary prevention strategies must work to transform toxic environments. Transformation will involve debunking the weight and diet myths that perpetuate weight prejudice at a societal level.

Prevention is always preferable to treatment of illness. Social and environmental contextualization of 'obesity' and eating problems leads to radically different approaches to prevention. Illness models that explicitly recognize socio-cultural factors as influential must consider changing social and cultural environments as a critical component of any prevention effort (Austin, 2000). "We must recognize the fact that no mass disorder affecting large numbers of human beings has ever been controlled or eliminated by attempts at treating each affected individual or by training enough professionals as interventionists" (Alberr, 1982, p. 1045, cited in Austin, 2000, p. 1250).

Feminist Health Visions

Many feminists have explored the topic of how to transform medicine into a more women-centred or gender-sensitive institution. A general consensus in feminist critiques of medicine is that "the medical relationship is characterized by an asymmetry between provider and patient and by an almost exclusive concern with medical topics to the nearly total exclusion of the social, biographical context of patients' lives" (Fisher, 1994, p. 303). The debates in this body of literature pertain to whether or not the system is salvageable and if so, what role health care practitioners should assume.

Hamilton (1994) offers a description of feminist critiques of medicine:

A feminist critique of medicine is concerned with issues of power, both as it shapes health, illness, and recovery and as it determines forms of and access to health care and research. A feminist approach will address how organized medicine relates to patients, to its own practitioners, and to other health care professionals. And, finally, a feminist approach will address how to change health care to better meet the needs of women, both as patients and as caregivers. (p. 59-60)

Her assertion that abandoning the current health care system entirely does not assure women's well-being is echoed by Foster (1989), Reissman (1998), Purdy (2001) and Garry (2001). These authors all suggest that the goal of feminist health care should be to reconfigure the system so that women can access medical services as they deem appropriate. Purdy (2001) argues that feminist medicine must, among other things, "sensitize every practitioner to the way women's roles can affect their health" (p. 259), recognizing that many of their clients will have internalized harmful hegemonic discourses. Individual health professionals comprise health systems; hence, health care practitioners have an ethical responsibility to cultivate this sensitivity and to examine their own beliefs and assumptions for sources of prejudice (Code, 1992). Vertinsky (1998) and Miers (2002) issue a similar challenge to medical culture as Purdy in suggesting that both individual practitioners and the broader medical institution must learn to listen to the experiences of women and situate them in socio-political contexts that affect health in order to negotiate mutual actions that will alter those situations women identify as in need of change. This alternative feminist discourse challenges medicine to develop contextualized understandings of women's lives and exercise power

responsibly, such that medicine will not attempt to treat 'symptoms' in ways that mask the social problems creating them.

In a study that privileged lesbian women's voices, Stevens (1996) explores common themes in 'satisfactory' exchanges with physicians. Stevens notes that while these responses reflect the experiences of lesbian women, some themes may be common to a broader range of women. In response to open-ended questions about positive and negative experiences with physicians, she found that positive experiences related to expressions of solidarity. By solidarity, she means "joining with clients to identify common interests and collaborate toward agreed-on goals" (p. 29). I believe the solidarity themes she highlighted in positive stories reflect a type of caregiving that challenges the culture of medicine and is applicable to the stories the women shared with me.

Within the notion of solidarity, three main themes emerged: compassionate competence, empowering information exchange and negotiated action. Compassionate competence is Stevens' (1996) term to describe health professionals who practice using "pragmatic clinical competence with sympathetic consciousness of clients' needs" (p. 29). This type of competence incorporates a compassionate and generous ethic. Descriptive terms for these types of providers include 'practical', 'down to earth', 'caring', 'respectful', 'keeping my interests in mind' (p. 29).

The second type of show of solidarity was empowering information exchange:

It was very important to women that physicians be willing to (a) elicit and attend to clients' knowledge needs, (b) impart relevant health information, and (c) explain the rationale behind their diagnoses and treatment recommendations. They wanted

access to knowledge that empowered them to promote and maintain their health as well as manage their illnesses (Stevens, 1996, p. 30).

Empowering information exchange is compatible with feminist health care visions, which suggest that clinical health care should focus on providing women with the support they need to make the choices best suited for their own lives.

The final theme of solidarity that Stevens noted was ‘negotiated action’. “Women wanted to be involved in identifying problems and seeking solutions. They appreciated joint decision making” (p. 30). This negotiated action encompasses the concerns raised by the women I interviewed that women’s subjective symptoms and concerns are valid and need to be respected in the discussion. Women’s own unique experiences factor into health; because of this, clinical practice needs to be more problem-solving in nature than prescriptive.

Feminist health care visions disrupt the epistemological assumptions about reality, subject and object in medicine (Foster, 1989). They do so by rejecting the concept of ‘Truth’ that is independent of human knowledge, situating both the ‘knower’ and the ‘known’ within the socio-cultural, physical and political environments that shape our knowledges and choices, and embracing social values that interrupt these positivist constructions. Feminist alternatives expect health professionals to use their power to produce health-promoting knowledges and discourses rather than reify harmful ones. These alternatives situate individuals and their illness experiences within the environments in which we live and understand ‘health’ as more than just physical. In essence, feminist health care visions are holistic in scope (Foster, 1989) and take a

balanced approach to responsibility for health, understanding that our agency is shaped and constrained by the world around us.

Conclusion

Medicine is a prominent social institution in North America. The authority we grant medicine means that medical knowledge is able to shape our understandings of health, illness, weight, and responsibility for health. This knowledge, interconnected with power, produces and reproduces dominant social discourses through which we make sense of our health and weight related experiences.

Medical knowledge, functioning through the dominant positivistic paradigm of knowledge production, is constructed as 'objective', implying transcendence from social and historical location. Additionally, the medical institution purports that its practitioners are 'value-neutral'. Many feminist epistemologists have highlighted the impossibility of this transcendence from social and historical location, arguing that assuming this unlocated position absolves both the institution and its 'experts' from responsibility from the impacts of their knowledges (Harding, 1991, 2004; Haraway, 1988, 1991; Code, 1996, 2000). Rather, the institution of medicine can be understood as exercising disciplinary power over the population. This disciplinary power involves strategies such as dividing of populations through systems of classification (and an over-reliance on measurement) that separate the 'normal' from the 'deviant' or the 'healthy' from the 'ill', and subjectification through our reliance on the 'experts' to mediate our understandings of our experiences (Foucault, 1984, 1995).

One particularly influential medical discourse assumes that individuals can control their health and their weight, often conflating the two. This fosters a system where self-surveillance naturalizes weight control as 'healthy' behaviours and assigns moral meanings to food, exercise and body fat. Failure to control one's weight is understood as reflective of personal character flaws. These discourses, based upon many myths and problematic assumptions, have known harmful effects on women.

Central to this study is the exploration of the contribution of medical practice and discourses to women's experiences of body (dis)satisfaction and weight preoccupation. The social constructionist critiques of health, medicine and the body outlined in this chapter, with the feminist theoretical conceptualization of health and health care, shape my assumptions and approach to this research. The dominant and alternative discourses about health, responsibility for health and weight presented here will be central to my analysis of women's stories, and ultimately help shape my sensitive practice guidelines for health professionals to consider when discussing body weight and size with women. In the next chapter, I will outline how I shaped this inquiry methodologically.

Chapter 2: Epistemology, Methodology and Methods

While medical science tells a concrete story rooted in social hierarchy and control, women have their own evidence to confront the story science tells with another story, based on the experience of living in their own bodies. (Vertinsky, 1998, p. 100)

The use of women's stories in my study constructs one alternative to the medical story that challenges health care providers to consider how their practices, relying on the 'expert' model of clinical interventions, reinforce androcentric ideologies. The goal of my approach is to not reconstruct "The Truth" but to assemble alternate versions that can be evaluated for their insights and contributions. The vision of this project is to develop an alternative framework for medical practice, one that responds to women's concerns about clinical medical care. The alternate version I present of this problem and possibilities for change is framed by the recent experiences of fifteen Canadian women. This chapter will explain my epistemological and methodological approach to constructing this situated, partial knowledge, including explaining my choice of methods, how I interpreted the data, and my attempts to be reflexive and responsible throughout this process.

Social constructionist approaches do not believe that there is one truth; all knowledge produced is partial and situated within the cultural, social, political and economic contexts within which it is formed. Rejection of positivist epistemology does not have to lead to extreme relativistic positions (Code, 1988, 1996; Haraway, 1988; Harding, 1991; Stone-Mediatore, 2000). Haraway (1988) argues that relativism is not a viable alternative to objectivism.

Relativism is the perfect mirror twin of totalization...both deny the stakes in location, embodiment, and partial perspective; both make it impossible to see well.

Relativism and totalization are both "god tricks" promising vision from everywhere

and nowhere equally and fully, common myths in rhetorics surrounding Science (p.584).

Code (1988, 1996) and Harding (1991) describe the alternative to these ‘god-tricks’ as locatable, partial and critical knowledges.

Women’s experiences with clinical health care are an important starting position for this study as the view available from this position is subjugated to the hegemonic story told by medicine. However, every position and the knowledges constructed from that position are marked (Haraway, 1988). What is crucial to this project of constructing an alternative account is a critical re-examination, deconstruction and interpretation that does not understand any position as ‘innocent’. This recognizes that situated, subjugated knowledges can be more transformative compared to hegemonic ones that often mask dominant interests (Haraway, 1988, 1991). With this recognition (that all knowledge is ideological) and by making ideologies explicit, we can negotiate through knowledge claims while remaining cognizant of the social locations and consequences of these claims (Code, 1996).

Aligned with this approach to knowledge is a re-construction of ‘objectivity’. The promise of a transcendent and value-free objectivity in positivism is impossible. The construct simply serves to render values and locations less visible in knowledge production, risking entrenchment of dominant conceptual frameworks (Harding, 2004; Haraway, 1991). Those who argue for situated, partial, embodied knowledges reject this version of objectivity (Code, 1996; Haraway, 1988, 1991; Harding, 1991, 2004). Instead, they reconstruct an alternative version of objectivity that recognizes the plurality and partiality of knowledge and considers neutrality and disinterestedness the exception rather

than the rule in knowledge production (Code, 1996). The reconstruction of 'strong objectivity' that Harding (1991) argues for recognizes social and historical location, makes values and interests explicit, and acknowledges that some values are helpful in the knowledge production process, while others reproduce privilege and oppression.

Critical to this epistemological position is that I situate myself in this work and explain the partiality of this knowledge. I attempt to accomplish this by making myself visible throughout this project, including my style of interviewing, the questions themselves, my approach to analysis and this written account. As I will elaborate, I made several choices throughout this process that illustrate this visibility. This chapter will make explicit both my location in the project and how my epistemological assumptions shape my methodological and method decisions.³

Stories of experience

Interviews can be opportunities to tell stories in our own terms (Anderson & Jack, 1991). Storytelling, that is, sequential ordering and causal inferences about events, is a cultural competency learned early in our lives (Chase, 1995). When we tell stories of our experiences, we rely on the interpretive devices and cultural discourses available to us to communicate (Chase, 1995; Jackson, 1998). While we remember particular events, we continually reinterpret them (Jackson, 1998). "Experience is at once always already an interpretation *and* is in need of interpretation" (Scott, 1992, p. 37). Stories of experience

³ I have not explicitly positioned myself as a solely poststructuralist or feminist standpoint epistemologist. I operate upon a blended epistemological position that builds on the strengths while overcoming some of the limitations of both 'pure' positions. I have assumed the explicitly political concerns of feminist standpoint with the post-structuralist conceptualizations of discourse, power/knowledge, experience and language. Such a position is an alternative to the positivist vs. relativist false dichotomy. This blended position is visible in the complement of analysis methods used in this study.

are neither raw sensation nor cultural form, but both simultaneously (Clandinin & Connelly, 1994). Thus, experience is always socially mediated.

Stories of experience are useful in the 'thickness' or the multiplicity of perspectives that they highlight, and the tensions within experiences that they can illuminate. Stories often contain conflict between concepts of the dominant culture and the immediate realities of our own experiences (Anderson & Jack, 1991; Stone Mediatore, 2000). Language and categories often reflect the experience of the powerful, which may be incongruent with women's lives (DeVault, 1990). While stories of experience are influenced by dominant cultural concepts, these stories do not always fit dominant forms (Anderson & Jack, 1991). Narratives reinforce and/or challenge hegemonic discourses (Brown, 2003; Jackson, 1998). "Once everyday experience is understood as involving the reflexive construction of meaning, a practical form of theorizing, it is clear that foregrounding women's experience does not mean taking that experience as a given" (Jackson, 1998, p. 46). This is not to deny that material realities shape women's experiences, but draws attention to the ways in which experience is understood through historically and culturally situated discourses (Jackson, 1998). Hence, it is critical for the researcher to make visible the historical and socio-cultural contexts of these stories and 'tune into' both dominant and alternative/resistant themes in analysis, examining how some narratives support or contest oppressive practices and structures (Jackson, 1998). In this way, retelling of personal stories presents new ways of understanding both hegemonic and alternative cultural discourses (Stone Mediatore, 2000).

This focus on women's stories and women-centred clinical practice guidelines may sound simplistic, essentializing or homogenizing. Attention to difference and diversity is now a given in feminist academia (Crosby, 1992) but there is no commonly agreed upon manner through which to be attentive. Differences are not essential, but political (Crosby, 1992) and thus, should not be removed from analyses of power in our societies (Hill Collins, 1998). Differences are complex; we are not simultaneously all or completely any of the markers of difference (Haraway, 1991). Haraway (1988) suggests that feminists can both problematize binary distinctions like gender and maintain the constructs strategic utility by understanding difference as situational, not intrinsic. This study is not an attempt to present a homogenous 'women's story', but to focus on the discursive constructs of weight in women's lives and the impacts of these constructions in relation to women's health care and health outcomes. Throughout this process, I remain open about issues of diversity and acknowledge the complexity of women's stories. Focusing on culturally dominant and alternative discourses women rely upon to make sense of their experiences ties this analysis to power and acknowledges differences as situational.

As social beings, we influence each other and create meanings through interactions (Berg, 2001, Krueger, 1994; Montell, 1999; Wilkinson, 1999). That is, self-reflection is not a private or subjective act; the concepts and categories we rely upon to make sense of our experiences are grounded in our cultures (Anderson & Jack, 1991). Individual interviews, as opposed to group interviews, are more suitable to access stories (Kitzinger, 1995). Individual, in-depth interviews are a useful data collection method when the researcher hopes to gather stories of experience and when the communication

form is well known (Miller & Crabtree, 2004). This interactive style of interviewing allows the discussion to move beyond 'reports' into the realm of the woman's construction of her own experience (Anderson & Jack, 1991). In-depth interviews focus on co-construction of meanings through dialogue between two socially situated actors.

I attempted to allow this research conversation to take the form of "sharing and hearing within a study-specific, confidential, open ended discourse" (Miller & Crabtree, 2004, p. 185). In in-depth, open-ended interviews, the impetus is on the researcher to invite the participant to share her stories. Sharing stories, as opposed to reporting, involves a shift in responsibility for the direction of the talk. The task for an interviewer is "to provide the interactional and discursive conditions that will arouse her desire to embrace that responsibility" (Chase, 1995, p. 12). The invitation to tell a story can be very simple, if it is the story that the participant wants to tell or came prepared to tell (Chase, 1995). Stories sound more complex than reports, "with different events toppling over each other as if each event is so tied to all the others that she can't talk about one without immediately bringing all the rest" (Chase, 1995, p. 9-10).

I utilized semi-structured interviews to collect women's stories of weight or eating-related conversations with health care professionals. This style of interviewing is congruent with the concern of being sensitive to various communication styles while covering pre-determined content. Digression from pre-established questions is expected, to avoid controlling or constraining the data, to elicit fuller responses, to respect the knowledge and communication norms of the participant and to respect perceived boundaries of the participant (Berg, 2001; Minister, 1991; Reinhartz, 1992). The interview

guide (Appendix B) serves as a prompt to ensure that each interview covers the same central topics.

My approach to interviewing was similar to that employed by Franklin (1996), where the interview can be a blend of 'shared understanding' and 'discourse' models (weighted heavily toward the discourse model). The shared understanding model of interviewing uses the conversation as an opportunity to attempt to understand how the participant experiences and makes sense of her life. In such an interview, the interviewee expresses meanings and occasionally forms new ones through the dialogue. The interviewer in such a model clarifies responses to assure understanding while attempting to reduce the influence of presuppositions by emphasizing open-ended dialogue. In this model, follow-up opportunities are highly recommended to allow the interviewee to clarify or further develop their ideas. In contrast, the discourse model of interviewing conceptualizes the interaction as a "situated speech event" (Franklin, 1996, p. 104). This model acknowledges that the interviewer interacts with the interviewee in a manner informed by her own personal experiences. Value-free objectivity and neutrality are not considered possible or desirable. In this model, the interview is more like a conversation where the interviewer may speak about her experiences and interest in the topic. New themes may emerge in the process, and connections among interviews may be made. Themes or statements made by one participant may be worthwhile to explore with subsequent interviewees (Franklin, 1996).

The hybrid of these two models is an acknowledgement that, while the interviewer structures the dialogue by asking the questions or guiding the conversation, the information collected is influenced by a number of social contextual factors, including the

range of available discourses, knowledge of the research focus and the researcher's ideas, expectations of communication style and content, trust and rapport, mood, fatigue, setting and previous knowledge of each other (or conversely, the interview being the first time the participant and I met). This hybrid approach to interviewing also allowed me to acknowledge the role of my past experiences as both a health care professional and a woman accessing medical care, creating a space to situate myself in the research process. It helped prevent me from over-generalizing: "hearing other people's stories also provides the researcher with an alternative case that *prevents* her generalizing exclusively from her own experience" (Reinharz, 1992, p. 34).

I have had personal experiences talking with health care practitioners that angered me, and felt that, had I not been able to challenge the practitioner, the interaction may have affected me negatively. Conversely, I have had a conversation about weight initiated by a general practitioner that I thought was handled very well. The use of my own personal experiential stories and interpretations of them in most of the interviews helped the women speaking with me understand my perspective, and I invited their thoughts on the experience. I found that telling my stories was an effective way to establish rapport (as will be discussed further in the next section) and exemplified the shifting nature of meanings and interpretations we assign to our own experiences. My example invited them to share their stories rather than simply answering questions, though it influenced how the participant relayed her story, just as any type of invitation does. However, my demonstration of storytelling highlighted my interest in hearing their stories, with all the complexity and messiness typical of narrating our past experiences. Some women started telling their stories without this prompt, an indication that she had come to the interview

prepared to share her own stories. Some women had heard my stories in the past in informal conversations, and hence had a sense of the breadth of what I was concerned about; for some, it was hearing my stories and my interpretations of them that interested them in participating in the study.

I used a variety of linguistic strategies to stimulate storytelling and analysis of experiences. I attempted to respect the dynamic nature of assigning meaning to experience by asking questions about their initial reactions and current thoughts or analysis on the experience. In my efforts to collect the stories from various women, I used open ended questions, probes, supportive phrases and prompts (like “mm hmm”), and direct questions to encourage the women to flesh out and clarify their experiences and the perceived impact of these experiences. I invited the complexity of women’s stories. This approach allowed for me to access detailed, contextualized descriptions of the women’s experiences (Miller & Crabtree, 2004). Throughout the interviews, new themes emerged that I had not thought of in my own experiences, and I incorporated these new themes, when appropriate, into subsequent interviews and follow-up conversations. As well, some of the stories told to me in earlier interviews were used as examples of certain situations in subsequent interviews, if relevant to the discussion.

This approach to interviewing is consistent with my epistemological and methodological assumptions in this research. If, to borrow Haraway’s (1988) words, “rational knowledge is power-sensitive conversation” (p. 590), then knowledge involves two actors or speakers, both with agency. I am not the neutral ‘knower’, concerned with bias and reproducibility of results. I am a situated and active agent in this process, talking with a woman who is also an active agent. Situated knowledges require that the ‘object’

be considered an active actor and agent, not a screen or resource. Each interview is different, due to a multitude of factors. Obvious influential factors in this study were whether or not the interview was in person or over the phone; the differences between these types of interviews will be described through the conversation analysis. Another example is that there were times when I relied much more on a question/answer dynamic than an open discussion; generally, I chose to follow the more 'typical' interviewing norm when the woman seemed more comfortable with the approach. The assumption that each interview is unique affected how I interpreted the interview texts, leading me to perform a basic conversation analysis to develop a better sense of the interview dynamic and critically reflect on the differences between in person and phone interviews, interviews with women I knew in comparison to those I did not, the strategies I used to develop rapport and invite the participant's elaborations, as well as how I handled power inequalities and ensured mutual understanding.

I agree with Baker (1998) that a researcher cannot erase power differentials in the research process, but needs to be attentive to this issue and attempt to minimize the differential. As explained in the previous chapter, power is expressed at local levels, in our interactions with other people. The potential for a researcher to exercise power to the detriment of the participant exists (Wallerstein, 1999), just as it exists in the medical clinic between the health professional and the client. How power is exercised is shaped by a multitude of factors. For my work, I utilized the strategies described by Sprague and Zimmerman (2004) that can help organize the research process in a way that respects the skills and dignity of those we study: drawing analysis from experience, attending to both the content and the form of communication (through complementary discourse and

conversation analyses), making ourselves visible in the process, and making visible the standpoints of those we study. Other characteristics, such as attentive listening, expressions of empathy and engaged dialogue with the participant were also helpful.

Much attention has been drawn to issues of authority and power expression in data collection methods, but these issues present in analysis as well (Chase, 1996; Speer, 2002). Chase (1996) notes that while we must acknowledge our authority in interpretation and ‘ownership’ of the interpretative texts, there are no set rules of how to accomplish this. I exercise the power of interpretation and presentation of the experiences these women shared with me, but believe that power should not be assumed to be synonymous with oppression. With this power comes responsibility to be accountable and transparent in my work, delineating differences between my interpretations and those of the women I interviewed, when appropriate. My commitment to making my perspective visible encouraged me to include the women interviewed in another stage of the research.

This set of values about power and transparency are congruent with ‘participatory’ research approaches, or what Fine (1994) describes as ‘activist feminist research’.

“Activist research projects seek to unearth, interrupt, and open new frames for intellectual and political theory and practice....The strength of feminist activist research lies in its ability to open contradictions and conflicts within collaborative practices” (Fine, 1994, p. 23). Fine suggests that participatory approaches are one of the key strategies for activist feminist research, thus valuing ongoing dialogue with research participants beyond data collection during interpretation and dissemination of analysis. I did not do all that is described as the ideal of ‘participatory research’, but I did attempt to respect the participants as agents in this process, co-constructors of meanings, not just providers of

stories.⁴ Collaborative research does not eliminate competing interests but affirms the commitments of both participants and researchers to co-construct meanings through the research process (Fine, 1994). In such a perspective, conflicts within the process are seen as opportunities for further dialogue rather than ‘problems’. I agree with Fine (1994) that the idea of a collective ‘we’ voice in research is a “fantasy never coherently achieved” (p. 30), but that does not mean that the attempt to develop a ‘we’ is not valuable, with its ongoing negotiations of disagreements. This approach acknowledges the complexity of difference, diversity and identity without becoming paralysed by it. The final outcome of this study is action oriented, and as such, benefits from a degree of agreement with both the pre-existing feminist literature and the perspectives of those women I interviewed who also problematize current weight-centred practices in health care.

The central aim of the project is to develop a vision for women-centred clinical care, not only to examine the cultural discourses that women rely upon to make sense of their experiences. This latter aspect is important to highlight the strength and pervasiveness of dominant discourses that fuel weight preoccupation/body dissatisfaction for many women as well as to illustrate resistance and alternatives to these dominant discourses in general, and in relation to health care professionals. The findings of the discourse analysis help to contextualize the recommendations for clinical practice through demonstrating the material impacts of weight-centred discourse on women’s lives while simultaneously introducing ideas for alternative discourses.

While I am situated (in relation to social privilege) in similar positions to most of the women I interviewed, I recognize my privilege in the process of analysis and writing.

⁴ While I am the author of the final written product, my ideas are shaped by a number of influences, including the perspectives of the women I interviewed.

As an attempt to use this privilege responsibly, I committed to a mechanism that include interested participants in further influencing my analysis while also providing triangulation data for this project. This was appropriate for a number of reasons. Many women offered to be interviewed because they were interested in my topic and my perspective on the problems. Unlike conventional social science research approaches that see 'invested' participants as problematic (see Berg, 2001 for an example), talking with women who were reflective about the actions of health care professionals in challenging or sustaining discourses that support weight discrimination was a strength in this study. My analysis does not take their stories/interpretations as a given, and remains cognizant of their social location. Many of these women had 'debriefed' about negative experiences with their peers and/or studied weight discrimination or weight preoccupation/body dissatisfaction in some detail. In essence, many of these women were already engaging in alternative discourses about weight and health and were articulate about the problems with weight-centred practice. I asked them not only to share their experiences, but their ideas about what is problematic about health care and how clinicians can structure clinical work to challenge harmful social discourses about weight and health. I was interested in how this group of women would respond to my vision, my proposed 'sensitive practice guidelines' to the current weight-centred paradigm. Several of them expressed interest in examining the guidelines as well. Many of them seemed personally invested in the outcome of this project, which makes sense to me; if I am shaping recommendations for clinical practice based on both my and their concerns about medicine, then what I put forward needed to be able to address their concerns.

I needed an appropriate mechanism to present my vision, based upon my analysis of both the literature and their experiences. My initial plan was to use a focus group for this purpose. When it became apparent that this would not be possible due to incompatible summer schedules, I chose to present the women I interviewed with an open-ended qualitative survey (see Appendix C). This survey, sent to all participants, asked them to reflect on three key documents: my summary of their stories, an article by Kratina (2003), which is the first and only published version of a comprehensive set of guidelines for the “health at every size” paradigm I have found, and an earlier draft of chapter four (my analysis of existing guidelines and recommendations for sensitive care provision). My application of their stories is visible in that chapter to frame the sensitive practice guidelines. This earlier chapter draft was built upon the results of my analyses of their stories. This survey mechanism created an opportunity for women to correct details in my interpretations of their stories (“member checking”), offer their perspectives on common themes in the stories (triangulation), consider how currently available guidelines could have changed their experiences, and critique my analysis/recommendations for practice.

I welcomed their input in this phase, as other authors have acknowledged that ongoing dialogue with participants helped strengthen their final result (Chase, 1996), is consistent with ‘activist feminist research’ (Fine, 1994) and challenges the traditional research divide of subject and object, one mechanism by which power is exercised in knowledge production (Cornwall & Jewkes, 1995). Providing a feedback mechanism does slow down the process and risks confrontation. I assumed these risks. Fortunately, only a couple women raised minor changes to their stories (regarding demographics). The

feedback indicated comfort with how I applied their stories, raised interesting contextual issues, and offered constructive criticism. Had more significant conflict or disagreement with my chapter developed, I would have attempted to discuss the conflicts with the woman in more detail. Hopefully I would have been able to negotiate with the woman in a way that addressed her concerns, but if necessary, I would have respected her right to withdraw from the study (an element of informed consent). This approach is more collaborative than that of traditional social science research, and more consistent with participatory research principles in knowledge creation, where the lines between subject and object are not as clear (Cornwall & Jewkes, 1995). Many words of strong support and encouragement came my way as a result of this process. The resulting endorsement of my construction of clinical practice recommendations by the participants in the study strengthens the result. It is true that I could have tested these guidelines in another way, but I was interested in hearing the response of the women with first hand experience. It is my hope to further evaluate the recommendations in the future through other mechanisms.

I chose to send the participants my recommendations chapter rather than the data analysis chapter for several reasons. First, the recommendations for practice are the crux of this project, supported by the analysis, and hence, are what interested several of the women interviewed to participate in this project. Second, the data analysis chapter is longer and written in more of an academic tone than that of the recommendations. It was important to me that what I presented was readable and would take a reasonable amount of time (that is, approximately the same amount of time as a focus group). Third, simply presenting the women with the data analysis results seems to ask 'have I got it right?'

(Chase, 1996). This approach is inconsistent with the notion that this data analysis, my interpretation of many stories, belongs to me, the author. But the recommendations chapter, in dissemination, might influence the future practices of some health care professionals, and as such, I wanted to ensure that my alternative vision for practice could have addressed their concerns. I analyzed this source of data thematically, comparing and contrasting the ideas to those that emerged in the interviews. I have incorporated their ideas and critiques into my final product, consistent with the idea that research is always a co-constructed process. Ultimately, the recommendations for clinical practice I present in chapter four are my written construction, but this construction has been influenced by the input of the women who responded to the survey.

Logistics of data collection

I received approval from Mount Saint Vincent University's Research Ethics Board in February 2004. I immediately contacted women who had previously expressed interest in participating in this study; these women knew of my work from past discussions in social and community education settings. In early March, after speaking with the directors or relevant contacts in these centres, I forwarded recruitment letters and posters (Appendix D) via email to the Dalhousie University Women's Centre, the Saint Mary's University Women's Centre, the Halifax YWCA, the Halifax branch of the Canadian Diabetes Association (to get to their self-help groups), the Eating Disorder Community Support network in Nova Scotia, the Self-Help Connection, the Eating Disorders Action Group, and a number of listserves, including Dalhousie Law and Saint Mary University's Atlantic Canadian Studies, International Development Studies and Women's Studies

programmes. I also sent a recruitment letter and poster through my own personal contacts. By April 8th, 2004, thirty women had offered to be interviewed. When a woman expressed willingness/interest in being involved, I explained more about the study, my interest in it, my need to audiotape the interviews, and the time commitment involved. One woman I invited to meet with declined when she found out I was not offering an honorarium for her participation. I accepted the first fifteen women who confirmed interest, asked a few to be 'reserves', and thanked but declined the rest.

The result was fifteen interviews, four of which were done on the telephone and six of which were with women I knew. While I acknowledge the shortcomings of telephone interviews, particularly in establishing rapport and the risk of misunderstanding each other due to lack of non-verbal clues, these four women had expressed significant interest in the study, but were unable to meet in person during the weeks I was interviewing. I was willing to adapt to changes in their situations, thus, chose to proceed with telephone interviews. Had I questioned the success of these interviews, I would not have used them, but the comparison of these interviews to those conducted in person alleviated this concern. Interviewing both women I knew and those I did not is unorthodox in qualitative research, but not necessarily problematic. Talk between women who know each other and those who do not will take different forms, but the norms or expectations about interview talk mediate some of these differences and these interview conversations can cover the same range of topics. Personal knowledge of the other person will affect trust, but so will many other factors. The conversation analysis is able to address both of these methodological concerns by highlighting both the differences and the similarities between these different interview contexts.

My plan was to interview twelve women initially, then decide if thematic saturation had been reached before doing any more interviews, to a maximum of fifteen. Because of the overwhelming response, I decided to proceed with fifteen interviews. The woman chose the time and date, and for the eleven interviews conducted in person, the location for the interview. This was her workplace, home, or a workspace in a University library. Before the interview began, we discussed the project, audiotaping and confidentiality arrangements again prior to her signing the informed consent form (Appendix E). For interviews that were conducted on the phone, I faxed or mailed the consent form prior to the interview, which they signed and returned to me by mail. Two additional interviews were added as two were not usable; one due to poor taping quality, and the other due to a misunderstanding of the topic by the participant. The recorded part of the interviews ranged from thirty to ninety minutes, with forty-five to fifty minutes being the norm. Length did not vary between phone and in person interviews and between interviews with women I knew and those I did not know. Undoubtedly, my comfort level and ability with the interviewing style improved after the first three interviews; these first three were among the shortest.

A professional who signed a confidentiality agreement transcribed these interviews verbatim. I reviewed the tapes against the transcripts to ensure accuracy and preservation of speech, and then sent the transcripts to the participants for 'member checking'. I asked the women to edit their words as they thought appropriate, in case they wanted one part of the interview struck from the record, needed to clarify any points, or thought they had misspoken their point. In retrospect, I will never do this again; I only did so because it was the only version of 'member checking' I was aware of. In the future, I

will provide research participants with a summary of my interpretations of the interview to which they can respond. From the women I spoke with about this process, they mentioned that they too would have preferred this method, as the transcripts were long to read and the desire to 'clean up' the language strong. Even though I explicitly asked women to not smooth out their speech and explained why pause words like 'um' are important, some women were torn in this process.

In our society, speech that is authoritative in tone and linear is valued, above that which has repetition, stuttering, pauses, interruptions and short supportive phrases (like 'mm hmm') (DeVault, 1990). Many researchers 'edit' speech, smoothing it out, either to lend it a more 'authoritative' tone or because they do not see the importance of these linguistic patterns. By doing so, they remove emotive signs of agreement, hesitation, politeness and disagreement that shape the meaning of the text (Chase, 1995).

Additionally, 'difficulty of expression' often speaks to situations where available or dominant discourses may be inadequate to communicate our experiences (DeVault, 1990). When women made changes, I compared the revisions to the original version to see what changes had been made. Five women made changes, and these were to correct typing errors, complete ideas/sentences that had recorded poorly (and had been marked as 'missing content'), or clarify confusing comments. I recognize that even these minor changes have implications for analysis, as it may change the tone of the statement (for example, from tentative to confident). When changes had been made, I was especially cautious about how I used this section of speech in analysis.

The women I spoke with ranged in age from 22 to 53, with ten of these women in their twenties. All had attended a post-secondary educational institution, and all but one

had completed a bachelor's level degree. Ten of these women had started or completed a graduate level degree. Eleven women identified as heterosexual, one as bisexual, and three as queer and/or lesbian. Their present household income levels varied greatly, from eleven thousand to one hundred and twenty thousand. Their household make-up varied: one woman was married, five resided with a common law partner, one with her two sons and two with their parents. The remaining women either lived independently or with roommates. In sum, the women I spoke with were well-educated white women, ranging in age, sexual orientation, financial background and living arrangements.

Before starting this study, my perception was that these types of experiences with health care providers are common among women, though not well documented in the literature. Hence, a convenience/snowball sample was chosen. Women noted two main reasons for offering to participate: they wanted to help me, or they were very interested/invested in the topic. Most came to our discussion of health care practice with their own ideas of what was problematic and helpful, and many had resisted dominant weight discourses and the weight-centred approach of some health care professionals. In this study, self-selection resulted in many women with critical and/or feminist perspectives offering to be involved. These women told their stories and expressed their concerns relying on both dominant and resistant/alternative discourses, which was desirable in this study. This particular group of women highlighted a range of discourses that resist the dominant ones, illustrating some methods by which women can express agency when dealing with oppressive expressions of power.

Self-selection of participants often raises concerns about 'skewing' the data through 'non-representation'. I contest the very concept of the 'representative sample', as

it relies on dualistic markers of identity that often rely upon stereotypes and fails to recognize the multiple, shifting and potentially contradictory meanings we assign to our experiences. We are not ever completely and solely 'lesbian', 'aboriginal', or 'middle-aged', for example; our identities are much more complex than these simple dichotomies suggest, and they change over time (Haraway, 1988). Lather (1991) suggests "dualisms which continue to dominate Western thought are inadequate for understanding a world of multiple causes and effects interacting with complex and non-linear ways" (in Hill Collins, 1998, p. 133). Hence, self-selection is not a 'weakness' in this study.

Analysis methodology and methods

Analysis methods can be understood as a form of 'listening' (DeVault, 1990). A critical, reflexive analysis of transcripts allows us to 'hear' submerged stories (Chase, 1995). "Understanding the meaning and significance of a story requires understanding how it is communicated within or against specific cultural discourses and through specific narrative strategies and linguistic practices" (Chase, 1996, p. 55). Additionally, feminist social constructionist and critical social science approaches to social research implore the researcher to be attentive to the interactive context within which this meaning is constructed. Hence, my approach to analysis had to listen to both linguistic techniques and use of culturally available discourses, as these are intricately linked in storytelling (Cameron, 2001).

I chose to use two complementary analytic strategies to listen to women's stories. An analysis of speech, linguistic patterns and strategies was useful to 'tune into' those gaps, silences, disruptions, contradictions, repetitions and other 'difficulties of

expression', as these can relate to those moments where dominant discourses are inadequate to tell our stories (Chase, 1995; DeVault, 1990). The conversation analysis also illustrates the speech strategies used in the interviews to address issues of power inequalities, establish rapport, and encourage discussion; that is, conversation analysis helps to illustrate the relationship between the researcher and the participant (Speer, 2002). Finally, the conversation analysis helps make explicit the differences and similarities between in-person and telephone interviews as well as those in interviews with women I knew in comparison to those I did not know. This method complements the discourse analysis through presenting the social/interactional context of this 'data' (Widdicombe, 1995).

The second phase of analysis was to examine the content of the interviews, being attentive to both hegemonic and alternative discourses employed to convey meaning. This discourse analysis allows me to listen for dominant medical and alternative social discourses of health, weight and the body⁵. While the literature summarizes these discourses, I wanted to see if these held in relation to women's stories. I also needed to examine the impact of these discourses on how the women perceive their health, bodies and weight as well as the influence of these discourses on their consultations with health care professionals.

⁵ The dominant discourses are those that conflate weight with health, assume dieting is effective and that the body is infinitely malleable, and imply that people are fat because they are lazy or stupid. Alternative discourses consider health holistically, as reflecting physical, emotional, mental and spiritual well-being, and challenge the weight and dieting myths inherent in dominant discourses that fuel weight discrimination.

Conversation analysis

I started my analysis of transcripts with the conversation analysis component. I relied primarily on Cameron's (2001) comprehensive overview of this analytic method to develop my framework for application. I chose to use this method as it helps me to discuss similarities and differences between in-person and telephone interviews and between interviews with women I knew and those I did not. These contextual factors influence the results; by doing this style of analysis, I was able to test the concerns about these methodological differences as well as account for issues of politeness/honesty, rapport and contradictions in the interviews.

Speech can be broken down into three levels or units: situations, events and acts. Speech situations are the social context of the talk; types of talk differ in relation to the social context. Each social context of talk has certain 'norms of interaction' (rules of speaking). The next level by which we can examine speech is to look at speech events. These are activities that happen through speech, such as arguing and interviewing. Interviews are considered an 'institutional' type of speech event, usually shaped by commonly understood norms of interaction. However, interviews that diverge from these norms can include more than one speech event. The final level of analysis is that of speech acts, including genres such as question/answer, storytelling, statement of opinion followed by agreement or disagreement, and passing, where one speaks without introducing new content. Conversation analysis helps a researcher to understand the linguistic tools used in the interviews, the effect of these strategies on the dialogue and the communication/construction of meaning, and locate moments where 'submerged

stories' attempt to surface. Being attentive to these moments in the transcripts helped me concentrate on the submerged stories when doing the discourse analysis.

This analytic method also highlights what norms of interaction shape the flow of the dialogue, which in turn illustrates levels of rapport, trust and politeness/honesty. Hence, I was able to examine the transcripts for specific strategies used to build rapport, attend to power differentials, discourage politeness (as being polite can override being informative or truthful), and hence, encourage open dialogue. While I felt, at the time, that I had been quite successful in establishing rapport with most of the women interviewed, there were a few interviews where I was unsure about how to interpret the interview atmosphere (i.e., speech situation). Examining the transcripts in this manner allowed me to look for indications of rapport and trust, helping me to interpret the dialogue.

The building of rapport involves personalizing of speech, by means such as frequent use of first names, "I" and "you", expressions of empathy, minimal positive support phrases (such as "mm hmm"), mirroring statements in agreement, and claiming common ground. Use of us/them language by myself or by the woman interviewed was understood as indicating the claiming of common ground and/or identity; when expressed by the woman interviewed, this type of inclusive language can be taken as indicative of rapport. Short encouraging phrases (like "mm hmm") or mirroring of phrases are expressions of agreement or understanding. To explore how power operated within the interview, I examined how much I maintained "second turn advantage" (the person who has the opportunity to evaluate the statements of the other), how much I adjusted my style to match hers, if she was able to move outside of the commonly understood norms of

interview speech without being challenged (if she tried to), and who delineated what was and was not relevant or acceptable. I examined the transcripts for linguistic responses that indicate how successful I was in application of these strategies. That is, I studied the transcripts for signs that I had established rapport, invited critique and dialogue, and respected her boundaries, ideas and challenges.

I examined the transcripts for the linguistic strategies used by the women that indicate distancing of themselves from what 'others' think and hesitation or uncertainty in answers. Attending to distancing in speech involves looking for strategies such as relaying how others would respond, offering stereotypical responses while laughing, using quoting intonations, lengthy pauses, saying "I don't know", prefacing answers with quasi-apologies and contrasting herself to others. Speaking in multiple voices or distancing strategies usually indicate that the speaker's perspective is in conflict with the hegemonic discourse. It highlights the multiple ways in which we can understand our world and experiences. This is critical to be cognizant of because if a comment made in a distancing way is taken out of context, often the woman will appear to contradict herself. Use of the word "well" can suggest a lack of complete agreement with the previous statement or that the answer is anticipated to differ from what the other wants to hear. The words 'might' and 'can' are understood as hedge words, which indicate the speaker is not taking an authoritative stand, which can occur for many reasons, not the least of which is gender communication norms (Cameron, 2001; DeVault, 1990). In situations where the interviewer is understood as the expert, hedge words can frame disagreement without seeming impolite. These moments of distancing and less authoritative styles of expression hint at moments where the woman may have attempted to challenge my comments,

dominant discourses, or tell submerged stories. Reading the transcripts with this analytic lens helps to explain what appear to be contradictions in the women's responses.

Conversation analysis is a helpful tool for illuminating the similarities and differences between in person and phone interviews. Phone interviews are not face-to-face interactions, and as such, the speakers have fewer clues to interpret the comments of the other (Cameron, 2001). The most significant difference is that, in telephone interviews, one can anticipate that there will be more 'passing'. With the lack of visual clues, passing phrases help each speaker feel confident that they can change topic without seeming impolite (Cameron, 2001).

Discourse analysis

Language is no longer understood as a 'given'. "Language does not simply reflect a pre-existing reality; it is not a transparent medium through which unchanging 'facts' or 'accurate' definitions are conveyed" (Kitzinger & Thomas, 1995, p. 35). It is through language that we actively construct meanings for our experiences. Language is never simply subjective, but intersubjective (Cameron, 2001). As such, the subjective 'voice' of an individual is shaped through social interaction. There are ideologies, metaphors, stories and meanings ("discourses") that are available to us in our cultures. When we produce an account or story of experience, we rely upon these commonly accepted meanings. Part of how we construct and articulate the meanings we assign to our experience is through use of available discourses in the society (Cameron, 2001; Jackson, 1998). This does not mean that individuals do not have agency or capacity to resist dominant ideas, but their

meanings rely upon available socially constructed stories (Cameron, 2001). If language was purely subjective, we would be unable to communicate with each other.

For Foucault, knowledge and power are inextricably linked:

The development of all these branches of knowledge can in no way be dissociated from the exercise of power...the fact that societies can become the object of scientific observation, that human behavior became, from a certain point on, a problem to be analyzed and resolved, all that is bound up, I believe, with mechanisms of power (Foucault, 1995, p. 44).

He further elaborates that “science also exercises power: it is, literally, a power that forces you to say certain things, if you are not to be disqualified” (p. 44).

Foucault (1995) describes discourse as a major strategy of power. Raby (2002) argues

discourses are also linked to relations of power, as many of them are constructed and reinforced by those in professional positions who hold a particular authority and thus create knowledge about certain subjects....These discourses may, in turn, be challenged by subversive, rival or newly emerging discourses (p. 430).

Not only do “discourses organize how we think, what we know and how we can speak about the world around us” (Raby, 2002, p. 430) but can be “regarded as products and reflections of social, economic and political factors and power relations...It is through discourse that material power is exercised and power relationships are established and perpetuated” (Widdicombe, 1995, p. 107). Discourses are deployed unevenly among people of different social locations, and have unequal effects (Raby, 2002).

Discourse analysis is, in itself, a vague term used by more than one theoretical approach, including both ethnomethodology and post-structuralism (Cameron, 2001; Widdicombe, 1995). In this project, discourse analysis can be considered a tool to 'tune into' cultural assumptions and ideologies reproduced through language (Lovering, 1995) and as a method to investigate the 'social voices' available within certain societies (Cameron, 2001). Discourse analysis allows us "to examine the implications of language in detail, including the full consequences of using the terminology of disease *and* the ways in which we position ourselves in the narratives we produce" (Hepworth & Griffin, 1995, p. 82). As a method, discourse analysis identifies relevant socio-cultural meta-narratives, examines the positions these discourses make available, and explores the power relations facilitated by particular discourses. In addition, discourse analysis accounts for both the historical/structural conditions that shape the development of certain discourses and their ideological effects (Widdicombe, 1995).

Our understandings of our lives are shaped by these discourses, but we can also influence how discourses evolve. We are social actors and through the intersubjective use of language and knowledge, we participate in and produce discourses. Discourse analysis can be critiqued for being relativistic and deterministic, but it can also be emancipatory; this is a function of application and approach (Wetherell, 1995). Discourses (that is, meta-narratives) are expressed at local sites and have material effects. Hence discursive changes can affect social, economic and political environments. If discourse analysis is applied as exploratory, outlining only 'what is' and not 'what could be', the results appear relativistic and deterministic. In activist feminist applications, critical discourse analysis also highlights 'what could be'. Because discourses change across time and contexts,

newly emerging/resistant discourses can foster social change (Squire, 1995, Wetherell, 1995). “We can make social transformation an *explicit* concern of our work, acknowledge the values which inform it, and situate all interpretations and readings in a realm in which they can be *interrogated* and *argued* about” (Gill, 1995, p. 178-9). In short, we can use discourse analysis as a political tool to facilitate social change. This is consistent with Fine’s (1994) construction of activist feminist research, where a researcher must examine ‘what is’ while highlighting ‘what could be’. Such a process can disrupt “ideological and theoretical inevitables” (Fine, 1994, p. 26) to challenge the institutions that often reproduce the status quo.

Thus, for my research, a discourse analysis was indicated to make visible or ‘listen’ to the discursive patterns of interpretations in the stories. These interpretations or meanings that we give to our experiences are shaped by the socially available discourses. Since “we draw on discourses culturally available to us in order to construct narrative accounts...there are often discursive regularities to these stories” (Jackson, 1998, p. 47). That is not to say that variation or differences in discursive patterns are impossible; variations of discourses are inevitable, and can be considered an expected consequence of varying social locations (Cameron, 2001). Critical discourse analysis is an analytic method that allows a researcher to ‘tune into’ both dominant and resistant/alternative discourses in our stories. In this case, this analytic approach can demonstrate the extent to which dominant medical discourses about weight, health, and responsibility for health do and do not shape women’s understanding of their own experiences, and the impacts of these discourses on their health. The discursive regularities and irregularities in their stories of health professionals’ actions highlight how health professionals reproduce and

disrupt dominant discourse through clinical practice. Development of a resistant discourse is one strategy by which we can effect social change.

In the analysis of the thematic results, I approached the data using what Franklin (1996) describes as primary, secondary, and constructed underlying narratives as a method to organize the data conceptually. The interviewees' stories are preserved, as told, as the primary narratives. Conveying only an uncritical summary of first-person 'voice' has limitations, as systemic oppressive elements may remain invisible (Baker, 1998; Olesen, 1994) and assumes "the unmediated worldviews of subjects constitute the best way to understand the world in which we live" (Sprague & Zimmerman, 2004, p. 47). As noted earlier, no position can be assumed to be 'pure', 'innocent', or unmediated, thus, an analytic framework needs to be able to challenge first person voice.

Secondary and constructed underlying narratives acknowledges the author's own voice. The secondary narrative is the researcher's own re-telling of the stories of the other person, while constructed underlying narratives explore less visible beliefs, attitudes, assumptions and discourses that may inform how the primary narrative is conveyed. It is in the constructed underlying narratives that acceptance of or resistance to dominant cultural discourses is most visible. This framework suggested by Franklin helps position myself as author of this analysis while respecting the contributions of the women who participated.

The interview transcripts were analyzed using this framework. In order to do this content analysis, I first had to code the interviews. While the system of coding I used had some similarities to that of 'grounded theory' (as described in Charmaz, 2004), in many respects I did not follow this system. Grounded theory is a system of methods to organize

qualitative research data collection and analysis developed by Glaser and Strauss (Charmaz, 2004). This method emphasizes inductive processes within the canons of 'good science' (that is, generalizability, reproducibility and consistency) (Denzin, 2004). Epistemologically, grounded theory relies on the non-located, transcendent construct of objectivity in 'good science', which is not possible or desirable. In my discourse analysis, I did start with individual transcripts, then developed "progressively more abstract conceptual categories to synthesize, to explain and to understand...data to identify patterns and relationships within it", like a grounded theory approach (Charmaz, 2004, p. 497). I did not develop my analytic codes only from the data, or delay my search of relevant literature, which are both key features of the grounded theory approach (Charmaz, 2004). I used both deductive and inductive approaches to develop a coding schema for my discourse analysis. I developed my understanding of dominant and resistant discourses from professional and academic literature as well as previous clinical experience.

I reviewed the relevant literature prior to re-reading all the transcripts to develop the codes (or categories) by which to organize the discourse analysis. Categories or codes were literal or analytical (Hesse-Biber & Leavy, 2004). Literal codes are those that contain references to specific content; for example, eating habits and motivations, exercise habits and motivations, or eating problems. Analytical codes are those that rely on my interpretations of discourses, and are used to build and clarify concepts and arguments. The complete list of codes used is in Appendix F. As is recommended, I started with literal coding before analytical coding (Hesse-Baber & Leavy, 2004). Specific excerpts of text were coded under multiple categories.

I did not follow my original plan to use a software package to assist me with coding because the university had replaced the software I was familiar with (NUD*IST 6) with one I did not know (Atlas Ti). Instructional workshops on Atlas Ti were unavailable, so I chose to code the interviews by 'cutting and pasting' excerpts of interviews on a word processing template. Once coding was completed, I read each code, summarized its content, and further developed my conceptual connections among codes. I coded each transcript three times: one to pull out each story, one using the literal coding tree, and one using the discursive/analytical coding tree. In my approach, the literal codes relate to specific topics (like 'eating habits'), while analytic codes reflect underlying constructed narratives or discourses. It was through this coding and subsequent writing process that my analysis highlights the assumed ideologies or discourses that underscore medical practices and that women relied upon to make sense of their experiences.

Second data collection phase

Once this process was complete and I was writing my analysis and recommendations chapters, I contacted the women interviewed to see if they were interested and available to participate in a focus group. The purpose of this second data collection phase was for triangulation, to respect the dynamic nature of assigning meaning to experience, to offer my perspective on the underlying discourses in this collection of stories and what I believed to be the implications for clinical practice, and to remain transparent about my use of their stories in this process of constructing sensitive practice guidelines. This discussion would have taken the form of a brainstorming

session, focusing on the underlying themes emerging in the women's stories and the guidelines for change.

After two attempts to schedule this group discussion, it became apparent that the schedules of those interested women in Halifax for the summer (n=8) were not compatible. Once cleared by my supervisor, the graduate co-ordinator and the Research Ethics Board at Mount Saint Vincent University, I proceeded with an open-ended qualitative survey that focused on much of the same content that I had intended for the focus group (though I might have focused more on recommendations for practice in the survey than would have been possible in the focus group). Several participants welcomed this change, as it allowed women outside of the city the opportunity to participate.

I have been unsuccessful in finding literature to frame qualitative surveys in this application in the methodological literature specific to qualitative surveys. However, from the response to the surveys, it appeared to be successful in creating an opportunity for women to respond to how I used their stories and to critique the set of recommendations I had assembled (as will be explained in the following paragraphs).

In early August, I sent the women the email survey. I chose to construct this survey in such a format that asked women to engage with the stories that I was working with, the current guidelines that exist, and my interpretations of these two documents. I also left a section for the women to respond to any concerns about how I represented their stories and make any additional comments. I attempted to explicitly invite criticism. This survey was comprised of open-ended questions (in Appendix C) relating to one of three documents, which they were asked to read and comment on in order: 1) my summaries of their stories, which had been edited to maintain confidentiality, and are almost identical to

those presented at the start of chapter three; 2) a four page article by Kratina (2003), which is the first and only published version of practice guidelines that I have found; and 3) a five paged (single spaced) version of my recommendations chapter, which included my response to Kratina's guidelines and my recommendations for reconstruction of guidelines. I estimated that the survey would take a maximum of two hours, including both reading and writing. I was conscious of this being a similar time commitment as a focus group. Six completed the survey and sent their responses back to me within one month (Alyssa, Ama, Ruby, Stella, Sally and Melina). Five other women sent apologies that they did not complete the survey in this time frame. The others did not respond at all or let me know that they were not planning on doing it. For those women who did not complete the survey, I indicated to them that it would be very helpful for me if they would read my summary of their story/stories and clarify any points I may have misunderstood.

A written survey, distributed via email, is not a face-to-face interaction; as such, I have fewer cues to interpretation. However, I did not approach this process as static; if I was unsure about what someone was arguing or discussing, I followed up with them directly. For the most part, the women made their points quite clearly, either through a thorough discussion or highlighting their argument with examples from the texts.

It was very helpful to include this feedback mechanism. It aided in establishing trust, making visible the value I assign to their perspectives and recognizing the dynamic co-construction of meaning. The women knew before the interview that I was committed to being accountable and responsible in how I used their stories. When the focus group

was not possible, I found an alternative method by which to fulfill my commitments.⁶

While I have written the final product, it has been very helpful to have their input in this process, and the ongoing engagement and interest expressed by these women in my thesis has been both motivating and inspiring.

Conclusion

Interviews are a useful method by which to access stories of experience. In this study, I interviewed fifteen women who shared personal stories of discussions about weight and/or eating with health professionals. Stories of experience are not ‘raw sensation’, but reflect already formed but always evolving interpretations of events in our lives. The telling of stories is not shaped only by the narrator, but also by the listener and the context in which the story is told. We rely on language to convey our stories and interpretations of experience. Language combines linguistic strategies and culturally available discourses to express meaning (Chase, 1995).

Analysis of these interviews needed a methodological framework that recognized the social contexts under which the discussion developed, the power of both speakers as active agents in shaping the discussion, dynamic co-constructions of meaning, and the reliance on discourse in communication of perspectives. For this reason, I chose to do both a conversation analysis and a critical discourse analysis on the interview transcripts. The conversation analysis of linguistic strategies used to shape meanings in the interviews illustrates the differences and similarities of in-person and telephone interviews as well as those between interviews with women I knew compared to those I did not. This analytic

⁶ As one participant wrote “As someone who does participatory research, I applaud your efforts and determination” (Melina, email communication, July 20, 2004).

method makes visible the active role of each speaker in shaping the dialogue. Also, it outlines what strategies I used and how successful I was in establishing rapport, encouraging storytelling, and dealing with issues of power inequalities in the interview context. Finally, this method brings attention to ‘difficulties of expression’, which can be a helpful clue for locating moments of discursive tensions.

Ideology and knowledge/power can be reproduced and challenged through discourse. The critical discourse analysis allowed me to highlight how both hegemonic and alternative discourses influence both medical practice and women’s interpretations of their experiences, relating these results back to the literature. These results are the foundation for chapter four, which outlines my recommendations for sensitive practice guidelines for clinicians to consider when engaging in weight, food and exercise discussions with women.

Chapter 3: Analysis results and discussion

In this chapter, I present the results of both the conversation analysis and the discourse analysis. The conversation analysis allows me to attend to the social/interactive contexts that shaped the interview dialogues. This section outlines the speech situations, with the 'norms of interaction', speech events, or types of speech, and the specific speech acts observable in the interviews that give clues to interpretation of meaning and allow me to be reflexive about power expression and rapport/trust. The conversation analysis component also describes the similarities and differences between interviews with women I knew in comparison to those I did not, and between in-person and telephone interviews. This analytic process increased my comfort with using interviews recorded under these contrasting social contexts; the conversation analysis demonstrates that although there are differences, the data is still appropriate for inclusion. The results of the conversation analysis set the stage for the stories and discourse analysis.

Certain linguistic patterns emerged, many typical of 'interview talk' as described by Cameron (2001). In general, the norms (or rules) of interaction that shaped these interviews included:

- 1) that I controlled the direction of the dialogue more than 50% of the time;
- 2) that I was acknowledged as the 'expert' or 'knowledgeable' on the topic;
- 3) that while two way disclosure occurred, it occurred when I thought it was appropriate or useful to stimulate further discussion, develop ideas, or ensure understanding;
- 4) that I had retained the power to challenge or not challenge any given statement;

- 5) that the women interviewed expressed their power by not responding to a question or changing the direction of the dialogue through their response;
- 6) that both the women interviewed and I used polite 'face saving' mechanisms at times, which creates issues of what can be read as 'truthful'. Hence, where these mechanisms were evident in the transcripts, I was especially cautious about taking the comments at face value;
- 7) that the expectation was that only one person speak at a time. Long silences and simultaneous speech were both responded to as problematic. In overlapping speech situations, one woman conceded the floor. Long silences would end by either a short 'passing' phrase or by introduction of a new idea. This is typical when both speakers are aware of audio-recording.

Speech acts that were most common in the interviews included question/answer, statement/response, storytelling and dialogue (a 'messier' type of speech where both speakers engage in the dynamic construction of new ideas). Interviews ranged in the extent to which they exhibited these various genres of speech. The first three interviews were disproportionately question/answer format due to both my lack of experience and the familiarity of the woman with my beliefs.

On the whole, the interviews with women I knew before the study (n=6) had fewer rapport building and politeness speech acts. Some of these women pre-emptively told their stories, and only needed passing or positive support phrases to encourage their own interpretations of both their experiences and medical culture on the whole. This is consistent with expectations as they already knew and trusted me. These interviews

followed the same norm of interactions as those with women I did not know prior to the interview.

The interview tone was informal, open and comfortable for most of the interviews with women I had previously met. The one exception was my interview with Alyssa, which seemed more formal and rushed. My understanding of why this was relates to the social context of the interview; the day before the interview, I found out she was dealing with an unanticipated personal crisis. She knew that I knew, and before the interview, I offered to cancel altogether or reschedule if the timing was bad. This was an awkward exchange, but she decided to proceed with the interview. In this particular interview, the tone was quite formal and direct, and the genres were predominantly question/answer and storytelling. When I would introduce a topic for conversation, she would generally 'pass' through a short agreeing phrase rather than engage in the dialogue. My sense was that, despite some early awkwardness, Alyssa was honest.

When speaking with women who did not know me prior to the interview, there was more personalizing and rapport building speech, particularly early in the interview. My most commonly used strategies were personal disclosure, claiming of common ground and expressions of empathy. Women's responses tended to be quite polite and formal until I had established rapport and demonstrated that I was interested in hearing their stories and interpretations. This latter element was best achieved through use of passing and attentive positive support statements that encouraged further elaboration. In the occasional instance where I thought the woman was uncomfortable with my passing back to her, I elaborated on what I thought to be a related part of her story. If she passed on this topic as well, I introduced a new question to change the direction with the hope

that she was still comfortable. In these nine interviews, I was more likely to relinquish second turn advantage and offer a summary of their comments to ensure my own understanding.

On the whole, these nine interviews tended to have a more formal tone, though over the course of the conversation, the participant's level of personal disclosure increased as did her willingness to engage in dialogue. In these interviews, there are more instances of what appear to be contradictions between earlier statements and later ones; in some cases, this suggests that women had moved beyond politeness to being more direct about their opinions, while in others, this contradiction seemed to be the result of unresolved tensions between competing discourses. For example, Alex, who has background in the health professions, seemed very conflicted between the construction of health as a physical quality only and the construction of health as involving both the mind and the body. Overall, the speech patterns of these nine interviews illustrate more rapport building and negotiation of speaking norms, likely reflecting an uncertainty about what I expected from them in the interview.

Two of the four interviews conducted by phone illustrated many of the expected elements of telephone speech. These two interviews were with women (Anne and Sally) whom I did not know personally, while the other two were with women (Daisy and Lucinda) who know and (from my understanding) like me. In the interviews with Anne and Sally, there were more signs of hesitation and politeness early in the conversations, which is to be expected, as we did not have body language as a communication medium through which to interpret the other speaker. I made many empathizing and personalizing statements. I believe I was successful in establishing trust in these two cases; both Anne

and Sally offered very personal, emotionally upsetting and potentially stigmatizing stories. In all of the four phone interviews, I relied less on positive support statements to encourage speech once I realized that these statements interrupted the flow of the conversation. While I recognize that phone interviews differ in some substantial ways, the conversation analysis illustrates that a degree of trust and rapport were established.

In all the fifteen interviews, expressions of power are visible through conversation analysis. In most of the interviews I set the direction, particularly during question/answer speech acts. I also controlled the extent of my personal disclosure (though I recognize that the women I interviewed may have done the same). My hope to not solely control the direction of the dialogue was also evident; I often relinquished second turn advantage and occasionally asked permission to change topics. Women expressed their power in a variety of ways: not engaging in certain topics, changing topics, answering abruptly, challenging me to explain my ideas and being the person to 'close' the interview. Two interviews are striking: Minerva and Ama. Minerva, an older woman with a higher degree of education and financial status than I, controlled much of the discussion pace, challenged me to explain myself when I offered new ideas, and closed the interview. This was also the interview where I was most likely to preface my summaries or impressions of her experiences with a quasi-apology. This linguistic pattern reflects my lowered confidence in this interview; her speech style was more authoritative than that of many women I interviewed. The interview with Ama was time pressured, and as such, she offered direct and sometimes abrupt answers. She tended to adhere to the typical interview norms of interaction quite strongly, and seemed less interested in conversation. While these descriptions may sound like I failed to garner their trust or establish rapport, I

do not believe that to be the case. After the interviews were completed, Ama was one of participants most committed to make a focus group fit her schedule, and alternatively, was one of the first to respond to the survey. She also started a lengthy conversation about my analysis and the general topic in a social setting. Minerva was very interested in some of my critiques of how her situations had been handled, and requested that I send her literature that further elaborated on our discussion. It is for these reasons that I believe both these women were engaged in the process, even though the interviews seemed more formal in some respects.

This conversation analysis has two major impacts on this study. First, it establishes that the differences between telephone and in-person interviews and those between women I knew in comparison to those I did not know were not problematic for this study. Second, the conversation analysis provides cues to interpretation, particularly in relation to moments where a woman may find dominant discourses inadequate to express herself or may be more polite than honest. I attended to these clues, which I had marked on the transcripts, during the discourse analysis. Related to this is an increased awareness of how to interpret what appears, superficially, as contradictions. In sum, the conversation analysis supports the use of telephone interviews, interviewing women I knew and did not know, and provides clues to interpretation for the discourse analysis.

The Stories

Isabelle is a 25-year-old straight feminist who has completed a B.A. and works full time. She and her common law partner's combined income is negative; that is, her income is less than his educational costs.

- 1) During her annual physical at a health clinic on campus, a physician who she's never met before said, "you should think about losing weight" or "you don't want to gain any more weight". Isabelle challenged her; the doctor responded with a slight change of tact, noting that now is good time to establish 'healthy' patterns. She recommended that Isabelle avoid fast food; this advice was useless for Isabelle, as she is a vegetarian and food conscious. This was the first time a health professional had raised her weight as an issue. Isabelle had been of a stable weight for many years. "It was disempowering I guess".
- 2) Same setting with a different doctor. This time, Isabelle raised weight as a concern, as she had been conscious of it since the previous incident. The doctor discredited BMI and supported Isabelle in her current activity and dietary patterns.

Lucinda is a 26-year-old heterosexual woman who lives independently. She has completed a MA, and now makes about \$47,000 a year. She comes from a financially secure background and is Mennonite.

- 1) She had a medical examination at Health Canada as a requirement of screening for a job. In the months prior to this, she had made some lifestyle changes – eating more nutritiously, started running and playing sports. During the screening tests, the nurse took Lucinda's weight; she did a double take and said "181 pounds!". Lucinda acknowledged the weight, and the nurse wrote it down. Lucinda was uncertain whether to understand the nurse's reaction as surprised or disparaging.

Lucinda dismissed this nurse as unprofessional, and the subsequent exchange with the physician was positive.

- 2) With these lifestyle changes, Lucinda lost 23-25 pounds over months. Her family physician, who has been her and her family member's primary caregiver for many years, noticed the weight loss and commented, "yeah, it's probably not a bad thing". Lucinda challenged the doctor on this statement; the physician explained/contextualized the comment that throughout Lucinda's university years her weight had fluctuated quite a bit. Lucinda left this meeting feeling it was a positive exchange.
- 3) As a child of 5 or 6 years, she was sitting in a doctor's office with her shirt off. The male doctor pointed, then poked her 'fat rolls' and said "you don't need that".

Alex is a 22-year-old bisexual undergraduate student with a low income. She has completed one bachelor degree in a health related field and is working on a second. She has studied eating problems, and distances herself from mainstream health care providers.

- 1) During a very personally stressful time in her life, Alex was vomiting involuntarily every day. She went to a doctor for a pregnancy test even though she had not been sexually active for a couple months. When she mentioned this to the doctor, he took it seriously, realized that she was under a great deal of stress and recommended counselling.
- 2) Alex went through a period where she was exercising 5 hours daily, which she acknowledged as positive for her physical body but not mentally/emotionally. Neither the kinesiologists with whom she had a lot of contact at the gym nor her

family doctor (whom she had contact with for unrelated reasons) realized that this might be problematic; her behaviours were supported by these people as positive.

Anne is a 29-year-old straight woman who has completed a bachelor's degree. She notes that she lives on a limited income (approx. \$11, 000/year) but enjoys her job. She is a practicing Roman Catholic, and identified as a social justice activist. Anne has congenital heart problems that require life long contact with cardiologists.

- 1) As a child and young adolescent, the cardiologist made 'oblique statements' about her weight implying that her health problems were a result of her weight and not her congenital heart defect. Looking back, Anne has realized that she was of average size and changes in her body were typical of puberty.
- 2) As an adult, Anne has raised weight as an issue with her general practitioner and cardiologists. The general practitioner simply says 'eat less, exercise more'. She finds this mantra too vague, and has pushed the cardiologists for more specific help for years. They told her to go to the 'Y'; she tried this, but the fitness professional on staff would not work with her because he felt ill equipped to provide recommendations to someone with her cardiac history and ongoing health issues.
- 3) Eventually, a nurse in the cardiology office helped her get a referral to a nutritionist. This nutritionist was encouraging and supportive, clearly articulating "your weight is not a crisis". She offered Anne support in 'tweaking' her eating habits; with this support, Anne lost 15 pounds.

- 4) This weight loss triggered a negative emotional response. Anne raised this with a psychologist who specializes in working with people with chronic health problems. This psychologist dismissed the topic, telling her she should not feel that way and refusing to explore the issue with Anne.

Alyssa is a 21-year-old straight woman from a financially secure background. She lives with her parents while she completes her undergraduate degree. Alyssa developed anorexia as a teenager. While she is no longer actively anorexic, she continues to struggle with weight preoccupation and body dissatisfaction attitudes and some behaviours (such as calorie counting).

- 1) Alyssa changed general practitioners, as she anticipated a better relationship with a female physician. This new GP has not taken a history that led Alyssa to disclose her past eating problems, and has not asked about current eating or activity patterns. Alyssa initiated a discussion about weight by asking the doctor what normal weight was for her height. The doctor responded that she was fine where she was, but that she should not gain any more weight. This resulted in a period of increased food vigilance and concern with her weight. It was the support and influence of her mother, a nurse, which helped her understand how weight and health are not synonyms.

Mae is a 48-year-old divorced, heterosexual woman with two children who are financially dependent on her. She describes her annual household income as adequate for meeting her family's needs. She has completed two undergraduate and a master's degree.

She is a second generation Canadian, with South American roots. She is a Buddhist.

Throughout the interview, she demonstrated her knowledge of weight prejudice and her paid work includes efforts to lessen discrimination.

- 1) Mae does not have one specific story, but her relationship with her general practitioner re: body weight and size has always been positive for her. Her weight usually comes up in the context of her annual medical exam, sometimes by her initiative, at other times mentioned by her GP. Her GP mentions her weight only when there is a significant change, which they discuss. Her GP is conscious of her eating and activity patterns, and if they cannot discern the root of weight changes, he refers her to an allied health professional. Mae has never felt rushed or judged in his office.

Ama is a 22-year-old single straight feminist, from a 'comfortable' financial background.

She is nearing completion of her master's degree. At the present time, her income is low.

Ama struggled with eating problems in her teenage years, and acknowledges that she can still be set off by insensitive comments.

- 1) Her first memory is of a general practitioner in another country who commented that 'it's okay that she's losing weight, but getting to 123 pounds would be a problem'. As Ama was losing weight due to anorexic behaviours, this number set the goal for her. This GP's style of history taking about her problematic eating behaviours included making statements that functioned as questions (e.g., 'you feed other people'). Ama noted that she learned 'tricks' through this line of questioning.

- 2) When she returned to Canada, a medical specialist in eating problems was the first to help her understand that she was ill. He did this by being very direct with her: “You are sick. You have to accept that”.
- 3) She was sent to a specialized clinic, where she was asked question after question about her behaviours and symptoms. Like with the first GP, this put ideas in her head and in some ways insulted her, as some of the questions were observable or obvious. Again, the oral and written questions presented her with new possibilities for problematic food and eating behaviours.
- 4) After her period of intensive treatment, she went to a private school. The school nurse saw Ama weekly to weigh her. While this nurse was very impersonal, Ama received her positively because she did not give Ama grief when Ama did not make a weight gain target and did not scold her for exercising more than she had agreed to. While her approach was cold, she did not seem critical of Ama.
- 5) A nutritionist Ama saw during this same time made clear food recommendations that Ama thought were crazy, but these gave Ama specific targets, ones that she later was able to attain.
- 6) A physician and a nurse followed Ama during college. The doctor was very one-track; he was concerned about pregnancy only. The nurse was distant but received positively by Ama because she approached weight as ‘fact: you weigh X’, without tying this to a judgment.
- 7) When her weight had increased significantly, Ama saw a naturopath who analysed her eating patterns and was able to normalize some of her ideas about food. For

example, he said “You have such strange ideas about food, you think fat is evil – you need fat to live!”. Ama increased her fat in her diet and lost weight.

- 8) The general practitioner who has had a long-term relationship with Ama, seen her ups and downs, is cold and difficult to talk to. Ama acknowledged that she avoids discussions of weight with this woman. This GP questions Ama if she is eating, and if Ama is eating and not emaciated, this GP appears to assume that Ama is healthy. After one weight gain period, Ama asked this GP if she was overweight. The GP responded, “Oh no, you are beautiful. You could, if, you know, you could lose maybe five pounds if you really wanted to.” And then, “But don’t lose any more than that, but if you really feel like you have to, then you could lose five.”. This number stayed in Ama’s mind.
- 9) Her most recent interaction was with an endocrinologist. Ama discussed her weight fluctuation and amenorrhea with her. In reference to her weight, the endocrinologist told her to stop worrying about it. The endocrinologist recommended she have a blood test to rule out thyroid problems. Ama left this discussion strengthened by the comment that she needed to stop worrying about her weight.

Ruby is a 28-year-old queer woman in a common law relationship. She is a feminist and fat activist. She has completed a BA and is in a master’s program. She comes from an intellectually rich household that was less financially secure. Her present income level is adequate.

- 1) Her long-term general practitioner was good most times; she usually asked activity related questions rather than being focused on weight. Over time, Ruby developed a sense of activism around weight, and this visit was the first day she refused to be weighed. Ruby sought out her GP because she had missed periods but knew she was not pregnant. Her GP did not take a focused history or run any tests; she told Ruby that she was too fat and needed to lose weight. Ruby acknowledged to herself that she may have gained some weight, but knew this was because she had quit smoking; the doctor did not ask about this.
- 2) About ten years ago, when Ruby was a teen, she was taken to the Emergency Department for severe abdominal pain. At the time, she was dieting using Slimfast, and had not had a bowel movement for some time. The doctors she spoke to scared her off fad diets, but did not discuss more general problems with dieting.
- 3) A couple years ago, Ruby walked into a minor emergency/drop-in clinic seeking treatment for a yeast infection. The doctor started the conversation with “so what are we gonna do about your weight?” She responded “first we’re gonna treat my yeast infection”, and the weight issue was dropped.

Stella is a 27-year-old queer feminist woman in a common law relationship. She has completed an undergraduate degree and is in a master’s program. She identified her family as upper middle class, Mediterranean and Anglican. She and her partner are financially secure. She has a history of anorexia, and continues to struggle with some problematic attitudes and behaviours.

- 1) Her younger brother has always struggled with his weight, and is an emotional eater. At one point, her family physician told her mother to “watch her [indicating Stella], there’s an influence there now”. Stella expressed frustration with this statement, as the major weight preoccupation influences she identified in her life were her mother (always dieting), her father (very fitness focused) and ballet.
- 2) The nutritionist at the ballet school reviewed the food logs the students were required to keep. Her food intake was often judged as the root of any performance limitations, but the issue was always that she ate too much of something, never that she lacked anything. Stella noted that this system encouraged the students to lie; she was not eating but writing some food down to avoid getting into trouble. Stella had contact with another nutritionist when she pursued competitive gymnastics in addition to ballet. While the recommendations differed between these two health professionals, both of these nutritionists had a vested interest in keeping her weight at a certain level.
- 3) At sixteen, Stella was hospitalized on a psychiatric ward for observation following a series of suicides in her peer group. During this time period, she had been engaging in many problematic eating behaviours but without garnering attention. Because she was heavily medicated, she needed to eat much more than she was accustomed to; she vomited involuntarily many days. A dietician met with her and spoke about Stella’s family history of obesity (which was inaccurate) and made comments like “you look like the kind of kid who starves herself for attention”. In group sessions, the dietician was critical of a suicidal girl who was depressed

about her weight; she held up Stella as a role model for this girl – “just take control of yourself”. This dietician called both these girls self-indulgent.

- 4) At age 20, Stella voluntarily admitted herself to a treatment program. She did not connect with her initial psychotherapist who had a gentle approach (described as a “how do you feel?” type). Stella met another therapist in the centre and requested to change. Working with this second therapist was substantially better; he explored Stella’s beliefs at more causal levels, challenged her and pushed her to be realistic. She made a contract for life with this practitioner, which included that she would never own a scale again.
- 5) She has not had any more recent problems with health care professionals, but noted that she is ‘out of the anorexic closet’ with them. She still struggles every time a new health professional or a form asks her for height and weight. She cannot answer the weight question and has been pushed to estimate. She knows that there are times when weight is a medically necessary factor (such as in determining anaesthetic amounts), but is ‘weirded out’ by the questions when weight is not relevant to the problem.

Sara is a 49-year-old lesbian woman in a long-term common law relationship. She has completed a bachelor degree and started a master’s program, but discontinued. She has some background in alternative health care. Her household annual income is approximately \$42,000. She self-identifies as from a white Anglo-Saxon protestant background. She has struggled with her weight and has had body image issues and

depressive episodes over the years. She worked as a fitness leader at one point. She was diagnosed with non-insulin dependent diabetes in the past five years.

- 1) In a northern community in Canada, Sara saw two different GPs. One had tested her blood glucose levels, but not informed Sara of the results. When she next saw a doctor, the other physician refused to believe that she had not been informed. He proceeded to tell her that if she did not lose 30 or 40 pounds in the next six months, she would be diabetic within five years. When she explained that years of dieting and weight loss attempts had been unsuccessful (and even counter-productive) for weight control, the GP replied that it was “just a matter of willpower”. This GP proceeded to tell his own story of losing 40 pounds when he realized he had heart disease. Sara later learned he had done this via a crash diet of noodle soup.
- 2) Sara has noted that her depression and weight concerns are interrelated. She was working with a psychiatrist on these issues. One day, he ate his lunch in front of her; it was all raw vegetables. He then proceeded to give her diet advice: “shit more than you eat”.
- 3) After Sara left the two GPs, she asked her new GP about diet pills. This GP responded by saying “I’m more concerned about your depression than your weight”.
- 4) Sara lost 35 pounds in about two weeks due to an ear infection. She expressed concern to the GP, who said it was fine because she was overweight. She challenged this by mentioning her known pattern of rebound weight gain. The GP dismissed her challenge.

- 5) Sara has seen several dieticians for her diabetes. She provides food diaries for these visits. One entry was 'don't ask'. The dietician said "I take it that was a bad day", then left it. At the end of the consultation, Sara said "oh, I'm so relieved because I thought you were gonna give me a hard time", to which the dietician responded "no, no, no. The diabetes gives you a hard time; it's not my job to give you a hard time".
- 6) Sara's current general practitioner spoke with Sara about non-medication strategies to manage her diabetes. She recommended a five to ten pound weight loss, explaining why this is helpful. Sara noted that this recommendation was realistic. This physician leaves dietary management up to the dietician in the diabetes clinic.

Sally is a 34-year-old single straight woman. She has completed her master's degree, and now makes approximately \$44, 000 annually.

- 1) Sally recently moved to a new city where it is difficult to find a GP accepting new patients. She settled with one she did not like much. Prior to this incident, the doctor had already prescribed antidepressants in a way Sally questioned. One visit, the GP weighed Sally and told her she needed to lose weight. She started grilling her about her eating habits but did not give Sally time to respond to her questions. She made several assumptions about Sally's eating habits that were incorrect, and then preceded to prescribe a diet that Sally objected to, with little food variety and many foods with additives. The GP did not ask about recent dietary changes; Sally knew she had gained some weight because she was eating

more chocolate due to high stress levels. The physician never asked about or discussed activity and never followed up on this conversation.

Daisy is a 23-year-old heterosexual student who lives with her mother and sister. She has completed one bachelor's degree and is working on a second. She is partially financially dependent; combined household income is approximately \$50,000 annually. Her mother has always been weight preoccupied and dissatisfied with her body, and had been anorexic earlier in her life. One of her sister's weight fluctuates significantly, and Daisy's twin is larger than Daisy. Daisy noted that she has some dissatisfaction with her body, but her athletic involvements 'protect' her from problematic eating behaviours.

- 1) Daisy currently sees a naturopath; diet changes are central to his philosophy. He starts each visit with taking weight; he usually makes no comment or is positive with Daisy, but seems critical of her mother. Daisy expressed that she does not need or want to lose more weight, but Daisy senses that the naturopath's assumption is that weight loss is good.
- 2) During her annual physical with a new GP a couple years ago, Daisy mentioned her poor circulation and sense of always being cold. The GP responded that this would not be a problem if Daisy gained 20 or 30 pounds, after acknowledging earlier in the exam that her weight 'looked good'. The GP did not take a complete history, hence was unaware that Daisy was a competitive athlete at the time; her circulation should have been much better than a non-athlete.

- 3) Daisy saw a physical therapist a couple of years ago for a back injury while she was competing. The activity history was extensive, and weight was never mentioned.
- 4) Daisy gained 20 pounds while overseas for a year, which she was uncomfortable with. After a second trip, she was quite ill and lost 20 pounds rapidly. She felt like she was 'wasting away'. Her GP was unconcerned and told Daisy she would gain it back when she was healthy again.

Minerva is a 53-year-old heterosexual, married woman. She has two children. She has completed a PhD and works full time. Combined household income is approximately \$120,000 annually. She stated she is from an upper middle class Jewish household. She noted that she was raised in a home where nutritious food was readily available and the prevailing logic was that children eat when they are hungry.

- 1) In the past two years, Minerva was misdiagnosed with heart disease by two GPs who work in partnership. A cardiologist later dismissed this diagnosis, but these GPs continue to be vigilant about her cholesterol and blood pressure. One GP referred her to a nutritionist. Minerva kept food logs before this appointment, and the nutritionist started the consultation with various measures, including body mass index (BMI). She explained to Minerva that these measures indicated she was in the 10-20% risk category for chronic illness. She singled out Minerva's BMI at 29 as problematic, indicating this meant that Minerva was overweight and almost obese. She then 'insisted' on a 20-pound weight loss via behaviour modification. It was only then that this nutritionist looked at Minerva's food logs

and realized that Minerva had nutritious eating patterns. She then asked about Minerva's activity patterns. Minerva does not own a car and walks more than 1 hour daily; she recommended that Minerva increase her daily walking, and used her own activity patterns as an example. Minerva did not feel that this woman's habits were transferable to her life. Minerva left this consultation with no solid recommendations and confused feelings about whether she was 'healthy' or not.

Jill is a 25-year-old straight woman. She has completed a bachelor's degree in a health related field and is now pursuing her master's degree. She is from a secure economic background, and has a limited student income. Until recently, she was a competitive athlete; she continues to be very active in sports.

- 1) In her first year of University, Jill gained then lost 15 pounds, and developed low back pain. She sought treatment from both her GP and a sports medicine doctor. Jill raised her breast size as a potential contributor to her back pain, and inquired about breast reduction as a potential treatment. Low-grade arthritic changes were noted on medical imaging (a very common finding even among people without pain). Her GP referred her to a physiatrist (physical medicine and rehabilitation specialist). This specialist took a minimal history, performed a physical screening exam, and then dismissed breast size as a causal issue. She proceeded to recommend that Jill lose 15-20 pounds. The physiatrist had not asked Jill about her eating and activity habits, did not know she was an elite athlete, and did not weigh her during this visit.

Melina is a 35-year-old heterosexual woman who lives in a common law relationship. She is the mother of 2, and additional relatives (a sister and her child) live in her home. Combined household income is approximately \$70,000 annually. She has completed her master's degree and works in her field. She has been 'heavier' for most of her life, even when very active and fit.

- 1) About ten years ago, she was diagnosed with interstitial cystitis (an inflammation of the bladder); the specialist raised her weight as an issue.
- 2) During her first pregnancy, even though she was very health focused in terms of sleep, eating and activity behaviours, she was told repeatedly to expect problems because of her weight. One resident verbalized his surprise when her blood pressure was in the normal range. Overall, she lost 30 pounds during this pregnancy.
- 3) When breastfeeding her premature son in the maternity ward, one nurse commented that she 'could feed a starving nation'; all the nurses on the ward came to look at her breastfeeding her son.
- 4) Melina noted that when she has musculoskeletal injuries, she receives inadequate care. Melina sustained a wrist injury; her doctor insisted that there was no swelling. Melina had to push for x-rays. When she injured her knee, the resident she saw discussed swelling management and prescribed anti-inflammatory medications for her. When she followed up with her GP, the GP said that there was no indication of swelling on the chart. The GP suggested the problem was arthritis before x-rays were taken, in spite of the history of trauma to the knee. Her GP only recommended weight loss; she did not recommend any treatment or offer

any other pain reduction strategies. Only with Melina's insistence did she get referred to physical therapy. The physical therapist was upset that no x-rays had been taken; with manual assessment, a ligamentous tear in the knee with lack of joint stability was noted. Melina did have x-rays taken, which showed low-grade arthritic changes (again, a very common finding on people with and without pain or problems). With Melina's insistence, she was referred to an orthopaedic surgeon; he took a detailed activity history and performed a physical exam. He recommended a joint brace to improve stability and reduce pain with activity. He acknowledged that body weight will affect joint pain, but did not suggest it was causal.

- 5) Melina saw a surgeon re: a possible breast reduction. MSI (the provincial insurance plan) has two qualifications for the surgery to be covered: a low BMI and a certain volume of breast tissue. According the MSI standards, Melina had six times the amount of breast tissue needed to qualify, but would have to lose 160 pounds to qualify for the surgery. The surgeon agreed with Melina's sense that this is discriminatory, but recommended a 50-pound weight loss before surgery to reduce surgical risks. In essence, MSI blames body weight for increased breast size, even though breast tissue is both mammary glands and fat tissue, in different proportions for different women and affected by genetics. The proportions of the different tissue types are only known via invasive means. This surgeon is now conducting a study that argues that the MSI standards are discriminatory, and examines alternative measures such as breast/rib cage/shoulder width disparities.

- 6) During her annual 'well woman's exam' with her GP, Melina explained her new activity pattern (i.e., above her usual walking routine). This conversation seemed to Melina the first time her GP was 'happy' with her; the GP disclosed to Melina how difficult she finds it to make time to exercise regularly.

The culture of medicine in the stories

Feminist health critiques of the biological reductionism and decontextualization inherent in the dominant culture of medicine came through in these interviews, often unsolicited.⁷ The women voiced concerns with the ways health professionals approached clinical care. They noted that the approaches of health care professionals relate to personalities, power inequalities, as well as conceptualizations and underlying assumptions of medical culture and society on the whole.

The women I spoke with conceptualized health as much more than physical in nature. Most mentioned physical as well as emotional, mental or spiritual dimensions of health, noting that 'good health' includes much more than behaviours and numbers. 'Good health' was difficult to describe for many women; the concept had intangible qualities and operates as a continuum rather than as an absolute. Health was noted to be a broad idea, influenced by personal behaviours; that is, eating nutritiously, getting enough sleep and being active all contribute to 'good health'. Alyssa used an analogy of sustainable development as a way to understand health. Ruby described 'healthy' as

⁷ In review, the culture of medicine is a system that relies on the scientific paradigm, emphasizes measurement and quantification, and grants epistemic authority to health care providers. This culture examines illness at the level of individuals (as opposed to illness placed in social, cultural and physical environmental contexts), conceptually removing individuals from the material realities of their lives. This culture reinforces the idea of 'individual responsibility for health', understanding health problems are a result of personal failing as opposed to social, economic, political or environmental sources. This medical paradigm or culture contributes to the social norm of self-surveillance, where individuals monitor their behaviours diligently. Finally, the dominant medical ideology assumes that physical health is 'health'.

“...feeling like I’m living in my body, like I’m using it, it works for me...”. Some women noted that what is healthy for some is not for others; much of this relates to underlying attitudes and assumptions. Stella remarked that she is now in the best health ever in spite of weight gain over the past five years; she obsesses over food less, has lower stress levels and is “...just letting my body be”. Anne noted a time in her life when she was ‘healthier’, which for her indicated a period when she discredited the entire dieting/weight preoccupation mentality. Some women were more performance focused in their description of health, in that being ‘healthy’ meant that they would be able to do all the activities that they want or need to accomplish over a day.

These women found their conceptualization of ‘health’ at odds with that of health care professionals. Some women expressed concern with the idea that physical health, observable on the body, has come to be synonymous with ‘health’. Several issues are imbedded in this concern. One is that for health professionals, ‘healthy’ has minimal connection to mental health. The concept of ‘health’ implied by health care professionals is one where physical health is the primary or only concern; mental health is a lesser subcategory. Speaking about her general practitioner, Ama said, “She doesn’t get mental health at all, right? She has no connection to mental health at all...”.

A second concern raised was that numbers or measurements are considered ‘truth’, while the subjective symptoms are, at times, ignored or dismissed. What cannot be reduced to a number is left unexamined, though may be of critical importance in understanding the experiences and concerns of the patient. They noted that the culture of medicine, with its obsession for numbers and measurement (a.k.a. ‘objectivity’), had an impact on how health professionals approached the idea of health. Several women

objected to the practice of reducing the patient to a collection of numbers: in Isabelle's story, her weight, one number, was the only justification provided to explain the label of 'unhealthy' the doctor applied to her. Minerva noted, "health professionals are, are very obsessed with bodies and weight and measuring". In her example, numbers alone were used to determine the need for a referral to a dietician; that is, the referring general practitioner did not know her eating habits. The consultation with the nutritionist turned out to be a source of much frustration for Minerva, as this clinician labelled Minerva as being in the 10-20% risk category for chronic illnesses such as heart disease and diabetes, but provided few constructive hints to change this risk categorization. I spoke with Minerva within days of her consultation with the dietician. She had been direct with the clinician that she thinks health professionals are obsessed with measures, but when the dietician used statistics and measures to build the case for weight loss, Minerva left the consultation confused about what she should do. Even though she places little faith in numbers, this dietician seemed to make her fear the consequences of inaction: "And so I really don't know, short of revamping me, what I'm gonna do differently". In sum, the reliance on blood pressure and cholesterol measures, and the ignorance of Minerva's personal health behaviours led to a referral to an allied health professional that was not only unhelpful, but also frustrating. The focus on numbers, particularly weight, rather than the individual person left many of these women feeling like their concerns had not been adequately addressed or that they left with more questions than answers.

Others explicitly expressed concern that weight is used as the primary or only measure of 'healthiness'. Not all women rejected the use of physical measures as indicators of health; they noted some numbers are very helpful when trying to reconfigure

the meaning of health. Both Stella and Alyssa, women who have battled eating problems for many years, have found measures such as blood pressure, heart rate and cholesterol as useful in helping them understand that not eating is destructive for their physical bodies. The context of the woman's own life shapes how different women will receive physical health related numbers and measures. What did appear to be agreed upon is the idea that health care professionals need to know the limitations of the measures they use and avoid over-reliance on one or a small group of numbers as a way of determining 'healthiness' of a patient. Incessant focus on weight often results in other relevant health questions not being asked and can lead to misattributing a person's symptoms to weight, consistent with critiques of reductionism.

The outward appearance of physical healthiness can be deceiving. Minerva raised the example that on any given day a person can appear well, but may have a stroke the next day. Alex's own experience provides a striking example of this: during her high school years, she exercised 5 hours each day. She remarked "Everyone was just like, 'wow, you're so motivated, you look great, you've lost a ton of weight'.... And just as I've learned more myself, looking back I realize just how bad it was". Her past attitudes towards her own body explain why this was not a 'healthy' time for her: "If I don't work out this week, I'm gonna get fat, I'm gonna gain 30 pounds in like a week. [MM HMM.] I honestly thought that! I'd just get disgusting if I stopped working out". Those who appear (on the physical surface) to be healthy can have a range of problems; this exemplifies the problematic conflation of appearance and physical health with 'health' in the broad sense, typical of weight prejudice.

These women explored the idea of health as inscribed on the body, implicit in the care they received. A comment made by Alex exemplifies this concern: “I never looked sick cuz I was very strong”. This construction of health as physical and inscribed on the body ties to paternalistic ideas that the health professional knows the patient’s body better than the patient does. Sara resisted this idea vehemently: “it’s a whole scientific thing, right? They want a number in black and white they can point to, as opposed to something as subjective as, you know, ‘I can tell by my energy level, dah, dah, dah, my vision and so forth’”.

From the stories these women shared with me, the dominant discursive construction of individual responsibility for health persists. Individual responsibility, particularly in its application to ideas about weight, is an idea some women were critical of while others internalized it in their own stories. In particular, those women who had had some long-term success with weight loss or maintenance via changing eating habits and activity patterns tended to adhere to this discourse. Isabelle noted that the judgmental statement made to her about her weight came at a time when she was active: “I wasn’t like a total slob”. Lucinda had recently made some significant lifestyle changes that led to a 30 pound weight loss, and noted that she “but all other things being equal, I don’t intend ever to hit that weight again”. This perspective is not surprising, considering that the dominant ideas about food and weight held true in her personal experiences to date. Sally mentioned “I know it’s not for someone to fix...me”, even though she demonstrated the range of her knowledge about weight myths. Others acknowledged that they feel physically better when active or eating more nutritiously, but were critical of the

judgmental attitudes towards body weight and personal behaviours that are visible in health professionals' language and in the general society.

Some explicitly raised social, cultural and economic influences on health as a critique to the clinical practices of health care professionals, though the issues are inherent in many of the stories and critiques that the women shared with me. Melina, Minerva, Ama and Stella raised concern that health care professionals do not acknowledge the social or environmental factors that influence individual behaviours. Minerva spoke of a nutrition education lecture she attended where the health professional's advice ignored the impact of economic realities and social class on food choices and availability. Ama raised the social determinants of health as central to health. Several mentioned the impact of genetics on their health and weight. This balanced approach to responsibility for health is not reflected in the practices of many health care providers that these women have come into contact with over the years.

Stella and Sara pointed out that even though a number of influences shape one's health, ultimately it is our body and we have to live in it. Stella remarked "...once all of that has worked to manifest this horrific situation, there's no one around that can say 'this is what you should do', you seek that out on your own, if you ever do". For Sara, this attitude manifested itself in her becoming more assertive with health care professionals:

I really have to become proactive about my health because...I came to the conclusion that although it's my body, and I think, I may not know as much technically about what's going on with it, but I'm living in it, right? I have a stake in it, [MM HMM] I have the biggest stake in it, and uh, so I'm not just gonna be an innocent bystander.

Some women raised concerns about the impact of the paradigm and the health care system on the quality of care they receive. When Melina sought out a breast reduction surgery for physical health reasons, it was the weight requirement of the public insurance system that made it inaccessible for her, not the medical opinion of her surgeon. Sara was told to lose 40 pounds or she would develop diabetes, but not referred to a health professional who could help her develop a strategy to reach that goal in a healthy and sustainable way. This 'just do it' mentality assumes that Sara's primary problem is one of willpower. Sally's general practitioner recommended a diet that lacks food variety and is full of food additives in a couple minutes rather than sending her to a dietician. This led us into an extended discussion of public and private health care systems in Canada. The fee-for-service system for physicians creates financial incentives for physicians; she once had a physician who had a rule that a patient could only raise one concern per visit, unless you could manage to slip a 'quickie' into the discussion. This can result in physicians not addressing issues that they cannot bill for. In addition, the system may encourage physicians to work outside of scope, as a two-minute 'counselling' session is something a physician can bill for, even if the discussion is inadequate in addressing the patient's needs. Problems like health care practitioner shortages and long waiting lists came up in our discussion as relevant to attempts to change the system.

Many women raised concerns about medical physicians working outside of their scope of practice. A related concern is that many physicians do not refer to their allied health professionals when it is indicated. This raises the question of whether or not physicians are knowledgeable about the expertise of these professionals. Anne's example is the most striking and disconcerting for me: she has congenital heart problems that

affect her blood pressure and appears to have an associated circulation problem in her legs. She has asked for specific activity guidelines, and has been told not to lift weights; beyond that, the only guideline she has received is ‘exercise more, go to the “Y”’. When she saw a fitness trainer at the “Y” to set up a program, he refused to work with her because of her cardiac history. My being a physical therapist factored into this discussion; I expressed my frustration that she has not been referred to a cardiac rehabilitation program or to an outpatient physical therapist that specializes in cardio-respiratory care. In either of these settings she would have gained the specific guidelines and support she needs to feel comfortable in engaging in regular physical activity. Anne told me that no one had ever suggested that such programs or professionals exist, even though she was in an urban setting where these resources are available.

Tied into this are issues of inadequate history taking. If a health care professional takes an inadequate history, they may oversimplify the problem and offer ‘one size fits all’ answers. As exemplified in most of the negative stories the women told me, the realities of their lives were not known to the health professional. Knowing so little about her, in essence decontextualizing her from her life, resulted in ineffectual or inadequate information. The history taken by the physiatrist Jill saw to explore the option of a breast reduction surgery was so limited that the recommendation was useless. She was told that her back pain was unrelated to her breast size and that weight loss was the best solution – even though the physiatrist had not weighed her. At the time, Jill was an elite athlete. Daisy’s situation was similar; as an elite athlete, her circulation should be better than the average person’s, but her physician was dismissive of her circulatory complaints, relating this to her weight. The circulatory complaints should have been a red flag for this doctor,

as many women with eating problems complain of cold extremities. In Alyssa's case, if the doctor had taken a complete history and known her past struggles with anorexia and ongoing body dissatisfaction, she might have been more sensitive when responding to Alyssa's question.

Though many of these women had challenged health professionals, the effectiveness of those challenges varied. That is, these women do not understand themselves as 'victims'; they acknowledge their agency in clinical encounters. They express this agency in different ways: changing or avoiding certain health professionals (Isabelle, Lucinda, Anne, Alyssa, Ama, Ruby, Sara, Sally, Daisy and Minerva), changing their communication style (Isabelle, Daisy, Anne, Alyssa, Melina, Ama and Stella), seeking second opinions (Stella), pursuing alternative/complementary care (Daisy, Sally) and avoiding health care altogether (Anne, Stella, Minerva, Daisy and Melina). Some of these strategies are more successful than others. If a woman changes her health care provider and finds one whose approach matches her needs better, then she still receives care when she needs it. Those who avoided health care altogether acknowledged that this is the riskiest strategy because a physical health problem, such as cervical cancer, may be more advanced, hence less amenable to treatment, when finally detected. Changing communication strategies works well for some, depending on the nature of the change and the personality of the health professional. Isabelle has integrated the lingo of her health care providers into her language, and found that the information she received back was more specific. Daisy walks into her annual physical with a written list of issues to discuss, which she has found to be a helpful strategy. Anne got into a heated argument with a cardiologist (she asked 'why' type questions to his recommendations, he refused to

answer, she continued to push - he now refuses to see her); she now makes a conscious effort to speak as unemotionally and frankly as she can. Ama and Stella are direct with health providers about their anorexic histories (to use Stella's term, they are "out of the anorexic closet"). They find providing this information, even when unsolicited, has helped them receive appropriate care. This approach stands in contrast to the one Alyssa takes; she avoids raising certain topics she knows she is sensitive about, which may result in incomplete, inadequate or inappropriate recommendations if the health professional takes an incomplete history. Melina is proactive and insistent in receiving the care that she knows a thinner person would receive, whether that involves being sent to a specialist, a physical therapist or for medical imaging. Melina makes a strong point though: if her physician assumes all her problems are due to her being fat, then detection will be delayed anyway. This certainly was the case with her knee ligament injury. Often late detection means poorer prognosis; knowing this, she tries to be an advocate for herself in the doctor's office, though she finds the effort frustrating and tiring. These women expect more from health care providers, but adapt to the current system to ensure that their needs are met.

Minerva sums up the issue with power inequality between clinician and patient succinctly: "...you and I know these people are always authorities and they act in an authoritative manner". This overstates the idea, but gets at a critical piece of this picture: ultimately, it is the health professional who has the power to write the prescription, send the patient to the specialist or therapist or for further testing. It is this power that makes the ethical responsibilities of health care professionals so pronounced. If a health care professional does not know the limitations of the measures they use, are prejudicial, save

time through incomplete history taking or examination or do not acknowledge the expertise of their fellow health care professionals, the quality of care the patient receives will be diminished.

Weight and medical culture

Medical culture in Canada, reproduced through health care professionals, is problematic in the area of weight. Weight and 'healthy' behaviours have become the new measure of 'good' living. The role that medicine assumes in our society means that, at this point in time, medical clinicians have a great deal of authority. When weight defines health, and health care professionals are held in high esteem as health experts, the results can be detrimental for women. From what these women shared with me, two major themes emerged on the topic of weight and health care: reliance on incorrect or incomplete scientific knowledge about weight, and the tendency for medicine to decontextualize patients from their environments, reducing them to numbers reflecting their physical health.

Some women raised specific concerns with the apparent entrenchment of problematic and inaccurate ideas about dieting and weight in medical practice. These problematic beliefs include assertions that 1) weight is within individual control; 2) thin is healthy, fat is unhealthy; 3) people who are fat overeat or have mental health problems; 4) weight loss is always desirable and good for your health; 5) dieting is an effective weight control strategy; and 6) the body is infinitely malleable (Berg, 1999b; Brownell & Rodin, 1994; Ciliska, 1993; Wooley & Garner, 1991). Cogan (2000) and Kratina (2003) refer to this as the weight-centred paradigm. This paradigm, when practiced, reinforces weight

and dieting myths, implicitly justifying weight prejudice. The negative weight-related stories shared by these women relate to one of these six inter-related myths.

Isabelle, Anne, Ruby, Sara, Sally, Minerva, Jill and Melina have all found themselves in clinical situations where weight loss was recommended without their weight and 'healthy' behaviour patterns being known to the clinician. Melina and Ruby found themselves in clinical situations where their weight history and 'healthy' behaviours habits were known to the clinician, and 'being fat' was used as the sole or primary explanation for their symptoms following minimal examination. Of these women, several were surprised by the recommendation to lose weight but did not challenge it at the time, though upon reflection or discussions got quite angry about the conversation in retrospect. Isabelle, who self-identifies as a feminist and has always been somewhat satisfied with her body, found the recommendation offensive:

...it's almost like hurling an insult your way, right? 'You're fat, you need to lose weight.' And it's coming from somebody who's an authority, so you can't question it and I didn't really have two legs to stand on. Like I couldn't have said 'oh no I'm not' because she would have been able to say 'well yes you are, look at my flipchart and I will show you that this is the case'.

Ruby and Sara verbally challenged the weight loss recommendation directly at the time. Ruby has since changed general practitioners, in part because of this experience. Sara offered information about her known weight cycling pattern to the clinician, who disregarded this contextual piece of information and stuck to his initial recommendation, insisting that weight control is "...just a matter of willpower". In this interaction, he assumed she overate because she was larger, that dieting is an effective long-term weight

control strategy and that she was solely responsible for her weight. Her inability to lose weight was simply a lack of willpower.

The reactions of the women to the clinician appear to relate to how aware they were of dominant weight and dieting beliefs/myths, how political they were about women's bodies and weight, and their own weight experiences. Ruby and Melina, both very political women when it comes to weight issues, use the language of 'health at every size' and problematize the practice of reducing all health problems to weight engaged in by some health care professionals. Jill, who described herself as quite secure with her body, was told she was overweight without being weighed. She did not challenge the physiatrist at the time:

I think it blew me so out of the water I was like I can't believe that she's telling me this. I can't believe she's using those words, just throwing them out, exactly the same thing. You're talking to a 20-something year old, you know, university student who is bombarded with body image issues all the time and you're just gonna walk out and throw those words at them?

Her academic background led her to dismiss this recommendation, but she acknowledged that for a short time, she did feel less satisfied with her body and her weight. Those most affected by the weight loss/judgmental comments were women who appear less knowledgeable about the problems with the dominant weight beliefs, had/have weight or eating problems or are less political about women's weight and bodies.

These experience stories bring to light how sensitive many women are to weight comments regardless of whether or not they have experienced eating or weight problems. Lucinda's example is striking; the issue at hand was a double take and a reiteration of her

weight, but Lucinda's reaction speaks to her awareness of weight as a potential site of judgment. Some women are proactive with health professionals in relation to this sensitivity. Ama discloses her anorexic past to health care professionals even when not asked about:

I don't have problems telling people, 'like I have a history of being really screwed up, that's the path and you should be sensitive to it, cuz I could go off the deep end and spend the next two months in either a bout of starvation or a bout of depression. You can throw me into that. It's real easy. I am that unstable so there you go, and know that in the way that you deal with me'.

Ama's struggle with her body weight and eating is more pronounced than some women's. However, if body dissatisfaction and weight preoccupation are as prevalent for Canadian women as the research suggests (Allaz et al., 1998; Jones et al., 2001), health professionals should not have to be reminded of its potential presence by each woman.

Jill's comments highlight several problems with the 'lose weight' solution. In this comment, she's speaking of an imagined internal dialogue after being told to lose weight:

... 'how am I supposed to go about doing that?', not to mention that you just made me feel like shit by telling me that, and now I'm gonna go and be upset and whatever and not really know how to do that, and probably jump into binge dieting or doing something like that and develop an eating disorder in and of itself.

In this example, Jill demonstrates her awareness that health professionals have influenced her sense of body satisfaction, and that restrictive dieting is a risk factor for eating problems.

Many women remarked that when health professionals do not take a relevant history before giving advice, they risk giving the wrong advice, with potential harmful outcomes. But the picture is bigger than relevant history taking and examination procedures. Many women argued that health professionals need to acknowledge the social and physical environments in which we live. Women are pressured by many sources to control their weight. While these pressures are internalized to the point that some women become their own worst critics, it is the external pressures that fuel these attitudes and behaviours. Beyond health care professionals, the women I spoke with mentioned families, peers, schools, workplaces, sports, media and capitalistic social trends like convenience obsession and time pressured lives as external pressures that influence our eating and activity patterns and our weight.

Many social and physical factors influence our abilities to be active and eat nutritiously. Jill and Minerva both spoke specifically about eating:

...food is such a social part of our culture, you know, and the fact that we made it into this horrible thing that people need to feel guilty about and always need to be thinking 'how many calories are in that?', or 'there's a lot of fat in that – oh my god, I shouldn't eat it, I shouldn't eat it, let alone the fact that I love it and you know, and somebody made it for me and it's really great...' (Jill).

...about five or eight people came and sat in a room and were educated by a nutritionist of what they should eat, and of course that was also absolutely insane because, well, first of all, I knew enough to know what you're not meant to eat, and what you're meant to eat, but the other people in the room were very poor people

who couldn't possibly afford, uh, the quality of calories that I can afford, and so when I pointed this out to them I was kind of banished. I said 'this is stupid.' I said 'these people here, they're asking about going to McDonald's twice a week because that's their really, their only outing, and if the only time they go out is to go to McDonald's, really, with the grandchildren what are you gonna do?'when somebody's staying at home alone, or is depressed and on their own and doesn't have much money. That person is gonna go to McDonald's cuz you're going to be with other people, and it's social. And also because it's very cheap, relatively...(Minerva)

When Ama and I spoke about exercise, she noted that "but a lot of this, it's about money and it's about access". Through comments like these, several women highlighted socio-economic status as an important determinant of health and contextual factor for understanding our lives.

Dominant social discourses and economic realities shape some aspects of our lives, and being active or eating a certain way just might not be realistic. This line of discussion that emerged in these interviews speaks to why the 'individual responsibility for health' discourse is flawed. What these women described in less direct terms amounts to what Minkler (1999) refers to as a balanced approach to health responsibility, where our families, peers, communities, genetics, cultures and economic/political systems are acknowledged as all affecting our health, in addition to our own attitudes and behaviours.

These stories exemplify the impacts of the combination of mainstream medical culture, which stresses the physical over other aspects of health, reduces individuals to measurements, holds individuals solely or primarily responsible for their health and

decontextualizes individuals from the environments within which they live, with inaccurate ideas about weight. These women's stories exemplified disempowering exchanges, useless recommendations, delayed or misdiagnosis for health problems, all of which can be harmful. The positive stories, when examined through the same criteria, support these critiques.

The health professionals portrayed positively by the women demonstrated a variety of characteristics. They all embodied some characteristics contrary to the dominant culture of medicine or to the dominant weight centred paradigm. Examples of the 'health at every size' alternative discourse in action are many. Isabelle's second general practitioner and Melina's surgeon could explain the limitations of weight measures. Mae's GP discusses weight only if it changes. Melina's orthopaedic surgeon acknowledged the role of weight in perpetuating joint pain, but did not blame the injury or the ongoing pain on her weight. This same surgeon knew Melina's activity history before making recommendations, so was able to offer her strategies that were specific to her needs. Lucinda's long-term family physician grounded her non-judgmental weight comments in Lucinda's own weight history. The nutritionist Anne met with was able to reframe the issue for Anne ("your weight is not a crisis") and provided specific guidelines that were helpful. Ama has several positive stories, most of which hinge on non-critical approaches to her weight, and treat the actual number as just that: one number. Melina's physical therapist was upset that Melina had not been sent earlier for care or medical imaging; through a physical exam, this therapist discerned that Melina had torn a ligament in her knee, and appropriate treatment finally began. One of Sara's general practitioners prioritized her depression over her weight, and the last dietician she saw was

not judgmental about her eating habits, saying “it’s not my job to give you a hard time”.

Sara’s current GP has talked about weight loss in a way that is less overwhelming:

...she made a point of telling me ‘it would be good if you could lose some weight because that will, that will be [a] really positive thing, you know, controlling the diabetes’, but she said ‘it’s important for you to understand that you don’t need to lose, like 30 or 40 pounds, or whatever, to see a difference. Your, uh, pancreas will respond to you losing like five, ten pounds, so even a small amount of weight loss would be a really good thing’.

Operating in a health at every size paradigm does not mean that weight is ignored, but that it is approached as is appropriate for the person and operates as only one of many measures of ‘healthiness’.

Several women noted that they did not feel judged by these health professionals and that they were treated as whole people. Mae, Alex and Sara all described situations where their practitioners’ habits counter the dominant culture of medicine. Mae and Alex’s doctors refer to allied health professionals without hesitation. Sara’s GP talked with her about strategies to manage her diabetes, but also referred her to a specialty clinic. Many of these women described health professionals that were open to answering questions and applying a problem-solving approach with them, as opposed to using an authoritative voice. In Sara’s words, the ideal health professional “...look[s] at me as a person not just as a collection of symptoms or diagnoses...”. It is this holistic and contextualized approach that feminist health visions stress as critical to providing women-centred health care.

Influential Discourses – Underlying Constructed Narratives

The pervasiveness of dominant discourses is evident in how these women talk about health, weight, health-promoting behaviours, and in how they react to health professionals. Over the interviews it became apparent that most of the women had, to varying extents, internalized dominant discourses about weight and the morality associated with ‘healthy’ behaviours, even if they were critical of these same ideologies.⁸ Isabelle spoke of the appointment where she felt judged by a physician. She implied that the comment was not deserved because at the time, she was swimming a few times a week; that is, “I wasn’t like a total slob”. Lucinda’s uncertainty about what the nurse was implying speaks to her sensitivity to weight judgments, yet she later mentioned that her attitude toward the doctor at Health Canada (“yeah, you better not give me crap about my lifestyle and my weight”) was because this woman was overweight. Daisy problematizes the thin ideal, but acknowledges her gut reaction to her doctor telling to gain 20 pounds: “Like I felt guilty for thinking ‘oh good, I’m skinny’, you know, ‘oh that was a compliment’”. Daisy gained weight travelling, but upon her return lost weight rapidly due to illness. She admitted “...secretly I was kinda like ‘sweet, I’m losing all that [name of country] weight (laughs)”, even though she knew her weight was not creating any physical health problems. All the women were aware of the dominant weight and dieting discourses; those who were resistant were those who invested energy into developing discourses that counter the dominant ones.

In the interviews, moral associations with food, exercise and ‘healthy behaviours’ were evident. Anne acknowledged that, in spite of having a congenital heart problem that

⁸ The following examples are not offered as absolute representations of the women but are isolated examples of our conversations that suggest that these discourses influence the way in which the women make sense of their experiences.

limits her ability to be active, “I can’t seem to stop feeling guilty that I’m making myself sick”. Sally noted “I try to make sure I get all the things I need to get, but I’m not so good at, um, laying off the not-so-good things”. Sally mentioned literature on intuitive eating, which she understands as a method of eating that strives to remove guilt associations from food. In reference to her diabetic diet, Sara said “I freely admit it’s, to me it’s, you know, you go into denial, right? It’s like you play this little game with yourself whereby you’re like, you’re cheating, you know? You’re like eating something you know you shouldn’t...”.

As is apparent from the comments of several women, this moral discourse for food and activity results in self-surveillance. Alyssa, a woman who has experienced eating problems in the past, told me “if you don’t do it, you’re sinning” in reference to exercise. She had similar response when I asked her about her opinions on dieting: “(laughs) That, honestly, that I almost feel like you always should be doing it, or should be – I’m constantly watching, even now, what I eat, you know, and counting points. And diets are, it’s almost taboo if you don’t do a diet.” Jill spoke of the guilt that she’s felt on occasions:

...there are still days when exactly like you said I go to eat something and I know that it’s fine to eat it and every once in a while and, you know, everything in proportion, but there’s that little thing in the back of my head that goes ‘oh dear, you really shouldn’t eat that’, or you know, feeling guilty like ‘oh, I should go out and walk around the block, I ate so much today, oh my god!’...I don’t know where that comes from and it really angers me about myself that I let myself sucker into that.

She went to mention that "...whether you want to or not, consciously or subconsciously are kind of always aware of that, somewhere in your, in your back thought...". For some women, this was more apparent when they spoke about their current eating habits. Stella described her eating habits as "...I probably know that on average I eat about 2200 calories a day – [MM HMM] which is sick that I know that. Like I don't even have to look at labels anymore, like I have them memorized". Ama noted "...I have phenomenal eating habits. Like, I don't eat anything that's remotely bad for me". All these apparent contradictions highlight how strong the dominant discourse remains in shaping women's understandings of their own experiences, even when she actively resists the discourse.

In the interviews with Ruby, Stella, Sally and Jill, I offered my favourite quotation when it seemed appropriate: "Certainly these days, when I hear people talking about temptation and sin, guilt and shame, I know they're referring to food rather than sex" (Rothblum, 1994, quoted in Germov & Williams, 1996, p. 103). This opened up a line of discussion that usually started with strong indicators of agreement. Sally's response to this idea includes the statement "we associate weight with control and that if you're overweight you're lazy, and it's a kind of almost like a sin to be fat because it's a moral thing". Ruby had heard this quote before, and described how she sees these ideas play out around her within her peer group:

It's everywhere! Go out to dinner with four feminist friends, you know, and [whispering] 'well should I have dessert, no I shouldn't have dessert, or that's oh, sinful or' blah, blah, blah. 'I'm gonna have to work this off for days' or, this, this idea of 'if I do this I'm gonna have to punish myself later'.

Conclusion

The results of the conversation analysis illustrate how the differences among interview contexts were not problematic in this study. It also illuminates issues of rapport, politeness/trust, and power. The method assisted me in the discourse analysis by highlighting the social contexts under which women spoke with me, providing clues to interpretation.

The fifteen women who shared their stories with me had a range of experiences, but a few common themes are notable. The culture of medicine, with its fascination for numbers, reductionistic tendencies, prioritization of physical health over other aspects (which is particularly problematic when prejudice affects their ability to do even this well), and authoritative approach to care delivery and decontextualization of patients from their lived environments, is evident in these stories. The weight centred paradigm persists in clinical practice. Most of these women were critical of these practices, but had, to varying degrees, internalized dominant weight and health discourses themselves; this speaks to the pervasiveness and strength of these discourses.

In the survey, women pointed out many of the same discursive themes (worded as ‘common threads or patterns’) in the stories I had used in the discourse analysis. For example, Stella noted, “it cannot be a coincidence that so many of us report that our health is discussed by doctors as being a weight issue”. Melina commented, “medical practitioners tend to make assumptions about weight/body size and health based on myths and stereotypes about what constitutes ‘healthy’”. Several women noted health professionals conflated weight with health, took poor subjective histories or ignored the histories, and were weight prejudiced. They remarked on the prevalence of body

dissatisfaction across a range of women, the power of health professionals and how it is sometimes used oppressively against women, and the lack of 'good science' to support the weight centred paradigm (that is, the continuing strength of particular myths about weight). The critiques offered by the women of both the culture of medicine and weight-centred practice are similar to those in both the literature and my discourse analysis. Hence, this survey process worked well as a triangulation mechanism.

In the interviews, these women presented a vision for health care through both their positive stories and their descriptions of ideal health care that is consistent with feminist visions of health care and the 'health at every size' paradigm. In the next chapter, I will examine this alternative paradigm in light of these women's stories. This examination will determine if one model, as described by Kratina (2003), provides an adequate model to address the concerns raised by these women.

Chapter 4: Changing clinical practice:

From weight-prejudiced to weight prejudice-sensitive

Both the academic literature and the women I spoke with noted that medical practice, informed by dominant medical discourse, tends to decontextualize patients from their environments. In addition, medical practices tend to reduce 'health' to a series of measurements and numbers rather than operating within the broader World Health Organization's definition of health as encompassing physical, mental, emotional and spiritual well-being. Medical weight discourses are evident in our broader culture, such that body weight, shape and composition now dominate how we understand 'health'. This weight discourse implies that being large or fat is the equivalent of being lazy, stupid or ignorant, the implicit assumptions in weight discrimination (Schwartz et al., 2003). Social discourses influence material realities, harming some while helping others. Ignoring this when talking with clients creates situations where recommendations made by health care professionals can range from useless to harmful. It is with this in mind that I offer an alternate vision for health care, one that incorporates changes at the level of medical culture as well as specific changes for clinical practice around the issue of weight.

The dominant medical weight-prejudiced paradigm, called 'weight centred' by some, emphasizes weight as a primary health determinant and concern in spite of a substantial body of knowledge that discredits this approach. Many have argued in favour of a 'paradigm shift' that is both more evidence based, more ethical and sensitive to the realities of people's lives (Berg, 1999a; Cogan, 2000; Ernsberger, 1999; Hawks & Gast, 2000; White & Parham, 2002). This most recent engagement with these issues has been called the 'health at every size' model (Cogan, 2000). This approach emphasizes quality

of life and reduction of factors that jeopardize our health, acknowledging that health is not solely determined by factors within our control (Cogan, 2000; Hawks & Gast, 2000). 'Health at every size' clinicians do not presume that thin is healthy and fit or that fat is unhealthy and unfit. The model strives to remove the moralistic, judgmental assumptions made about larger people in Canadian society by removing the focus from weight as a primary determinant of health (Robison, 2000; Thompson & Trattner Sherman, 2000). The 'health at every size' approach understands 'health' as existing on a continuum and encompassing more than physical attributes. This alternative conceptualization creates the possibility that one can be 'healthy' even in times of illness (Robison, 2000).

Conceptual development of this model has led to questions of how clinical practice should be structured to ensure it reflects a 'health at every size' approach. Much of this discussion stems from literature that is concerned about the effects of weight bias, which found that larger patients were accessing preventative health services less than their thinner counterparts due to experiences of weight discrimination (Ciliska, 1993; Yanovski, 1998). From this starting point, recommendations about how to overcome weight bias when providing health services to larger people were developed (Lyons & Miller, 2000; National Association to Advance Fat Acceptance, 2004; Wann, 2003). Other examples of weight related practice guidelines have been compartmentalized into those for persons from racial and ethnic minorities (Hawks, 2001) and older adults (White & Parham, 2002). These do not emphasize that issues of weight preoccupation or body dissatisfaction are common among women of many weights and sizes, across age and

ethnicity. Additionally, this reliance on compartmentalized identities is problematic in its inability to challenge the underlying assumptions of the culture of medicine.⁹

It is my belief that a simple ‘do’/‘do not’ checklist will be insufficient to change clinical practice. Changing clinical practice relies on taking on both the assumptions of the weight centred paradigm and the underlying issues with the culture of medicine, and will undoubtedly involve growing pains. Herein lies my task: to construct guidelines for clinical practice that are sensitive to women’s weight issues in this culture, challenge the weight centred paradigm and respond to the critiques and visions for women-centred care.

Guidelines for a ‘health at every size’ approach to clinical practice could be valuable for two reasons. First, health professionals may limit the time and attention they will invest in learning new practice strategies, particularly when those new strategies challenge ingrained patterns and assumptions¹⁰. Secondly, accepting the argument that as individuals, we are all shaped by a complex interaction of complex identities, such as ‘woman’, ‘low income’, ‘middle aged’, ‘queer’, ‘arthritic’ or ‘white’ means that any set of guidelines that divide clinical practice along these identity constructs will be limited in scope and effect. Guidelines must be able to focus on providing treatment to people, in all their complexity, not reducing the focus to their weight or isolated aspects of their identities. Prior to outlining my construction of ‘sensitive practice guidelines’, I will present and critique the only version of comprehensive published guidelines I have found to date.

⁹ I recognize that by focusing on ‘women’, I have relied on one such identity construct. This examination focuses on the discursive construct of weight in women’s lives; a future step for this work is to examine the discursive construct of weight in men’s lives and explore if their needs can be met by the model I will present here. I am not assuming that this model is or is not sensitive to men’s needs; that remains to be examined.

¹⁰ “Change means growth, and growth can be painful” (Lorde, 1984, p. 123).

In feminist standpoint epistemologies, the purpose is not to replace one cultural monolith with another, but to find common threads and patterns from various standpoints, and build from those points of consensus (see Harding, 1991 for an extensive discussion of this approach). This process involves making values and beliefs visible and negotiating on points of difference, although it is not assumed that consensus with all social actors can be reached, as some have vested interests in the status quo. Harding (1991) offers her perspective that multiple groups on the margins have contributions to make to this process, in that their perspectives must be heard and incorporated into feminist models and vice versa. The purpose is not to create a 'cultural monologue' or 'Truth' which is believed to hold across all cultures and times, but to create 'situated knowledges' (Haraway, 1988). Situated knowledges recognize historical contingency and cultural location, and do not rely on the transcendental 'vision from everywhere and nowhere' typical of positivism. Situated knowledges are partial, locatable, and critical, allowing for a web of connections to other knowledges.

Fine's (1994) construction of activist feminist research complements the idea of 'situated knowledges'. Feminist activist scholarship involves three main principles:

First, the author is explicit about the space in which she stands politically and theoretically – even as her stances are multiple, shifting and mobile. Second, the text displays critical analyses of current social arrangements and their ideological frames. And third, the narrative reveals and invents disruptive images of 'what could be' (p. 24).

This chapter presents my vision of ‘what could be’. The ‘sensitive practice guidelines’ offered here are a ‘situated knowledge’, shaped by cultural and historical location as well as values.

Health at every size clinical practice guidelines

In 2003, Kratina published ‘health at every size’ clinical practice guidelines for health professionals that are designed to apply across the range of gender, age, ethnicity, sexual orientation, ability levels and such. Kratina does not outline her methodology used to develop these guidelines in the article and did not offer an explanation to me in personal communications. Kratina’s published guidelines have become a starting point for my project. I chose to alter my project, starting with the question of whether or not the concerns raised by the women I spoke with and the literature are addressed by this set of guidelines, and if not, recommend amendments to these general ‘health at every size’ clinical practice guidelines.

The critiques of weight prejudice in medicine that frame the need for a shift from weight-centred to ‘health at every size’ form the theoretical foundation of Kratina’s guidelines. These recommendations are designed to be evidence based, ethical and health promoting, in contrast to the weight centred paradigm practices that are built upon weight-biased science and reinforce harmful social discourses. The focus of this approach is to treat the person, not their weight. It is with these arguments in mind that she constructs four tenets of ‘health at every size’ clinical practice: 1) focus on actual health enhancement rather than weight; 2) respect the range of ‘healthy’ bodies rather than reinforce the pursuit of an ‘ideal’ weight; 3) promote eating well as pleasurable, without

reinforcing moral discourses about food; and 4) encourage enjoyable rather than regimented activity.

In Kratina's first tenet, the focus is on the individual and confrontation of weight and dieting myths. She recommends the health care practitioner break out of 'thin is healthy/ fat is unhealthy' and 'weight gain is bad/weight loss is good' assumptions. She suggests that health care professionals should ask clients background questions about body satisfaction (when appropriate), and focus on factors that are changeable when weight discussions are necessary. For example, a health professional can ask "what, if anything, concerns you about your eating patterns, physical activity and/or body? Would you like assistance with any of these concerns?" (p. 20). Additionally, a health professional is obligated to perform complete examinations rather than dismissing all complaints as weight related. In essence, these recommendations focus on care delivery that is free of weight bias/prejudice and approaches the topic of weight, when indicated, sensitively.

Kratina's second tenet of respecting the range of 'healthy' bodies deconstructs dieting myths. "If being told to lose weight actually helped people lose weight, there would be no fat people....Few people would elect to be fat in a culture that so flagrantly hates fat people" (p. 20-21). Kratina acknowledges that the starting point in challenging this myth is the level of body satisfaction of the health care providers in their own bodies. This starting point situates health professionals within the same culture as their patients, recognizing that they are influenced by the same dominant harmful weight discourses as their patients. The reason Kratina provides for her focus on size/body acceptance is that when someone likes something, they tend to take better care of it; if the 'something' in

question is our body, a higher degree of body satisfaction will result in people taking better care of their bodies.

Kratina's third tenet, eating well based on internal cues of hunger and satiety, asks health professionals to guide their patients in developing abilities to identify body signals, balanced with basic nutritional knowledge. This involves legitimizing all foods, so that people can eat without negative emotions attached to food. The health-enhancing properties of food are not just physical; someone who eats chocolate with enjoyment should not feel guilty in doing so, but should be encouraged to eat this with a conscious enjoyment and attentiveness to internal physical cues. Even though certain foods are health enhancing, balance is what is critical in nutritious eating. For example, carrots are nutritious, but not a recommended addition for someone who eats fruits and vegetables primarily. The emphasis is balance in eating, without emphasizing moral discourses around food (that is, 'good' and 'bad' food).

Kratina's final tenet offers a reconstruction of physical activity not unlike that for food. Instead of tying activity to moralistic discourses, health care professionals are to encourage activity for the health benefits beyond weight control. Physical activity is promoted as a way to take care of your body rather than as a method of weight control. This tenet is consistent with research on activity adherence, which notes that enjoyment and convenience (in terms of location, time and finances) are two primary determinants of people's activity levels (Roitman, 2001). She highlights two other activity research findings for practitioners to discuss: any amount of activity will produce health benefits and that physical activity can be done in intermittent or consistent segments. She offers an interesting way to problem solve with the patient: ask her what she thinks of when she

hears the term 'exercise', as opposed to what comes to mind with the word 'play', then recommend 'play'.

Knowing that health care professionals are measurement oriented, she concludes by recommending an alternative to weight as the pinnacle of healthiness. Her alternative is a measure of 'metabolic fitness', which considers specific measures such as "cholesterol, triglycerides, glucose and insulin levels, blood pressure" (p. 23) as better indicators of physical health. In essence, she challenges health professionals to use the evidence available to redefine realistic goals and successful treatment indicators with their patients.

Critiques of Kratina's 'Health at every size' Model

This is the first published attempt at formal practice guidelines for weight issues I have been able to find. These guidelines offer health professionals a compromise that is palatable. Kratina builds this model upon a central concept of medical discourse: 'scientific evidence'. She offers health professionals an evidence-based, measurement-focused alternative to weight to indicate 'healthiness'. This approach is consistent with the research on weight and health, but does not articulate a comprehensive challenge to the culture of medicine. From the literature review and the interviews I conducted, both the broader culture of medicine and weight centred practices are problematic and in need of transformation.

In the survey, women agreed that many of the concerns they raised are addressed in Kratina's approach. They constructed health as something less tangible than physical indicators inscribed on the body or a collection of behaviours. Several women told me

that it is important that health professionals are factual (not to be confused with judgmental or critical), which involves knowing that health is not an absolute quality. This realization, when combined with knowledge of the limitations of the measures used in clinical practice, creates a more constructive way to approach care provision. They argued for contextualized conversations, where the health professional knows the history and current body satisfaction of the person before engaging in weight-related conversations. They noted that questions about 'normal' body weight and dieting should be seen as opportunities to challenge weight myths. They challenged health professionals to not use weight as an all-encompassing explanation for health problems, but instead to be consistent in their assessment and treatment recommendations, regardless of weight. Neither Kratina nor the women I spoke with argued against health professionals discussing weight with women; both emphasize this dialogue can be helpful, dependent on the elimination of 'fat is unhealthy/unattractive/morally weak/mentally ill' myths, how the discussion is raised and the lived realities of the person being central to the discussion. Overall, the concerns women raised that were weight specific have been covered in Kratina's guidelines.

Kratina covers specific concerns with the weight centred paradigm well, but leaves some of the underlying discourses unexamined and as such, risks reinforcing them. Kratina makes several assumptions in her recommendations. The first is that health professionals know the problems inherent in the weight centred paradigm. While it captures the desirable 'short and to the point' element, Kratina secures primarily the attention of the converted, both in her content and in the journal of publication. She assumes that health care professionals are cognizant of and willing to change power

dynamics in clinical settings. Related to this is the assumption that health care professionals have the range of necessary communication skills to make this approach work. She offers a couple of helpful examples, but does not provide a comprehensive discussion or offer a relevant resource to assist with this. Finally, Kratina does not challenge the individual responsibility for health discourse in this article. Some may argue this is not within the scope of her project, but I believe that if she is building from the evidence on weight and health, the problems with this health responsibility discourse need to be more explicit. She challenges health professionals to work outside of an incredibly strong discourse about weight and health, yet is not giving the non-converted enough information to justify the shift. In terms of the culture of medicine, Kratina does not address 'one size fits all' medicine, the 'individual responsibility for health' mantra and issues of power/authority in clinical practice. For example, the reason she provides for helping people move toward 'body acceptance' slips into typical medical culture assumptions that larger people do not 'take care' of their bodies, and perpetuates the focus of prevention/treatment on the individual. I believe that contextualizing her arguments in critiques of the culture of medicine and highlighting/explaining her assumptions better could strengthen these guidelines. In essence, I think that Kratina (2003) has only addressed part of the problem.

While Kratina's model hints at individuality of care, her approach may be understood as a 'one size fits all' in two respects. First, she does not acknowledge that clinical consultations occur between two situated individuals with specific identities and personalities. There is a slight hint at this in tenet two, where she encourages health professionals to address their own body dissatisfaction issues and weight beliefs, but this

does not capture the full concern. Clinical interactions are between two individuals who react to each other. That is, practitioner and client characteristics, such as gender and weight, influence how each interacts with the other. While the culture of medicine constructs the idea of abstract, value-free, neutral health professionals, this is not the reality. Privilege exists along several lines of identity in this society and affects clinical care. Several women mentioned that health professional's gender, weight and ethnicity affected the expectations they had on care from the professional. Some found they had more success with female health professionals or health care professionals with larger bodies; some were shocked when a female health professional was insensitive; and some were dismissive of judgmental or insensitive health professionals who had trained outside of Canada. The rationales varied, but included the ideas that women should know the pressures on other women to be thin, that health professionals who were of larger builds should know from their own experience how complex the variables affecting weight are, or that health professionals from other cultures may assume their own cultural beliefs are shared with their clients. Either way, one size does not fit all when it comes to health care delivery; the identities and personalities of those involved will impact on communication and dynamics in clinical practice. Hence, it is critical that health professionals understand what it is that they bring to clinical care, and to recognize that they need to be able to adjust their communicative approach to meet the needs of those seeking their assistance.

The second way in which these guidelines are 'one size fits all' is the absence of attention to the role of the social, cultural, and physical environments, and biological influences on health. She assumes that health care professionals know these. I do not believe that this is the case; there are still many examples of situations where health

professionals tend to blame people for not 'taking charge' of their health (as is noted in one of Stella's stories) and simply reiterate the same, vague information (as noted in one of Anne's stories). This is what I refer to as the 'individual responsibility for health' model, where individuals are removed from their social, physical and cultural environments and blamed for their problems. Minerva provided an example of this in her group education class with a nutritionist: the focus was not weight loss but healthy eating (i.e., the stated purpose was outside of the weight centred paradigm), but the presentation was such that the socio-economic and cultural influences on eating habits were ignored. This type of example (and there are many) leads me to question if this approach fleshes out the concerns about judgmental attitudes and balanced responsibility for health that are raised in the feminist literature and by the women I interviewed. Several women I spoke with encouraged health professionals to focus on changeable behaviours rather than weight, keeping in mind a balanced approach to health responsibility that recognizes the role of factors beyond individual control, such as socio-economic status, genetics and physical environments.

Another major concern about the culture of medicine that the women expressed to me concerns power and authority in clinical settings. Kratina recommends a style of clinical interaction that the women interviewed agree with: a style where the client prioritizes the issues in consultation and the role of the health professional is to provide constructive education and support, appropriate to the patient's learning and communication styles. From the way Kratina implies this in her article and the lack of links to relevant literature, she seems to assume that this approach can be taken up easily. This seems like an oversight to me; considering what the literature says about medical

practice and what the women I spoke with told me, not all health professionals have responsive communication skills and ethical/sensitive/evidence based approaches to care delivery. Two potential problems are embedded in this issue: professionals may not recognize power inequalities exist and impact care, or believe that the power differential is not problematic. Kratina does not highlight these potential sites of problems.

Manifestations of this concern are evident in the stories some women shared with me. In Anne's stories, one cardiologist steadfastly refused to answer her questions, a psychologist refused to explore an issue she raised, and she was never referred to an exercise specialist who could help her develop a sense of appropriate activity levels, though she has asked for this information from both her general practitioner and her cardiologists. Sally and Minerva both found themselves in situations where they were unimpressed with the quality of care they received but struggled to find another general practitioner due to staffing shortages. Melina's family physician dismissed many of her symptoms as a function of her weight without doing a complete physical examination. It was only with her insistence that she received adequate assessment and treatment. When physicians are the gatekeepers to the range of health services, they hold a substantial amount of power; this authority makes them more responsible from an ethical standpoint. This does not come through in Kratina's guidelines.

Some of the positive stories women shared with me highlight how power differentials can be addressed within a 'health at every size' model in clinical practice. Mae's general practitioner is conscious of her eating and activity patterns, lets Mae set the agenda for consultations and knows his limitations (and hence makes referrals when the problem is outside of his expertise). Melina's physical therapist performed a complete

orthopaedic examination and deduced that her knee pain was a result of a ligament tear, not her weight. This examination spurred a consultation with an orthopaedic surgeon. He acknowledged the role of weight in perpetuating joint pain, but did not emphasize weight loss as the primary treatment; instead he offered useful treatment options to improve her abilities that were specific to her activity patterns. Ruby, Melina, Sara, Ama and Anne have all met health professionals who resist using weight as the catch-all explanations for health problems. The common denominator in these positive stories is a health professional who uses power responsibly, in the best interests of their clients. While I believe Kratina's guidelines imply this, she does not spell this out. I believe an explanation is necessary for health professionals to consider if they are going to implement this approach to health care practice.

When authoritative use of power is combined with an 'individual responsibility for health' model, patients can feel judged and disempowered. The relationship exacerbates the imbalance, where the health professional has the power to label the problems patients encounter a result of personal failing. Consider Sara's experience, where a GP recommended weight loss: Sara challenged this recommendation, offering her known pattern of weight gain following loss. The physician dismissed her concern, stating it was all a question of willpower. These types of situations do not offer patients any potential solutions and risk making them feel worse about themselves.

In the interviews, a common thread that emerged was the issue of 'incomplete information'. This thread ties to the power/authority issue. If health is understood as an intangible continuum, then scientific measures provide only an incomplete picture. Measures do have their place; Stella, Alyssa and Ama all noted that measures beyond

weight have helped them develop a new understanding of the idea of 'healthy'. The issue at hand is over-reliance on numbers. Kratina offers a helpful suggestion of how to ask sensitive questions that will partially complete this incomplete picture. She suggests that health professionals create opportunities for people to ask for advice, rather than repeating the same information incessantly. This recommendation acknowledges that people often know what they need to know; it is the integration that is difficult. Integration is situation and person specific, and using a problem solving approach (that may integrate harm reduction strategies) is more helpful than repeating a mantra. Another piece of this relates to an idea that Ama touched on in our discussion: readiness to change. If a patient is not ready to acknowledge the problem or the potential change, a health professional may not be able to help much at that point. In this situation, the role of a health professional is to ensure that the patient knows why the issue is of relevance and where they can turn for more information or support if needed at some time in the future; in essence, that the patient is informed. While this suggestion is helpful, it will not assist health professionals in responding to the range of situations they may encounter, and does not acknowledge that health professionals will only ever have incomplete information about their patients. I would hope that health professionals who understand this will have a grasp on their role that is similar to the one that Kratina, I and the women interviewed all advocate for. A health professional who works knowingly with incomplete information will understand that there are limits to what they can identify, and that "the patient might know their body better than the doctor in some ways" (Anne).

Good intentions are important, but not enough. Even well-intentioned health professionals can practice in ways that are problematic. Sally mentioned how her physical

therapist incessantly encouraged her to be more active. While this therapist had her best interest at heart, these conversations were reduced to nagging for Sally and became annoying. Effective and responsive communication styles are not automatic for health professionals. Kratina does not broach this issue, and in this absence, the implication is that this is not a problem, that health professionals are merely misguided in their approach to weight. In addition, women who have internalized fear of fatness may have complicated responses to this model. In the survey, Ama mentioned how, as a woman with a history of anorexia, a health professional working within a 'health at every size' model would have 'freaked me out'; for her, fear of fatness still holds significant influence in her life. This response reminded me to proceed with caution when constructing recommendations, to not assume that all women would adjust easily to a discursive shift towards 'health at every size'.

Concerns that good intentions are useful but inadequate extends beyond communication styles; the concern extends to include dominant discourses. This is where I see the need for Kratina's model to expand. Inequality, prejudice and privilege are all normalized in dominant discourses and ideologies in North America, such that they become automatic: the dominant discourse suggests that people get what they deserve in life. This is where an examination of attitudes, biases and practices is indicated so that a health professional can be critical, looking for manifestation of harmful myths and discourses in clinical practice. Kratina notes weight bias/prejudice, but she does not acknowledge that clinical dynamics are affected by other biases.

In essence, Kratina's clinical practice guidelines for 'health at every size' address only part of the problem. She addresses weight centred paradigm practices well, but does

not acknowledge the role of the culture of medicine in perpetuating harmful ideas about health and health responsibility that are part of this problem.

In addition to these major concerns, I would recommend that Kratina make two minor revisions to her guidelines. She quickly mentions "...unrealistic, culturally imposed weight-related goals..." (p. 23) that patients may have, but does not suggest how to discern the impact of these influences on patient's body satisfaction. A simple question of what motivates eating and activity behaviours would get at this issue (or at least it did in my interviews), and create the opportunity to dispel weight and dieting myths. This issue fits with her first tenet of 'health at every size' and provides more background information (i.e., reduces the amount of 'incomplete information') for problem solving discussions. This suggestion was raised by many women: when entering into discussions about weight, a health professional needs to know both behavioural patterns *and* motivations for those patterns if they are to offer anything constructive. As Sally noted in the survey, Kratina writes from the perspective of the dominant culture, assuming certain constructions of healthy/ideal weight and food are held by all Canadians. It is crucial that sensitive practice guidelines be able to consider the impact of our varied socio-cultural environments on our experiences of health and weight.

Kratina could and should offer more encouragement to health professionals, acknowledging how influential weight prejudice and dieting myths are in our society, easily highlighted by many of their own experiences. She should stress that working in this model means working against the current (i.e., the dominant discourse), but that this approach is both more evidence based and more ethical. I also think that she should emphasize that some of these recommendations will take time to develop the skills to

implement; hence health professionals should not berate themselves when they fall into old patterns. As Code (1992) notes, developing the knowledge as well as the perceptive and cognitive capacities to provide sensitive care is not easy, but is the ethical responsibility of health care providers.

Changing the culture of medicine

Kratina's guidelines do not comprehensively address problems inherent in 'the culture of medicine'. This culture relies on specific ontological and epistemological assumptions. The positivist paradigm is dominant in Western societies and medicine at present. Changing the culture of medicine has to start at the level of challenging the epistemic principles medicine assumes in its practices. The epistemic principles in question include what is privileged as knowledge and who is a recognized 'knower'. Medicine constructs knowledge as that which has been developed within the rules and structure of positivism. Knowledge constructed in this manner assumes that all knowers can be substituted for another. Knowers are those who are 'objective', where the term reflects the ability to dissociate one's self from one's social location. While this knowledge includes experience in the form of empirical sensory observation, only those privileged as 'knowers' who present the information in a credible fashion will have their observations validated.

Related to the constructions of authoritative knowledge, knowers and objectivity are Cartesian dualities. These either/or constructs are evident in medicine in both obvious (e.g., healthy/ill) and less visible ways (particularly through stereotypes that produce discriminatory bias in scientific knowledge) (Code, 1992). That is to say that either/or

ways of understanding our world are entrenched in positivism and influence how questions are constructed, what can and cannot be questioned, and the methods chosen to examine the question and the analysis. This entrenched dualistic approach to knowledge, as an inherent part of the dominant paradigm, is normalized. At this time, to work outside of this model is to be accused of being 'ideological', 'subjective' and/or 'biased'. As noted in the literature (and in a less direct way, in the interviews), all knowledge is influenced by the subject's social location, culturally available social discourses, and as such, is ideological.

In contrast to the construction of the dominant paradigm, the interaction between the health care professional and the patient is between two socially located actors, both with some degree of agency. The knowledge applied in health care developed within a paradigm that relies on certain beliefs, assumptions and biases. Recognizing this within medical practice will be a fundamental shift, but one that is necessary for changing clinical health care into a version that will reflect the ethical obligations of medicine to 'above all, do no harm'. Clinical practice built upon an alternative epistemological and ontological foundation that recognizes social locations of both subject and object, the role of power in the clinical encounter and bias in knowledge would differ from that grounded in positivism.

The conceptualization of 'solidarity' by Stevens (1996) provides a vision for what health care would look like if this ontological and epistemological shift occurred in the culture of medicine. Stevens addresses the issues of power and authority in clinical health care in a fashion that complements Kratina's (2003) 'health at every size' model. Clinical practice that is modeled upon compassionate competence, empowering information

exchange and negotiated action allows women to make informed decisions appropriate for their lived realities (Stevens, 1996). Health professionals are respectful, sensitive, practical and knowledgeable, supporting patients in making these decisions. The role of the health professional is not to dictate action, but to help the woman problem-solve responses to her unique health situation. This relies on the health professional keeping both the best interests of her patient and an evidence-based approach to health in mind when discussing recommendations.

Perhaps it was beyond the scope of Kratina's article to raise all these issues, but at some point, a more comprehensive description is needed if we are to have the desired effect of spurring a paradigm shift in health care practices around weight and health. I have included the additions for any such comprehensive guidelines I see as indicated from the literature and the perspectives of the women I interviewed.

In the survey, women were asked to comment on an earlier draft of this chapter. They responded positively and constructively to my critiques and recommendations for women-centred, sensitive clinical practice, framed by the stories shared by the women I interviewed. For example, "I think your summary and critiques are bang on" (Stella). To the sixth survey question, which asked "do you think I'm missing something?", Ama replied "No - and in this piece you get to what I was talking about earlier". Constructive criticism included expanding the study to include health care providers (Alyssa), that while my critique was 'valid' my writing style was too academic and challenges to health care professionals were too revolutionary for presentation to health professionals (Sally), that I should consider the impact of the nation-wide shortage of GPs on clinical practice (Sally), that I need to be more explicit in making recommendations (Melina), that a more

varied sample, particularly with less educated women, might have resulted in very different stories of experience and resistance (Ama), and that any guidelines developed need to be situated temporally, open to re-evaluation (Ruby). The constructive criticisms offered by these women shape, partially, how I will present the sensitive practice guidelines to health professionals as well as the ideas I present for future research in my concluding chapter.

Presenting sensitive practice guidelines

Herein lies the crux of my project: to present an alternative for clinical health care that can address both issues of harmful weight-centred approaches and problematic elements of the culture of medicine. This constructed alternative for clinical practice is located historically and culturally. I have explicitly described the values, assumptions and foundational knowledge for these sensitive practice guidelines. In sum, I offer a situated, partial knowledge, located in a specific cultural and historical context.

Ultimately, this study is action oriented, and as such, needs to offer some concrete direction for clinicians. My initial plan to develop 'sensitive practice guidelines' has evolved, as I have come to recognize the epistemological problems with universalizing. However, I have not just developed these recommendations for clinical practice only from the experiential stories of fifteen women. This vision brings together core principles of medical ethics with empiricist and qualitative research that exemplify the problems inherent in current practices. These experiential stories illuminate that these problems still happen, the mechanisms through which they are practiced, and highlight how some clinicians structure practice to address the concerns about harmful weight-centred

approaches and oppressive expressions of power. What I will present in this section is an outline of how I will present these sensitive practice guidelines to clinicians. This section integrates my arguments and vision for clinical care with my thoughts about how to succinctly present sensitive practice guidelines about addressing weight related issues to clinicians.

Sensitive practice involves more than just addressing the assumptions that shape weight-prejudiced practice. At the core of sensitive practice in relation to any concern is the issue of power. To be comprehensive, any presentation of the sensitive practice guidelines has to review the concepts of power and social discourses. This includes a range of topics: how power is conceptualized; the relationship of power with knowledge (power/knowledge); how clinicians express power (including overt and covert expressions); how clients express power; and the responsibility of health care professionals to exercise power responsibly. If health professionals do not agree that they express power in the clinic and that how they do so can harm or promote their client's health, then it is unlikely they will concern themselves with 'sensitive practice' of any form. If health professionals agree that they have an ethical responsibility to use their power to the benefit of their clients, and can accept this broader construct of harm that I introduce, then the foundation will be stronger to introduce principles of sensitive practice.

I will focus on the idea of 'social discourse', explaining the concept and relating the concept back to power and health care practice. I will introduce the broader discourses that shape medical knowledge and practice including individual responsibility for health and the construction of 'health' as primarily physical, linking these to weight centred

discourse that associates moral qualities with body size and weight as well as food and exercise behaviours. I will exemplify how these types of discourses affect clinical care; that is, I will introduce the arguments of the decontextualization of clients from their lived environments and reductionistic tendencies of medicine. Examples will come from both the literature and the stories of the women interviewed in this study.

From this broad introduction, I will focus on the 'weight centred paradigm', outlining how this paradigm has evolved, what it assumes (that is, weight and dieting myths), the problems and implications of those assumptions (that is, the harmful effects of the assumptions), and how this paradigm shapes dominant social discourses. In essence, I will tie dominant medical discourse about weight with our culture, highlighting how we use 'weight centred' discourse to make sense of our own experiences. The stories will help frame this part of the presentation well.

What makes these guidelines difficult is that they require health care professionals to be very introspective, likely challenging some very deeply held assumptions and beliefs about health and weight. Those who are already cognizant of these issues may not find this process that challenging. For others, this may challenge the foundation of their knowledge and/or touch on very personal body dissatisfaction/weight preoccupation issues, making this introspection very difficult. What the guidelines are meant to do is provide a tool by which each health professional can examine their own clinical practices.

I anticipate a more receptive audience if the guidelines can be very specific. That is possible to a point, though some of the larger concerns of reductionism and medicalization are not easily reduced to a simple 'do' or 'do not'. While I offer the

following list of 'health at every size' practice guidelines, many of these ideas inter-relate and depend on each other.

1) *Examine the evidence cautiously*¹¹. Harmful beliefs about weight and individual responsibility have not been supported by scientific evidence. The 'evidence' also articulates just how common weight preoccupation and body dissatisfaction are for girls and women in Canadian society. It is your responsibility, as a health care professional, to keep these issues in mind when working with clients. The responsibility is yours to know the uses and limitations of your clinical assessment tools as well as the efficacy and risks of recommended treatments – that is, to know the 'evidence'. The implications for sensitive clinical practice are far-reaching including such concrete tasks such as changing understandings and use of 'body mass index', discouraging periodic dietary restriction weight control methods (which are known to cause long term weight gain), and not relying on body weight as a clinical decision making tool. Related to this is the question about whether or not measuring weight should be a regular practice (Doutekis, Feightner, Attia & Feldman, 1999). Other measures of 'metabolic fitness' (such as cholesterol, triglyceride, glucose and insulin levels, blood pressure, resting metabolic rate as described by Kratina, 2003) are much more reliable and specific than weight.

2) *Understand that all clients do not have equal agency*. Socio-cultural and physical environments influence your clients and can constrain their choices. There is a significant body of literature that demonstrates the deleterious effects of poverty on health through a

¹¹ I use the term 'evidence' cognizant of my earlier critiques of the concept. I use it in the sensitive practice guidelines to help capture the attention of the health care professionals.

variety of mechanisms. We cannot assume that our clients all have the same resources. Simple infrastructure, such as access to grocery stores and walking trails, and certain economic resources, such as the finances to purchase supportive walking shoes, cannot be assumed. It is not usually an issue of laziness, ignorance or stupidity when clients do not follow all our recommendations, though this is what the weight centred paradigm purports. When we place the responsibility on individuals to behave certain ways, and judge them when they do not conform, we risk alienating and disempowering our clients. This can affect how they access care in the future.

3) *Understand that your cultural environments influence your clinical practices. Hence, examine your own beliefs about weight and food.* It is illogical to fail to acknowledge that we are each influenced by the physical, economic and socio-cultural structures in which we live. We live in the same societies as our clients. We are influenced by many of the same cultural discourses as our clients, and as such, may have to deal with our own body satisfaction issues. If you find yourself using the moral language of 'should' or 'should not' in relation to food or activity in either your own life or your clinical practice, you need to take a step back and reflect on this. There are many good resources to help you do this. Robison (2001) offers an online self-behavioural assessment. Eating disorders organizations often have multiple resources; for example, the National Eating Disorders Information Centre highly recommends health professionals read Goodman's (1995) *The Invisible Woman: Confronting Weight Prejudice in America* in addition to several self-help books that deal with body satisfaction and weight preoccupation specifically.

4) *Take a thorough weight history before making weight-related recommendations.* That is, develop contextualized understandings of your clients. Accepting the ‘health at every size’ paradigm does not mean that weight should never be discussed with clients. Weight is a topic that will invariably enter into discussions. For example, clients may come to you with questions about ‘healthy’ weight ranges or weight loss support. This can be an opportunity to examine their beliefs about weight and gather information about their patterns and motivations. Knowing more about what motivates a client to behave in certain ways can help you gain insight into what may be significant body dissatisfaction or weight preoccupation. Having this information helps you provide very specific and supportive information appropriate for that individual.

5) *Be conscious of the set-up of your clinical environment.* The National Association to Advance Fat Acceptance (2004) offers specific physical environmental recommendations: 1) ensure you have the range of blood pressure cuff sizes available, as using small cuffs on larger people causes false readings; 2) have longer needles and tourniquets available; 3) have large size gowns available; 4) toilets should have a split in the front, and urine specimen cup holders with handles are helpful; 5) have several sturdy, firm, armless and tall chairs in your waiting room and office with good space between them; and 6) ensure examining tables are wide and secure. On this last note, it is important to note that many examining tables have weight limits around 300 pounds; every clinic must have at least one examination table that has a higher weight capacity.

6) *Never use weight as a causal explanation without doing a proper differential diagnosis process.* This is a typical expression of weight prejudice, and obviously still in practice according to the range of stories in this study. Body weight may be a factor in the cause or perpetuation of a problem, but is rarely the sole cause. Related to this problem of recommending weight loss is the one consistent result of decades of research on long-term weight loss: we do not know of effective, safe and sustainable weight loss methods.

7) *Be language conscious.* As reviewed earlier, it is through language that we can reproduce or challenge harmful dominant weight discourses. Contentious terms like ‘overweight’ and ‘obese’ are loaded terms in a fat phobic society, ones that have been defined by a measure (BMI) that is not reliable when applied at the level of individuals. When we talk with our clients about eating or activity, we must recognize the contemporary cultural moral associations projected onto food, exercise and body size. Through choice of language, we can begin to challenge these ideas.

8) *Promote nutritious eating and regular activity for reasons other than weight control.* We know that nutritious, balanced eating and regular activity have enormous health benefits. But we also know that issues of accessibility and enjoyment have an enormous impact on our behaviours as well. With that in mind, we can recommend people take time to ‘play’ more as well as eat nutritiously and with enjoyment. But one has to keep in mind an earlier principle: our clients often have limitations to their ability to follow all our recommendations

9) *Recognize your role as well as your limitations.* People come to you because they have specific concerns or questions. Your role is to assess those concerns, offer referral or treatment, and support the client in making informed choices. Clients will not/cannot always follow all our recommendations, for a range of reasons. If health professionals do their job well, clients know what health care supports are available. Judging a client for failing to follow recommendations (i.e. labelling them 'non-compliant') fails to acknowledge that the actions and decisions of our clients are influenced by multiple factors.

10) *Believe that knowledge does not equal behaviour change.* If you find yourself sounding like a broken record with a client, it may be that you are assuming that she just needs more information. People often know the information but may be unable or uninterested in implementing the behaviour change. Often our role is to problem-solve with our clients, but ultimately, it is their decision to make.

11) *Resist the temptation to believe that people should pursue 'good health' at all costs, where this idea is tied to the idea that healthiness is the ends rather than the means.* As was clear in the interviews, health encompasses far more than being physically fit. With the prevalence of chronic illness in this society, 'healthy' cannot be understood as 'disease free'. Being healthy is much more than this idea, and as such, our role is to help each client realize her own contextualized ideal of health.

12) *Work within your expertise.* This seems like a self-explanatory statement, but the stories and the literature are rife with examples where health professionals overstep their boundaries. Sara's example of the psychiatrist that told her to make sure she 'shits more than she eats' is a perfect example of this. Anne's cardiologist is not an exercise specialist, but never offered to send her to a cardiac physical therapist that could help her. When you are unable to either answer a question with specifics or to take the time to talk with the client, refer them to someone who can or do your research before making recommendations.

13) *Develop a range of communication styles.* Our clients have a range of communication styles; our ability to work with them depends on our ability to engage in meaningful dialogue with them. Health professions programs all have educational resources specific to this.

14) *Acknowledge that medical knowledge discredits certain experiences as important to health.* Medical knowledge is constantly changing, and as such, we can never assume that we 'know' every sign and symptom that is clinically relevant to a person's health. If we are unable to explain a symptom or a sign, it is irresponsible of us to dismiss it as irrelevant. [I will exemplify this idea through an illustration that is relevant to the particular group of professionals].

When I present these to health professionals, I will conclude with several ideas. I will acknowledge that what I propose 'feels' political or explicitly value-driven, but will

review how all medical knowledge and practices are political and value-driven. What this model for sensitive practice proposes is a paradigm where the assumptions and values are visible. I will discuss how those who dismiss this idea of sensitive practice reject our ethical responsibility to 'above all, do no harm' and will ultimately contribute to the reproduction of harmful social discourses. This process of both introspection and integration is not necessarily easy, but is essential if we are to practice in non-discriminatory and health promoting ways. Awareness is the first step, and while it may overwhelm some, being aware of the problem and how it influences clinical practices is critical. Gaining this awareness is the necessary step so that we can begin to change clinical practice, and hence, health professionals need to congratulate themselves for getting this far and use this awareness as a tool for change.

I acknowledge that these recommendations may not explicitly cover every topic of this thesis in detail. Issues of power expression in clinical care are more implicit than explicit in these weight sensitive practice guidelines, but inform many of the recommendations. Likewise, the issue of self-surveillance is not addressed in any direct manner. I believe that issues of self-surveillance are foundational for several of the guidelines, particularly practicing in a manner that recognizes how influences beyond our control affect our behaviours.

Conclusion

While changing the approach of clinical health professionals is only one step in changing the culture that fuels body dissatisfaction and weight preoccupation, it is a significant one considering the influence that medicine has on our society at this point in

time. Health professionals hold a significant amount of power and authority in influencing how we understand our health and our bodies. If health professionals develop a 'health at every size' discourse to challenge the dominant weight centred one, this alternative will gain strength and help displace health-deteriorating dieting and weight myths held in our society.

A critical question remains: how do we stimulate this paradigmatic shift? It is much easier to call for the shift than to make it happen. A comprehensive platform reflecting the range of concerns are necessary to start rebuilding clinical practice into a form that supports women's health in general and in relation to weight issues specifically. This platform will need the support of a broad range of actors for implementation. It is important that research be done with other groups of people, to see the patterns of agreement and potential gaps in this platform. That is, I agree with Harding (1991) that the search for patterns and common threads with ongoing negotiations of disagreement from many standpoints will be necessary to build consensus.

Implementation will be a political process, as many powerful interests (the dieting, pharmaceutical and fitness industries for starters) have a lot invested in the weight centred paradigm. To be successful, this process will need to include a range of involved parties, from health activists, social scientists, weight researchers and specialists, health professions educational programmes, continuing education systems, and licensing and governmental bodies. A secondary consideration for guideline implementation is educational approach. It is beyond the scope of my thesis and outside of my expertise to explore the range of educational possibilities and approaches, but implementation must involve some creative and determined approaches to education of health professionals, for

those in training and already practicing. Constant pressure from health activists at several points on the system is a method we can employ to stimulate change in the medical professions.

Chapter 5: Conclusion

Through this thesis project, I have developed a comprehensive set of sensitive practice guidelines for health professionals discussing weight, eating and exercise with women. Feminist critiques and visions for medical culture, deconstruction of the weight-centred paradigm in medical knowledge and practice, and examinations of women's body dissatisfaction and weight preoccupation in Western societies shape these guidelines. These guidelines offer health professionals practical strategies to engage in weight, food and eating related discussions with those seeking their care.

The underlying assumptions of this thesis have influenced the entire process. I argue that medical knowledge, the foundation of clinical care, is powerful in shaping our understandings of our bodies and our health. I build upon Foucault's theory about power/knowledge to describe the 'culture of medicine'. In particular, I agree that power is reproduced through local practices, of which medical clinical care is but one example. Dividing practices, systems of classification, self-surveillance and subjectification are strategies of power described by Foucault that have specific relevance to my description of the 'culture of medicine', as well as relevance for how I envision change. Changes in the language and clinical practices of health professionals can foster change in how we, within this society, understand our bodies, our weight and our health.

I assume that the medical system can change, but that changing weight-centred practice involves more than mechanistic changes in clinical care. That is, changing weight-centred medical practice involves a fundamental shift in how health professionals understand health, responsibility for health, their role in supporting behaviour change, their role in changing dominant discourses about health and weight, and understanding

the limitations of positivist approaches to medical knowledge. Founded in the ethical principle of non-maleficence, I argue that health professionals can cause harm by producing and reproducing dominant discourses about weight and health. This foundation then lends itself to envisioning clinical care that does not reinforce health-deteriorating discourses that equate 'thin' with 'good' and 'fat' with 'bad'. I argue that health care professionals cannot place the onus of responsibility for health on the client alone, but must contextualize each person in the socio-cultural, economic and political influences that shape and constrain her choices. While this is only one discourse, it is integrated with and influences many other health and weight discourses. In essence, the social change needed to reduce women's experiences of weight preoccupation and body dissatisfaction is possible if health professionals both accept their responsibility for producing/reproducing health and weight discourses and will actively work against certain harmful dominant discourses in their own clinical practice.

Epistemologically, I assume that we cannot talk of "Truth" that holds across all cultures and times, but that we can create knowledges that are located in specific historical and cultural contexts. This rejection of the belief that there is one pure reality, independent of the human mind, is consistent with social constructionist approaches to knowledge, where no concept is 'sacred'. This critique extends to the positivistic construct of 'value-free objectivity' that is impossible to practice, yet upheld, absolving the knower of responsibility for the knowledge produced. Instead, I recognize that the values upon which we develop knowledge shape the outcome. Hence, it is critical that the values shaping knowledge are explicit. Finally, I build upon the ideas of many feminists who reject positivism's false division between the subject and object, and have

approached this work explicitly recognizing my role in shaping both the interviews and the written product.

Building upon this foundation, I spoke with fifteen Canadian women about their experiences when dealing with health professionals about weight related issues. These conversations highlight the ongoing pervasiveness of weight-centred discourses, attitudes and practices among health professionals, while offering possibilities for change. My assumptions outlined above influenced how I interpreted the transcripts of these interviews, where I looked at both the illustrations of weight-centred and 'health at every size' clinical care and the discursive/linguistic strategies through which each woman communicated her interpretations. This approach to analysis does not privilege 'first person voice', but recognizes that we communicate meanings through linguistic patterns and culturally available discourses. This type of analysis, particularly with this group of critical/feminist women who self-selected to participate in this study, was able to highlight just how pervasive dominant weight-centred discourse remains in shaping how we make sense of our own experiences. The dominant discourses about health and weight circulating in our society at this time work against understandings that our health is shaped by a range of factors, most of which are not captured by measures such as weight or calories.

This analysis highlights how women have agency, but that some strategies of resistance are more successful than others in accessing medical care. Regardless, I place significant responsibility for change on health professionals as a function of both their authority in influencing our beliefs about weight and health as well as their own ethical

commitments. It is this responsibility, combined with current weight-centred clinical practices that suggest the need for the reconfiguration of health care.

Other authors have attempted to develop approaches for practice informed by 'health at every size' assumptions (Kratina, 2003 being the most comprehensive). I argue that these approaches are incomplete, making too many assumptions about the communicative abilities of health care professionals and not challenging the culture of medicine. I propose an alternative comprehensive model, moving the discussion of both the strategies and the implications of implementing a 'health at every size' model of practice beyond what has been previously constructed by Kratina (2003). What is unique about my proposed sensitive practice guidelines is my integration of critiques of the broader medical culture with specific concerns about weight-centred practice.

The sensitive practice guidelines developed in this thesis are not universal or static. This proposed model for practice is a 'situated knowledge', positioned within specific historical and socio-cultural locations. Hence, I do not believe this set of guidelines is in a 'finalized' format; I do not know if it is possible to offer a final version when medical knowledge and practices continue to change. These guidelines offer health professionals a model through which to examine their own practice routines, focusing on issues of dominant health and weight discourses as well as the implications of strategies of power exercised in clinical care. That is, this analysis ties together contemporary critiques of the culture of medicine with specific concerns about the weight-centred paradigm.

The sensitive practice guidelines I propose here provide an alternative vision for clinical care. There are some obvious extensions of this work that are important for

dissemination and integration of this proposed alternative into clinical practice. I believe it would be valuable to discuss this model with health professionals, to listen to the concerns they may have about this model and further develop the sensitive practice guidelines to address these concerns pre-emptively. That is, I believe it would be helpful to discern what health professionals accept or problematize about the approach in order to be able to ensure that the model is sufficiently explained and critiques addressed. Knowing specific points of resistance would enable the 'health at every size' theorists to be strategic about their approaches. Related to this, a critical exploration with health professionals that examines the clinical decision-making process about offering referrals and treatments for patients might highlight weight prejudice more clearly. This extension will strengthen the presentation of sensitive practice guidelines.

A second extension of this study would examine successful models of adult education. It likely will not matter how sound the model is if we do not also present it effectively to health professionals. Knowing what does shift the practices of health professionals in a long-term fashion is critical to success of fostering change. Collaborative work with researchers well versed in medical education would be extremely helpful to the implementation of this model.

Once the model has been disseminated effectively, it would be useful to evaluate both the integration into clinical practice and the effects of having a 'health at every size' practitioner as a caregiver. This would involve examining what the health professional changes and how they interpret these changes on their clinical practice. Through this, cues will be available about future supports needed to enhance the 'health at every size' approach to clinical care. Kratina (2003, 2004) notes that resistance to this model sounds

like ‘the health at every size model to clinical care gives everyone permission to be fat’. Examining the health impacts of having a ‘health at every size’ approach at both the individual level and within populations would be able to address these fears. I conceptualize this as an enormous task that would involve quantitative and qualitative work.

Finally, as a situated knowledge, it will be important to re-examine this model over time, ensuring that it remains relevant and continues to reflect contemporary concerns. I cannot offer an exact timeline for such a project, but suggest that those of us in this field will need to remain cognizant of shifts in weight prejudice, as these shifts may indicate times when we need to re-examine our focus.

This proactive approach to primary prevention of weight preoccupation and body dissatisfaction will not alone shift our weight-prejudiced culture. However, medical practice, with the authority it holds in shaping culturally available discourses about health and weight, should be considered a critical entry point to changing dominant weight and health discourses that fuel moral judgments about individuals based on their weight. This women-centred, proactive primary prevention approach holds health professionals accountable to their ethical credo to ‘above all, do no harm’.

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Appendix A: DSM IV Criteria for Eating Disorders¹²

Anorexia Nervosa

- The patient will not maintain a minimum body weight (for example, 85% of expected weight for height and age).
- Despite being underweight, the patient intensely fears becoming fat.
- Self-perception of the body is abnormal, shown by at least 1 of:
 - Unduly emphasizes weight or shape in self-evaluation
 - Denies seriousness of low weight
 - Has a distorted perception of own body shape or weight
- Due to weight loss, a female patient has missed at least 3 consecutive periods (or periods occur only when she is given hormones).

Specify whether:

Binge-Eating/Purging Type. During an anorectic episode, the patient often purges (vomits, uses laxatives or diuretics) or eats in binges.

Restricting Type. No bingeing or purging during an anorectic episode. This is the more usual type.

Bulimia Nervosa

- The patient repeatedly eats in binges. In a binge episode the patient has *both* of:
 - Consumes much more food than most people would in similar circumstances and in a similar period of time
 - Feels that the eating is out of control
- The patient repeatedly controls weight gain by inappropriate means such as: fasting, self-induced vomiting, excessive exercise or abuse of laxatives, diuretics or other drugs.
- On average, *both* of the above behaviors (binge eating and inappropriate control) have occurred at least twice a week for at least 3 consecutive months.
- Weight and body shape unduly affect the patient's self-evaluation.
- These symptoms do not occur solely during episodes of Anorexia Nervosa.

Specify whether:

Purging type: The patient often induces vomiting or misuses diuretics or laxatives. This is the more common type.

Nonpurging type: The patient fasts or exercises excessively but does not often induce vomiting or misuse diuretics or laxatives. (Morrison, 2003)

¹² This entire page is quoted directly from Morrison (2003). It has not been formatted APA 'long quotation' style due to its content.

Appendix B: Individual Interview Guide

Section 1 – Contact with Health Professionals

1. What type of health care practitioners have you had contact with over the years (ex/ family physicians, medical specialists, dieticians, social workers, psychologists, physical and occupational therapists, complementary health care providers)?
2. Do you have regular contact with some or all of these types of professionals? How often, on average do you see them?
3. Do you have any health problems that you understand to be affected by your food intake or exercise? (e.g./ diabetes, high blood pressure, ulcers)?
4. Which of these have you had conversations about your weight or eating/exercise habits with any of these practitioners?

Section 2 - Discussions of weight, shape, or size with practitioners.

Often women have conversations with health care professionals about their body weight, eating and exercise habits. Let me provide you two of my own examples to illustrate:

- 1) The first time I met a physician, she looked at me and said, very matter-of-factly, “I don’t want you putting on any more weight. You’re the high end of normal.”

This bothered me because I had been the same weight for a long time, which was within the ‘healthy’ range and because she did not consider my dietary or exercise habits in such a statement.
- 2) Another family physician I’d seen periodically for a long time noticed that over one year, I had lost 10 pounds. In a calm voice she said “I’m comfortable with your weight right now, but if you lose any more, you will be underweight, and I

will discuss this with you further.” I was comfortable with her approach because it communicated her awareness of the change without making any accusations.

You already mentioned to me that you’ve had at least one conversation with a health professional about your body weight, eating and exercise habits. I wondered if you could share your story/stories.

Probes for each story:

1. Who initiated this discussion?
2. When was this discussion?
3. What actually happened?
 - Were you weighed?
 - Was a diet recommended? What type, and for what reason?
 - Were you offered diet pills?
 - Did the health care practitioner ask about your eating or exercise habits? If so, were these taken into account in the conversation?
 - Do you remember the health professional mentioning if you were or were not of ‘normal’ weight?
4. How did you feel about this at the time?
5. *If it was a negative experience:* did you give feedback to the practitioner?
6. *If yes:* how was it received? *If no:* why not?
7. How do you feel about it now? *If different:* why do you think this has changed?
8. Why do you think you remember this experience?
9. What made this experience positive/negative for you?

10. *If negative:* in your opinion, how could the health care practitioner have changed their approach to make this conversation less negative for you?

11. Can you remember any other similar experiences? [*If so, explore each story with above listed probes as needed.*]

Section 3 – Impact on personal wellbeing and access to services and alternatives

1. What sort of impact, if any, has this had on how you access health care providers? *For those with negative experiences:* did you ever go back to this same health professional?

What influenced that decision?

2. Do you remember if this/these experience(s) had an impact on how you feel about your body? In what way?

3. Other than specific one-on-one exchanges with health care providers, does anything else about accessing mainstream health care affect how you feel about your body?

4. In what way?

5. *For negatives:* In your opinion, how could this be changed to be more positive?

6. What are your opinions on dieting? On exercise?

7. What are your typical eating and activity patterns? What motivates you to keep up these patterns? [probes: health reasons, weight control, appearance]

8. Do you feel that you are in good health?

Section 4 – Socio-demographic and other background information

1. Age

2. Ethnic/racial identity

3. Socioeconomic status – present and past
4. Dis/ability status
5. Educational attainment
6. Marital and parental status
7. Sexual orientation
8. Religious affiliation

Inform participant of her option to review/revise transcripts and of future invitation to focus group. Ask participant to choose pseudonym.

Appendix C: Survey Questions

Women-Centred Sensitive Practice Guidelines for Weight Issues: A Proactive Primary Prevention Approach

Research pseudonym: _____

Date: _____

*****Please add as much space as you need to answer each question*****

Please read the stories of the women I spoke with.

1. What is striking to you in these stories?
2. What themes or common threads do you see in these stories?

Please read the article “Health at every size: clinical applications”.

3. In relation to your own experiences, do you think your concerns would be addressed if the health care practitioner(s) had followed these guidelines?
4. In light of all the stories, what do you think of these guidelines?
5. What do you see as strengths of her guidelines?
6. What are the limitations/problems you see with these guidelines?

Please read my ‘Thoughts on the article’ document.

5. What are your reactions to my summary and critiques?
6. Do you think I’m missing something?
7. Do you have any concerns with how I’ve represented you in what you’ve read?

General comments:

Appendix D: Recruitment Letter and Poster

March 16, 2004

To Whom in May Concern,

I am a Master of Arts student in Women's Studies in the Tri-University Programme in Halifax. As part of my degree, I am conducting a study entitled 'Women-Centred Sensitive Practice Guidelines for Weight Issues: A Proactive Primary Prevention Approach'. The purpose of this research is to develop sensitive practice guidelines for health professionals to consider when discussing weight issues with women. My hope is that this research alerts clinicians in a variety of fields to the experiences of body dissatisfaction and weight preoccupation for many Canadian women, the negative effects of these issues, and spur reflection on how health clinicians can structure their practices to ensure that conversations about weight, exercise and food address issues do not worsen their client's experiences of body dissatisfaction or weight preoccupation.

I am currently recruiting women to interview for this study. I hope to talk to a variety of women, including those of who do not feel that they are affected by body dissatisfaction, those with chronic health conditions affected by diet and activity, and those with eating problems and/or weight concerns. I am particularly interested in those women who felt like that conversation had, or had the potential to have, a particularly positive or negative impact on her. In this tape recorded interview, we will discuss both my and her experiences in these situations, what we felt made the conversation positive or negative, and brainstorm about how these discussions could be approached in ways that are more sensitive and constructive. After the interviews are completed, these women will be invited to critique my analysis of their experiences and my ideas of how clinical practices can be structured to be more women-centred and health enhancing.

This research study has received approval by the Mount Saint Vincent University Research Ethics Board. Confidentiality will be respected.

If you would like to discuss this project in more detail or are interested in being interviewed, please feel free to contact me directly at

Thank you!

Sincerely,

Patty Thille, B.Sc.(P.T.), B.A. (WGSt.), M.A. Candidate (W.St.)

Have you had a conversation with a health professional about your eating or exercise habits, body weight or size?

Did it affect you how you feel about your body or your weight?

*If you answered yes and are willing to talk about this experience,
I would love to talk with you.*

I am a Master of Arts student in Women's Studies in Halifax, and hope to interview women about their experiences with health care providers. Your input will be valuable in helping build recommendations to make weight discussions more women-friendly.

All information provided will be kept confidential.

For more information, please contact:

Patty Thille

Appendix E: Consent Form¹³

Individual Interview Consent Form

You are invited to participate in this research project entitled “Women-Centred Sensitive Practice Guidelines for Weight Issues: A Proactive Primary Prevention Approach”. Please read the following information that explains the project and if you would like to participate, sign at the end of this form. This project is part of the principal researcher’s Master’s of Arts in Women’s Studies.

Purpose of the Study:

Individual interviews, followed by a focus group will be used to gather stories of women’s experiences of conversations with health care practitioners regarding body weight. The study will explore how these conversations affected women’s sense of satisfaction with their body, preoccupation with their weight and access to health care services. The researcher will not seek names of health care providers in the community.

You can participate in this study through an interview, and if you are willing, a group discussion at a later time led by the principal researcher. The individual interview will be arranged at your convenience, and might last approximately one to one and a half hours. With your permission, the interview will be audio-taped and then made into a written record. This written record will not include your name or any other information that identifies you. You will be asked to review this written record, and if you so choose, make changes. The audio-recording and written transcript of this interview will be locked away, available only to the principal researcher and her supervisor. Both the audio and written record of this interview will be destroyed five years after the completion of the principal researcher’s thesis.

Principal Researcher:

Patricia Thille, M.A. Candidate _____
Women’s Studies, Mount Saint Vincent University, Halifax, N.S. B3M 2J6

Research Supervisor:

Dr. Catrina Brown, PhD _____
Maritime School of Social Work, Dalhousie University
6414 Coburg Rd, Halifax, N.S. B3H 3J5
(902) 494 7150
cgbrown@dal.ca

¹³ Please note that this content was photocopied onto MSVU Women’s Studies letterhead.

I understand that:

- all information I provide will be kept confidential by the researcher and supervisor
- the interview will be audio-taped, but my name or voice will not be used in any discussions or publications of the research
- I can choose to not answer particular questions
- my participation in this study is voluntary, and I can withdraw at any time without penalty
- a potential benefit for me as a participant in this project is it may increase my awareness of factors that influence my satisfaction with my body.
- the only potential risk for me is that I may experience some emotional stress from discussing my experiences of conversations with health care practitioners
- if I have concerns or questions about the conduct of this research project, I can contact the Chair of the Mount Saint Vincent University Research Ethics Board, Dr. Stephen Perrott at:

Research Office, Mount Saint Vincent University Halifax, NS B3M 2J6

TEL:

stephen.perrott@msvu.ca

I have read and understood the information given to me about the research project. I have been provided with enough information to make a decision as to whether or not I would like to participate in the interview. I am willing to participate.

Name: _____ Date: _____

Signature: _____

Appendix F: Coding Categories

Coding Tree 1: Literal codes

Personal weight beliefs

Clarifying concepts

Diet vs. dieting

Ideal/normal/perfect body

Perfect/good health, being 'healthy'

Impact of stories on health care

Choice of practitioners

Formal complaints

Changing communication styles

Getting second opinions

Avoidance of care

Eating/Food

Beliefs

Habits

Motivations

Fad diets

Exercise

Beliefs

Habits

Motivations

Eating Problems

Beliefs

Types

Prevention

Recovery

Resistance to health care practitioners

Direct

Indirect

Why or why not?

Coding Tree 2: Analytic codes

Dominant discourse: Health

- Healthy/ill dichotomy
- Physical as health
- Physical > and/or unaffected by mental, emotional, social (ie, biological primacy)
- Individual responsibility for health
- Health is within individual control

Dominant Discourse: Weight Centred paradigm:

- Thin is healthy, fat is unhealthy
- Thin is good, in control, willpower
- Fat is bad, out of control, lack of willpower
- Weight loss is always good
- People who are fat overeat, are lazy or stupid
- Weight loss is good for your health
- Dieting is an effective weight control strategy
- The physical body is infinitely malleable
- Only young women weight dissatisfied/preoccupied

Morality and:

- Food
- Exercise
- Weight

Implications of dominant weight and health discourse on medical practice:

- Quantification – snapshots with BMI
- Surveillance
- Food and exercise as the means to control weight (ie, eat less, exercise more)
- Morality associated with personal behaviours
- Weight loss as only or primary goal, focus

Critiques of dominant medical culture (beyond those evident in above categories):

- Medicalization
- Decontextualization (of person from family, community, culture, social/political systems)
- Lack of assumed/purported objectivity
- Working out of scope
- Sterile environments
- Assuming all health complaints caused by fat

Ethical responsibilities of health care professionals:

- Non-judgemental
- Above all, do no harm
 - reconceptualizing harm beyond physical
- Treat the person, not the weight

Recognize that, as a result of medical dominance culturally, we trust their statements

Alternative discourses (Health at every size):

- Health as a continuum

- Whole person

- Context matters

- Fat can be healthy

- Socio-cultural responsibility

- Environmental factors

- Genetic factors

Weight prejudice

- Of health care professionals

- Of society

- Of interviewees

Practitioner characteristics

- Gender

- Ethnicity/country of training

Contributors to harmful weight discourses

- Family/peers

- Institutions

- Media/business

Suggestions of (+) strategies for health care professionals